GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H **1**

HOUSE BILL 434

Short Title: Federal Health Insurance Changes/AB. (Public)

Sponsors: Representatives Dockham; and Brawley.

Referred to: Insurance.

March 10, 1997

1 A BILL TO BE ENTITLED
2 AN ACT TO CONFORM NORTH CAROLINA HEALTH INSURANCE LAWS TO
3 RECENTLY ENACTED FEDERAL LAWS CONCERNING HEALTH
4 INSURANCE UNDERWRITING AND PORTABILITY, MATERNITY
5 COVERAGE, AND COVERAGE FOR MENTAL ILLNESS.
6 The General Assembly of North Carolina enacts:
7 Section 1. Article 3 of Chapter 58 of the General Statutes is amended by
8 adding a new section to read:
9 "**§ 58-3-176. Medical underwriting; portability; enrollment; termination of**
10 **coverage.**
11 (a) Definitions. – As used in this section:
12 (1) 'Creditable coverage' means coverage under one or more of the
13 following plans, provided that the plan is not followed by a lapse of
14 coverage longer than 63 days, excluding waiting periods:
15 a. A group health benefit plan.
16 b. A certificate or policy of individual insurance.
17 c. Part A or B of Title XVIII of the Social Security Act.
18 d. Title XIX of the Social Security Act, other than coverage
19 consisting solely of benefits under section 1928.
20 e. Chapter 55 of Title 10 of the United States Code.

1 f. A medical care program of the Indian Health Service or of a
2 tribal organization.
3 g. A health plan offered under Chapter 89 of Title 5 of the United
4 States Code.
5 h. A public health plan, as defined by federal law or regulation.
6 i. A health benefit plan under section 5(e) of the Peace Corps Act.
7 (2) ‘Eligible individual' means an individual who meets all of the following
8 at the time of application for coverage:
9 a. Has accumulated at least 18 months of prior creditable coverage,
10 the most recent of which was under a health benefit plan
11 provided by an employer, church, or government plan.
12 b. Has no other health insurance coverage and is not eligible for
13 Medicare coverage.
14 c. Had elected and has since exhausted group health insurance
15 continuation coverage under COBRA or Article 53 of this
16 Chapter.
17 (3) ‘Enrollee' means an insured or a dependent of the insured under a group
18 health benefit plan.
19 (4) ‘Group health benefit plan' means a plan of health care coverage
20 provided by an insurer to an employer group, including a small
21 employer group.
22 (5) ‘Health status' means the physical and mental medical condition of an
23 individual and includes prior medical history, claims experience, receipt
24 of health care services, evidence of insurability (including conditions
25 arising out of acts of domestic violence), disability, and genetic
26 information.
27 (6) ‘Insurer' means an insurance company subject to this Chapter, a service
28 corporation organized under Article 65 of this Chapter, a health
29 maintenance organization organized under Article 67 of this Chapter,
30 and a multiple employer welfare arrangement subject to Article 49 of
31 this Chapter.
32 (7) ‘Preexisting condition provision' means a policy provision excluding or
33 limiting coverage for a condition for which medical advice diagnosis,
34 care, or treatment was recommended or received within the six-month
35 period immediately before enrollment.
36 (8) ‘Small employer' means a small employer as defined in G.S. 58-50-
37 110(22).
38 (b) Exceptions. – This section does not apply to the following types of insurance
39 benefits:
40 (1) Accident only, disability income coverage, coverage issued as
41 supplemental to liability insurance, automobile and homeowners'
42 medical payments coverages, and credit insurance.

