GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

H **3**

HOUSE BILL 681
Committee Substitute Favorable 6/29/89
Committee Substitute #2 Favorable 8/3/89

Short Title: HMO Solvency/Premium Tax. (Public)

Sponsors:

Referred to:

March 16, 1989

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE SOLVENCY PROTECTION OF HEALTH MAINTENANCE ORGANIZATIONS; TO PROVIDE FOR MORE PROTECTION OF HMO ENROLLEES; TO PROVIDE FOR A FRANCHISE OR PRIVILEGE TAX ON HMOs; AND TO CREATE AND MAINTAIN A FUND TO PAY FOR THE COSTS OF SUPERVISING, REHABILITATING, CONSERVING, OR LIQUIDATING IMPAIRED HMOs.

The General Assembly of North Carolina enacts:

Section 1. The General Assembly finds and declares that:

(1) Health maintenance organizations (HMOs) provide one of the more promising means of providing health care benefits to the citizens of North Carolina.

(2) Previous North Carolina General Statutes set minimal solvency requirements to encourage the growth of HMOs.

(3) The expenses of HMOs and health care costs have grown to the point that minimal solvency requirements are no longer prudent public policy.

(4) One-fourth of the HMOs licensed in North Carolina have become insolvent, thereby adversely affecting over 60,000 North Carolinians; and more mergers and further thinning of the HMO market are anticipated.

(5) For over 12 years HMOs have been regulated without contributing to the cost of such regulation.
(6) The regulatory oversight of HMOs has become increasingly more involved and time consuming for the Department of Insurance.
(7) All other forms of State-regulated health care benefits coverage pay a tax into the General Fund, a portion of which is used to support the cost of regulation.
(8) For every person who transfers from a regulated, taxed insurance plan to an HMO, the State suffers a tax revenue loss.
(9) The General Assembly believes that similar and interchangeable regulated insurance products should be taxed as equally and equitably as possible to offset the cost of regulation.

Sec. 2. G.S. 57B-2 is amended by adding new subsections to read:

"(k) 'Subscriber' means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the HMO; or in the case of an individual contract, the person in whose name the contract is issued.

(l) 'Participating provider' means a provider who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the HMO, other than copayment or deductible.

(m) 'Insolvent' or 'insolvency' means that the HMO has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(n) 'Carrier' means an HMO, an insurer, a nonprofit hospital or medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

(o) 'Discontinuance' means the termination of the contract between the group contract holder and an HMO due to the insolvency of the HMO and does not mean the termination of any agreement between any individual enrollee and the HMO.

(p) 'Uncovered expenditures' means the amounts owed or paid to any provider who provides health care services to an enrollee and where such amount owed or paid is (i) not made pursuant to a written contract that contains the 'hold harmless' provisions defined in G.S. 57B-15.3; or (ii) not guaranteed or insured by a guaranteeing organization or insurer under the terms of a written guarantee or insurance policy that has been determined to be acceptable to the Commissioner. 'Uncovered expenditures' includes amounts owed or paid to providers directly from the HMO as well as payments made by a medical group, independent practice association, or any other similar organization to reimburse providers for services rendered to an enrollee."

Sec. 3. G.S. 57B-2(f) reads as rewritten:

"(f) 'Health maintenance organization' or 'HMO' means any person that undertakes to provide or arrange for ~~one or more health care plans~~ the delivery of basic health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles. For the purposes of 11 U.S.C. §109(b)(2) and (d), an HMO is a domestic insurance company."

Sec. 4. G.S. 57B-3(a) reads as rewritten:

"(a) Notwithstanding any law of this State to the contrary, any person may apply to the Commissioner for ~~and obtain~~ a certificate of authority to establish and operate a health maintenance organization in compliance with this Chapter. No person shall establish or operate a health maintenance organization in this State, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this Chapter. A foreign corporation may qualify under this Chapter, subject to its full compliance with Article 17 of General Statute Chapter 58."

Sec. 5. G.S. 57B-3(c)(4) reads as rewritten:

"(4) A copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in ~~paragraph (3)~~ subdivision (3) of this subsection and the ~~applicant~~HMO;".