1 (2) Dental, vision, long-term care, nursing home care, and Medicare
2 supplemental insurance, if provided in a policy separate from the health
3 benefit plan.
4 (c) Medical Underwriting Restricted. – An insurer shall not refuse to enroll an
5 individual or a dependent of the individual under a group health benefit plan because of
6 the health status of the individual or dependent.
7 (d) Guaranteed Renewability. – An insurer shall not unilaterally discontinue nor
8 refuse to renew any of the following, except as provided in subsection (e) of this section:
9 (1) A group health plan.
10 (2) The coverage of an individual or a dependent of the individual under a
11 group health plan.
12 (3) The coverage of an individual under a policy or certificate of individual
13 insurance.
14 (e) Exceptions to Guaranteed Renewability. – An insurer may unilaterally
15 discontinue or nonrenew a health benefit plan or individual health insurance coverage
16 under any of the following conditions:
17 (1) The plan sponsor or individual insured has failed to timely pay
18 premiums.
19 (2) The plan sponsor, a person insured under the plan, or an individual
20 insured has committed a fraud or made a material misrepresentation
21 with respect to coverage under the health benefit plan.
22 (3) The insurer is discontinuing coverage in the market in accordance with
23 subsection (j) of this section.
24 (4) With respect to group health benefit plans, the plan sponsor has not
25 complied with the insurer's participation or contribution requirements.
26 (5) With respect to a health maintenance organization, the individual
27 insured or the enrollees of the plan sponsor no longer live, reside, or
28 work in the plan's service area.
29 (6) With respect to employer or individual participants in an association
30 plan, the participant is no longer a member of the association.
31 (f) Premium Equity. – An insurer shall not charge an enrollee in a group health
32 benefit plan a higher premium than a similar enrollee in that plan solely because of the
33 enrollee's health status.
34 (g) Riders; Preexisting Conditions Provisions. – With respect to an individual or
35 the individual's dependent under a group health benefit plan, an insurer shall not limit or
36 exclude coverage, through a rider, endorsement, or any other means, for a specified
37 disease or medical condition otherwise covered under that plan. An insurer may apply a
38 preexisting condition provision under a group health benefit plan or under individual
39 health insurance coverage only in accordance with the following criteria:
40 (1) The period during which coverage is limited or excluded may not
41 exceed 12 months following the date of enrollment of an enrollee nor 18
42 months following the date of enrollment of a late enrollee.

1 (2) This period must be reduced by the waiting periods or portions thereof
2 satisfied under all prior creditable coverage. An insurer may determine
3 creditable coverage based on benefit categories or without regard to
4 benefits, in accordance with rules adopted by the Commissioner.
5 (3) A preexisting condition provision may not be applied to any of the
6 following:
7 a. Pregnancy or a pregnancy-related condition.
8 b. A newborn who is covered under creditable coverage no later
9 than the thirtieth day following birth.
10 c. A child adopted or placed for adoption before age 18 who is
11 covered under creditable coverage no later than the thirtieth day
12 following adoption or placement for adoption.
13 d. A potential but undiagnosed condition relating to genetic
14 information about the insured.
15 (h) Special Enrollment Under Group Health Benefit Plans. – An employee or a
16 dependent of the employee (if dependent coverage is offered) who failed to enroll during
17 the open enrollment period in the group health benefit plan sponsored by the employer
18 may enroll in that plan during a special enrollment period under the following conditions:
19 (1) The employee or dependent must have been covered under another
20 health benefit plan at the time of open enrollment.
21 (2) If required by the insurer or plan sponsor at that time, the employee
22 must have declined enrollment in writing because of the other coverage.
23 (3) If the other coverage was continuation coverage under COBRA or
24 Article 53 of this Chapter, it must be exhausted.
25 (4) If the other coverage was not continuation coverage, the employee or
26 dependent must have lost eligibility for the coverage or the employer
27 stopped contributing premium.
28 Unless extended by the insurer, the special enrollment period begins with the loss or
29 exhaustion of coverage under subdivision (3) or (4) of this subsection and ends 30 days
30 later.
31 (i) Individual Insurance for Individuals With Prior Group Coverage. – An insurer
32 that provides individual health benefit plans in this State shall not deny an eligible
33 individual coverage under an individual health benefit plan nor impose a preexisting
34 condition limitation or exclusion under the plan. However, an insurer may limit an
35 eligible individual to two policy forms if those forms are designed for, made generally
36 available to, and actively marketed to, and enroll eligible and other individuals and are
37 representative of individual health insurance coverage offered by the insurer in this State,
38 as determined in accordance with federal law and rules adopted by the Commissioner.
39 An insurer may deny coverage to individuals under this subsection if the denial is
40 applied uniformly, is not based on the health status of the individuals, and meets one of
41 the following criteria:
42 (1) A health maintenance organization may limit enrollment to individuals
43 who live, work, or reside in the plan's service area and may deny