Sec. 6. G.S. 57B-3(c)(9) reads as rewritten:

"(9) A financial feasibility plan, which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or a recognized actuarial consultant, a projection of balance sheets, cash flow statements, showing any capital expenditures, purchase and sale of investments and deposits with the State, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year; ~~A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated,~~ and a statement as to the sources of working capital as well as any other sources of ~~funding.~~ funding; ~~The three-year projection shall be prepared by the applicant's staff actuary or by a recognized actuarial consultant;~~".

Sec. 7. G.S. 57B-3(c) is amended by redesignating subdivision (12) as (14) and by adding the following subdivisions:

"(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 57B-15.2;

(13) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances; and ".

Sec. 8. G.S. 57B-3(d)(1) reads as rewritten:

"(1) A health maintenance organization shall file a notice describing any significant modification of the operation set out in the information required by subsection (c) of this section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. ~~A request for expansion of service area is a modification subject to the terms of this section.~~ Changes subject to the terms of this section include expansion of service area, changes in

provider contract forms and group contract forms where the distribution of risk is significantly changed, and any other changes that the Commissioner describes in properly promulgated rules. Every HMO shall report to the Commissioner for his information material changes in the provider network, the addition or deletion of Medicare risk or Medicaid risk arrangements and the addition or deletion of employer groups that exceed ten percent (10%) of the health maintenance organization's book of business or such other information as the Commissioner may require. Such information shall be filed with the Commissioner within 15 days after implementation of the reported changes. Every HMO shall file with the Commissioner all subsequent changes in the information or forms that are required by this Chapter to be filed with the Commissioner."

Sec. 9. G.S. 57B-6 reads as rewritten:

"**§ 57B-6. Reserves.**

Every health maintenance organization after the first full year of doing business ~~after the passage of this section~~ shall accumulate ~~and~~, maintain, and segregate in a separate account, in addition to proper reserves for current administrative liabilities and whatever reserves are deemed adequate and proper by the Commissioner ~~of Insurance~~ for unpaid bills, and unearned membership dues, a special contingent surplus or reserve at the following rates annually of its gross annual collections from membership dues, until said reserve shall equal three times its average monthly expenditures:

(1) First $200,000 4%
(2) Next $200,000 2%
(3) All above $400,000 1%

Any such health maintenance organization may accumulate and maintain a contingent reserve in excess of the reserve hereinabove provided for, not to exceed an amount equal to six times the average monthly expenditures.

In the event the Commissioner ~~of Insurance~~ finds that special conditions exist warranting ~~a decrease~~ an adjustment in the reserves or schedule of reserves, hereinabove provided for, it may be modified by the Commissioner ~~of Insurance~~ accordingly. The Commissioner shall adopt rules that he considers necessary to provide for standards for the adjustment of contingent reserves."

Sec. 10. G.S. 57B-11 is repealed.

Sec. 11. G.S. 57B-15.2(b) reads as rewritten:

"(b) Each full service medical health maintenance organization shall maintain a minimum net worth of not less than ~~seven hundred fifty thousand dollars ($750,000)~~one million dollars ($1,000,000), which shall be increased by the amount of the contingency reserves calculated annually in accordance with the provisions of G.S. 57B-6. The net worth calculation shall be computed in accordance with statutory accounting principles generally recognized in the regulation of health maintenance organizations and the Commissioner may promulgate such regulations as he deems appropriate to carry out the provisions of this section. If a health maintenance organization fails to comply with the net worth requirement of this subsection or subsections (c) or (d) of this section, the

Commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees."

Sec. 12. G.S. 57B-15.2(c) reads as rewritten:

"(c) The minimum net worth for a health maintenance organization authorized to operate on July 17, 1987, and having a net worth of less than ~~seven hundred fifty thousand dollars ($750,000)~~ one million dollars ($1,000,000) shall be as follows:

(1) $150,000 by December 31, 1987
(2) $300,000 by December 31, 1988
(3) $450,000 by December 31, 1989
(4) ~~$600,000~~ $750,000 by December 31, 1990
(5) ~~$750,000~~ $1,000,000 by December 31, 1991

The net worth amounts required by this section shall be in addition to the contingency reserves required by G.S. 57B-6."

Sec. 13. Chapter 57B of the General Statutes is amended by adding the following new sections to read:

"**§ 57B-15.3. Hold harmless agreements or special deposit.**

(a) Unless the HMO maintains a special deposit in accordance with subsection (b) of this section, each contract between every HMO and a participating provider of health care services shall be in writing and shall set forth that in the event the HMO fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the HMO. No other provisions of such contracts shall, under any circumstances, change the effect of such a provision. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the HMO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the HMO shall maintain a special deposit in cash or cash equivalent as follows:

(1) Every HMO that has incurred uncovered health care expenditures in an amount that exceeds ten percent (10%) of its total expenditures for health care services for the immediately preceding six months, shall do either of the following:

a. Calculate as of the first day of every month and maintain for the remainder of the month, cash or cash equivalents acceptable to the Commissioner, as an account to cover claims for uncovered health care expenditures at least equal to one hundred twenty percent (120%) of the sum of the following:

1. All claims for uncovered health care expenditures received for reimbursement, but not yet processed; and
2. All claims for uncovered health care expenditures denied for reimbursement during the previous 60 days; and
3. All claims for uncovered health care expenditures approved for reimbursement, but not yet paid; and

4. An estimate for uncovered health care expenditures incurred, but not reported; and

5. All claims for uncovered emergency services and uncovered services rendered outside the service area.

b. Maintain adequate insurance, or a guaranty arrangement approved in writing by the Commissioner, to pay for any loss to enrollees claiming reimbursement due to the insolvency of the HMO. The Commissioner shall approve a guaranty arrangement if the guaranteeing organization has been in operation for at least 10 years and has a net worth, including organization-related land, buildings, and equipment, of at least fifty million dollars ($50,000,000); unless the Commissioner finds that the approval of such guaranty may be financially hazardous to enrollees. In order to qualify under the terms of this subsection, the guaranteeing organization shall (i) submit to the jurisdiction of this State for actions arising under the guarantee; (ii) submit certified, audited annual financial statements to the Commissioner; and (iii) appoint the Commissioner to receive service of process in this State.

(2) Whenever the reimbursements described in this subsection exceed ten percent (10%) of the HMO's total costs for health care services over the immediately preceding six months, the HMO shall file a written report with the Commissioner containing the information necessary to determine compliance with sub-subdivision (b)(1)a. of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the HMO that the requirements of this section should be waived or reduced, the Commissioner may waive or reduce these requirements to such an amount as he deems sufficient to protect enrollees of the HMO consistent with the intent and purpose of this Chapter.

(3) Any cash or cash equivalents maintained pursuant to the terms of this section shall be maintained as a special deposit controlled by and administered by the Commissioner in accordance with the provisions of G.S. 58-7.5.

"**§ 57B-15.4. Continuation of benefits.**

(a) The Commissioner shall require that each HMO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to enrollees who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commissioner may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the HMO's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves such as the Commissioner may require;

(4) Letters of credit acceptable to the Commissioner;

(5) Any other arrangements to assure that benefits are continued as specified above.

"**§ 57B-15.5. Enrollment period.**

(a) In the event of an insolvency of an HMO upon order of the Commissioner, all other carriers that participated in the enrollment process with the insolvent HMO at a group's last regular enrollment period shall offer such group's enrollees of the insolvent HMO a 30-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent HMO the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(b) If no other carrier had been offered to some groups enrolled in the insolvent HMO, or if the Commissioner determines that the other health benefit plan or plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent HMO, then the Commissioner shall allocate the insolvent HMO's group contracts for such groups among all other HMOs that operate within a portion of the insolvent HMO's service area, taking into consideration the health care delivery resources of each HMO. Each HMO to which a group or groups are so allocated shall offer such group or groups that HMO's existing coverage that is most similar to each group's coverage with the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology.

(c) The Commissioner shall also allocate the insolvent HMO's nongroup enrollees who are unable to obtain other coverage among all HMOs that operate within a portion of the insolvent HMO's service area, taking into consideration the health care delivery resources of each such HMO. Each HMO to which nongroup enrollees are allocated shall offer such nongroup enrollees that HMO's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology. Successor HMOs that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

"**§ 57B-15.6. Replacement coverage.**

(a) Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior HMO contract or policy providing such hospital, medical or surgical expense or service benefits, shall immediately cover all enrollees who were validly covered under the previous HMO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date

of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

"**§ 57B-15.7. Incurred but not reported claims.**

(a) Every HMO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such HMO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) Such liabilities shall be computed in accordance with rules adopted by the Commissioner upon reasonable consideration of the ascertained experience and character of the HMO."