1 coverage to individuals within the service area if it can reasonably
2 anticipate and demonstrate to the Commissioner that (i) it will not have
3 the capacity within that area and among its contracted providers to
4 deliver services adequately to these individuals because of its
5 obligations to existing enrollees and (ii) its anticipated inability to
6 deliver these services is not a pretext for denying coverage based on the
7 health status of the individuals. Denial of coverage under this
8 subdivision precludes the health maintenance organization from offering
9 any coverage in the individual market within the affected service area
10 for 180 days.
11 (2) An insurer may deny coverage in the individual market upon
12 demonstrating to the satisfaction of the Commissioner that it lacks the
13 financial capacity to insure additional persons, without regard to their
14 health status.
15 (j) Termination of Coverage. – An insurer may stop writing coverage in a group
16 health benefit plan market or the individual market only in accordance with the
17 following:
18 (1) If all coverage is to be discontinued in the market for small employers,
19 as defined in G.S. 58-50-110(22), the market for other employer groups,
20 or both, or the market for individual insureds, the insurer must do the
21 following:
22 a. Notify all affected plan sponsors and plan participants or
23 individual insureds 180 days in advance.
24 b. Discontinue renewal of policies in the market from which it is
25 withdrawing.
26 c. Discontinue writing new policies in that market for five years.
27 (2) If coverage is to be discontinued only for a particular type of plan, the
28 insurer must do the following:
29 a. Notify all affected plan sponsors and plan participants or
30 individual insureds 90 days in advance.
31 b. Offer for purchase other coverage to affected plan sponsors or
32 individual insureds, and if the plan sponsor is a small employer,
33 the offer shall include all available plan coverages.
34 (3) Discontinuations and offers of alternative coverage shall not be based
35 on the health status of those insured.
36 This subsection does not prohibit an insurer from modifying the coverage available
37 through a particular plan in accordance with State law."
38 Section 2. G.S. 58-50-110 reads as rewritten:
39 **"§ 58-50-110. Definitions.**
40 As used in this Act:
41 (1) 'Accountable health carrier' means that as defined in G.S. 143-622(1).
42 (1a) 'Actuarial certification' means a written statement by a member of the
43 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, and to the extent applicable, the provisions of G.S. 58-3-176, 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.

(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) Repealed by Session Laws 1993, c. 529, s. 3.3.

(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.

(5a) 'Case characteristics' means the demographic factors age, gender, family size, and geographic location.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.

(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.~~ include benefits described in G.S. 58-3-176(b).

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

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) 'Late enrollee' means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the end of the initial enrollment period provided under the terms of the health benefit plan in effect at the time the employee first became eligible; 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 was covered under a public or private health benefit plan that provided, at the time the individual was eligible to 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, in writing, during the enrollment period that coverage under another employer health benefit plan was the reason for declining coverage;

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

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;

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;~~ order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or

e. The individual or employee enrollee makes a request for enrollment of the spouse or child within 30 days ~~of~~ after the

~~individual~~ individual's or employee's marriage or the ~~birth or adoption~~ birth, adoption, or placement for adoption of a child.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(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.~~ preexisting condition provision as defined in G.S. 58-3-176.

(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 individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 49 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. 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 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 definition. For purposes of this Act, 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."

Section 3. G.S. 58-50-125(c) reads as rewritten:

"(c) ~~The~~ Except as provided under G.S. 58-3-176, 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."

Section 4. G.S. 58-50-125(g) reads as rewritten:

"(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 that is not physically located in the HMO's approved service areas;

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

(3) Within an area, where the HMO can reasonably anticipate, and 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 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."

Section 5. G.S. 58-50-130(a) reads as rewritten:

"(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 must define preexisting conditions as "those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the effective date of the person's 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 health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan. As used in this subdivision with respect to previous coverage, the meaning of "health benefit plan"is not limited to the definition in G.S. 58-50-115, but includes any health benefit plan provided by a health insurer, as that term is defined in G.S. 58-51-115(a), or any government plan or program providing health benefits or health care.~~

~~(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. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of such period in the health benefit plan currently held by the small employer.~~

(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.

(5) Notwithstanding any other provision of this Chapter, no small employer carrier, insurer, subsidiary ~~or~~ of an insurer, or controlled individual of an insurance 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 an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act.

(6) 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).