Sec. 14. G.S. 57B-17 reads as rewritten:

"**§ 57B-17. Rehabilitation, liquidation, or conservation of health maintenance organization.**

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies, except that the provisions of Articles 17B and 17C of Chapter 58 of the General Statutes shall not apply to health maintenance organizations. The Commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon one or more grounds set out in Article ~~17A~~ 46 of Chapter 58 of the General Statutes or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State.

For the purpose of determining the priority of distribution of general assets, claims of enrollees and claims of enrollees' beneficiaries have the same claims' priorities as established by G.S. 58-683, for policyholders and beneficiaries of other insurance companies. Any provider who is obligated by statute, agreement, or court order to hold enrollees harmless from liability for services provided and covered by an HMO has a priority of distribution next subordinate to that of policyholders under G.S. 58-683, so that his status is after claims for unearned premiums, but before claims of general creditors. Providers who are not obligated to hold enrollees harmless shall be treated as general creditors and shall pursue claims against enrollees until final resolution of the estate of the liquidated HMO."

Sec. 15. Chapter 57B of the General Statutes is further amended by adding the following sections:

"**§ 57B-26. Franchise or privilege tax.**

(a) For the purposes of raising revenues sufficient to defray the expenses of the administration of this Chapter and to create and maintain the fund provided for in G.S. 57B-27, an annual franchise or privilege tax is hereby levied upon every HMO subject to this Chapter at a rate of one-half of one percent (1/2 of 1%) of the gross annual premium collections from enrollees. The tax is payable to the Commissioner on or before each March 15. The tax levied in this section is in lieu of all other taxes upon

HMOs except: fees and licenses under this Chapter; any taxes imposed under Article 5 of Chapter 105 of the General Statutes; and ad valorem taxes upon real and personal property owned in this State. For the purpose of computing the tax under this section, gross premiums do not include:

(1) Premiums or dues received by an HMO for Medicare or Medicaid risk contracts or risk arrangements.

(2) Premiums paid by The Teachers' and State Employees' Comprehensive Major Medical Plan.

(b) All provisions of Chapter 105 of the General Statutes, not inconsistent with this section, relating to administration, auditing and making returns, the imposition and collection of tax and the lien thereon, assessments, refunds, and penalties, shall be applicable to the tax imposed by this section; and with respect thereto, the Commissioner has the same power and authority as is given to the Secretary of Revenue under the provisions of Chapter 105 of the General Statutes.

"**§ 57B-27. Administration fund for supervision, rehabilitation, conservation, or liquidation.**

(a) There is created a special administration fund for supervision, rehabilitation, conservation, or liquidation of HMOs. The fund created by this section shall be separate and apart from any other funds and from all other State monies. The State Treasurer shall be the custodian of the fund; and all disbursements from the fund shall be made by the State Treasurer upon vouchers signed by the Commissioner. The State Treasurer shall invest the assets of the fund in accordance with the provisions of G.S. 147-69.2 and G.S. 147-69.3. The sole purpose of the fund is to pay all expenses incurred by the Commissioner or his deputies or designees in any proceeding under G. S. 57B-15.1 or Article 46 of Chapter 58 of the General Statutes, in supervising, rehabilitating, conserving, or liquidating an HMO. The fund shall not be used for the payment of claims by individuals, contract holders, providers, or other entities arising from the insolvency of an HMO.

(b) From the revenue generated by the tax provided for in G.S. 57B-26, the fund shall receive five hundred thousand dollars ($500,000) per year until the money in the fund reaches the amount of one million dollars ($1,000,000). Thereafter if the amount of money in the fund falls below one million dollars ($1,000,000), the fund shall receive from such tax revenue amounts sufficient to maintain a fund balance of one million dollars ($1,000,000)."

Sec. 16. G.S. 57B-2 reads as rewritten:

"(b) 'Enrollee' means an individual who ~~has been enrolled in~~ is covered by an HMO~~a health care plan~~."

Sec. 17. Section 15 of this act shall become effective January 1, 1991, and shall apply to contracts issued or renewed on or after that date. The remainder of this act is effective upon ratification.