~~(7) 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.~~

~~(8) In the case of an eligible employee or dependent of an eligible employee who was excluded from or denied coverage by a small employer carrier on or before August 14, 1992, the small employer carrier shall provide an opportunity for such eligible employee or dependent to enroll in the health benefit plan currently held by the small employer not later than the next plan anniversary on or after August 14, 1992.~~

(9) The health benefit plan must meet the applicable requirements of G.S. 58-3-176."

Section 6. G.S. 58-50-130(d) reads as written:

"(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:~~ materials, of the following and shall provide this information to the small employer upon request:

(1) Repealed by Session Laws 1993, c. 529, s. 3.7.

(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.

(5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible."

Section 7. G.S. 58-51-15(a)(2)b reads as rewritten:

"b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions ~~must be covered no later than one year after the effective date of coverage.~~ are covered under this policy...........(insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions ~~are defined as~~ mean 'those conditions for which medical ~~advice~~ advice, diagnosis, care, or treatment was received or recommended ~~or that could be medically documented~~ within the ~~one year~~ six-month period immediately preceding the effective date of the person's coverage.' ~~Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that~~

~~portion of the waiting period that was met under the previous plan. As used in this policy, the term "previous plan"includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition provision applies to an insured person, all health benefit plans must credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~ Credit for having satisfied some or all of the preexisting condition waiting periods under previous health benefits coverage shall be given in accordance with G.S. 58-3-176."

Section 8. G.S. 58-51-80(b) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons thereby insured conforms to the requirements of the following subdivisions:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis.

(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least five years; shall not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); shall not make health insurance coverage through the association available other than in connection with a member of the

association; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

a. The policy may insure members of the association or associations, employees of the association or associations, or employees of members, or one or more of the preceding or all of any class or classes for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

~~c. A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage, in writing.~~

c. The policy shall make health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such member (or individuals eligible for coverage through a member).

~~(2) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50"must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(3) Policies may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage."Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit~~

~~must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan"includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. For employer groups of 50 or more persons and for groups under subdivision (1a) of this subsection and under G.S. 58-51-81: In determining whether a preexisting condition provision applies to an eligible employee, association member, student, or to a dependent, all health benefit plans shall credit the time the person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage~~."

Section 9. G.S. 58-51-80(h) reads as rewritten:

"(h) Nothing contained in this section applies to any contract issued by any corporation defined in Article 65 of this Chapter. ~~Subdivision (b)(3) of this section applies to MEWAs, as defined in G.S. 58-49-30(a).~~"

Section 10. G.S. 58-53-1 reads as rewritten:

"§ 58-53-1. Definitions.

As used in this Article, the following terms have the meanings specified:

(1) ‘Group policy' means a group accident and health insurance policy issued by an insurance company and a group contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(2) ‘Individual policy' or ‘converted policy' means an individual health insurance policy issued by an insurance company or an individual ~~health services~~ contract issued by a ~~health~~ service corporation or health maintenance organization or similar corporation or organization.

(3) ‘Insurance' and ‘insured' refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided by reason of a disability extension.

(4) " Insurer"means the entity issuing a group policy or an individual or converted policy.

(5) " Medicare"means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(5a) ‘Member' or ‘employee' includes an insured spouse or dependent of a member or of an employee.

(6) ‘Premium' includes any premium or other consideration payable for coverage under a group or individual policy.

(7) 'Reasonable and customary' means the most frequently used level of charge made for the supplies or for a specific service in the geographic subarea in which such supplies or services are received, of like kind or by physicians, or other practitioners, with similar qualifications."

Section 11. G.S. 58-53-5 reads as rewritten:

"**§ 58-53-5. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.**

A group policy delivered or issued for delivery in this State ~~which~~ that insures employees or ~~members, other than the members and their dependents, if they have elected to include them, whose eligibility under the group policy does not extend to any employee(s) the insured may have~~ members for hospital, surgical or major medical insurance on an expense incurred or service basis under ~~Articles 1 through 67 of~~ this Chapter, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose ~~insurance for these types of~~ coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical, and medical insurance under that group policy, for themselves and their eligible spouses and dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions ~~applicable to those forms of insurance~~ and to the conditions specified in this Part. Provided, the terms and conditions set forth in this Part are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical, or major medical plans ~~already in force, or hereafter placed into effect,~~ that provide continuation benefits equal to or better than those required in this Part."

Section 12. 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 ~~one year~~ 18 months 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 participation 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 terminated. The insurer that insured the group ~~prior to~~ before 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."

Section 13. G.S. 58-53-50 reads as rewritten:

"§ 58-53-50. Restrictions.

A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred because:

(1) Of termination of employment or membership and either he was not entitled to continuation of group coverage under Part 1 of this Article or failed to elect such continuation;

(2) He failed to make timely payment of any required contribution for the cost of continuation of insurance;

(3) He had not been continuously covered 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 termination of active employment ending with such termination;

(4) The group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of date of termination; or

(5) He failed to continue his insurance for the entire maximum period of ~~one year~~ 18 months following termination of active employment as provided for in Part 1 of this Article, unless that failure to continue was because of change of insurer by the employer and the change of insurer was consummated during the one year continuation period. In that event the employee or member shall be entitled to be issued a converted policy by the insurer that provided the group policy to the employer before the change of insurer."

Section 14. G.S. 58-53-55 reads as rewritten:

"§ 58-53-55. Time limit.

In order to be eligible for conversion, written application and the first premium payment for the converted policy must be made to the insurer not later than 31 days after the date of termination of insurance provided under Part 1 of this Article. The effective date of the converted policy shall be the day following the later of:

(1) The termination of insurance under the group policy when it is not replaced by one providing similar coverage within 31 days of the termination date of the immediately prior group plan; or

(2) The termination of the ~~one year~~ period of continued coverage under the group policy or policies."

Section 15. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-31. Additional requirements.**

(a) No policy shall be used in this State unless it provides for an offer of nonforfeiture, which shall not be less than an offer of reduced paid-up insurance benefits, extended term insurance benefits, or a shortened benefit period. No policy shall pay a cash surrender value unless the dividends or refunds are applied as a reduction of future premiums or an increase in future benefits.

(b) The Commissioner shall adopt rules to provide for annual reports by insurers of the number of claims denied, number of rescissions, and the percentage of sales involving the replacement of policies.

(c) No policy shall be used in this State unless the insurer has developed a financial or personal asset suitability test to determine whether or not issuing long-term care insurance to an applicant is appropriate. A personal long-term care worksheet and disclosure notice of issues an applicant should know before buying long-term care insurance shall be completed and provided before an application is taken. The insurer shall use the financial or suitability form and format standards as developed and adopted by the NAIC. Each applicant that does not meet the recommended financial or personal asset suitability test criteria shall receive a letter of notification and shall be given an option to waive the results of the financial suitability test and proceed with the purchase of the policy.

(d) The Commissioner shall adopt standards to handle consumer complaints about noncompliance with State requirements.

(e) Every policy shall include an offer of an alternative plan of care benefit. The alternative plan of care benefit shall not duplicate benefits provided elsewhere in the policy nor shall it substitute home health care services as defined in G.S. 131E-136(3). An alternate plan of care benefit shall allow the insured to stay home whenever medically acceptable. The alternate plan of care benefit may specify service, special treatments, and specific levels of care. The insurer shall disclose the full cost of the alternative care benefit and the method and amount of reimbursement. Alternative care benefits may include, but are not limited to, services such as the purchase of durable medical equipment, wheelchair ramps, grab bars, emergency response systems, and the payment of Meals-On-Wheels or other similar food delivery programs in the insured's area. All long-term care insurers shall offer to add the alternative plan of care benefit to any long-term care policy issued or issued for delivery in this State without additional proof of medical insurability. All benefits are subject to the following conditions:

(1) The treatment plan shall be agreed to by the insured, the treating physician, and the insurer.

(2) The treatment plan shall be developed and coordinated with the treating physician.

(f) No policy used in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1 (1) 'Activities of daily living' means at least bathing, continence,
2 dressing, eating, toileting, and transferring.
3 (2) 'Acute condition' means that the individual is medically unstable
4 requiring frequent monitoring by a physician or registered nurse.
5 (3) 'Bathing' means washing oneself by sponge bath, or in a tub or
6 shower, including the task of getting into and out of the tub or
7 shower.
8 (4) 'Cognitive impairment' means a deficiency in a person's short or
9 long-term memory, orientation as to person, place, and time,
10 deductive or abstract reasoning, or judgment as it relates to safety
11 awareness.
12 (5) 'Continence' means the ability to maintain control of bowel and
13 bladder function; or, when unable to maintain control of bowel or
14 bladder function, the ability to perform associated personal hygiene
15 (including caring for catheter or colostomy bag).
16 (6) 'Dressing' means putting on and taking of all items of clothing and
17 any necessary braces, fasteners, or artificial limbs.
18 (7) 'Eating' means feeding oneself by getting food into the body from a
19 receptacle (such as a plate, cup, or table) or by a feeding tube or
20 intravenously.
21 (8) 'Hands-on assistance' means physical assistance (minimal, moderate,
22 or maximal) without which the individual would not be able to
23 perform the activity of daily living.
24 (9) 'Mental or nervous disorder' shall not be defined to include more
25 than neurosis, psychoneurosis, psychopathy, psychosis, or mental or
26 emotional disease or disorder.
27 (10) 'Personal care' means the provision of hands-on services to assist an
28 individual with activities of daily living.
29 (11) 'Toileting' means getting to and from the toilet, getting on and off
30 the toilet, and performing associated personal hygiene.
31 (12) 'Transferring' means moving into or out of a bed, chair, or
32 wheelchair.
33 (13) 'Skilled nursing care', 'intermediate care', 'personal care', 'home
34 care,' and other services shall be defined in relation to the level of
35 skill required, and the nature of the care, the definition of which may
36 require that the provider be appropriately licensed or certified."
37 Section 16. G.S. 58-65-25 reads as rewritten:
38 **"§ 58-65-25. Hospital, physician and dentist contracts.**
39 (a) Any corporation organized under ~~the provisions of~~ this Article ~~and Article 66 of~~
40 ~~this Chapter~~ may enter into contracts for the rendering of hospital service to any of its
41 subscribers by hospitals approved by the American Medical Association and/or the North
42 Carolina Hospital Association, and may enter into contracts for the furnishing of, or the
43 payment in whole or in part for, medical and/or dental services rendered to any of its

subscribers by duly licensed physicians and/or dentists. All obligations arising under contracts issued by such corporations to its subscribers shall be satisfied by payments made directly to the hospitals or hospitals and/or physicians and/or dentists rendering such service, or direct to the subscriber or his, her, or their legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospital(s) and/or physician(s) and/or dentist(s) or both rendering such service, and all such payments heretofore made are hereby ratified. Nothing ~~herein~~ in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) ~~On and after January 1, 1956, all~~ All certificates, plans or contracts issued to subscribers or other persons by hospital and medical and/or dental service corporations operating under this Article ~~and Article 66 of this Chapter~~ shall contain in substance a provision as follows: 'After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period. ~~No claim for loss incurred or disability (as defined in the certificate, contract or plan) commencing after two years from the date of issue of this certificate, contract or plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specifically described, effective on the date of loss, had existed prior to the effective date of coverage of this certificate, contract or plan.~~'"

Section 17. G.S. 58-65-60(e) reads as rewritten:

"(e) A ~~hospital~~ service corporation may issue a master group contract with the approval of the Commissioner ~~of Insurance provided such~~ if the contract and the individual certificates issued to members of the ~~group, shall comply~~ group complies in substance to the other provisions of this Article and Article 66 of this Chapter. ~~Any such~~ The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in ~~said~~ the contract, and in accordance with an adjustment schedule filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If ~~such master group~~ the contract is issued, altered or modified, the subscribers' contracts issued ~~in pursuance thereof~~ under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

~~(1) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for coverage or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(2) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage."Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subdivision, a "previous plan"includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care, except that nothing in this section shall apply to a guaranteed issue product designed for uninsurables. For employer groups of 50 or more persons: In determining whether a preexisting condition 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 plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

~~(3)~~ (e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

~~(4)~~ (e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation 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 corporation's plan."

Section 18. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other provisions of this Article. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

~~(b) For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50"must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~

~~(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage."Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any previous plan. Credit must be given for that portion of the waiting period which was met under the previous plan. As used in this subsection, a "previous plan"includes any health benefit plan provided by a health insurer, as those terms are defined in G.S. 58-51-115, or any government plan or program providing health benefits or health care. In determining whether a preexisting condition 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 plan if the previous plan's coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.~~

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term ‘employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation 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 corporation's plan."

Section 19. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-169. Required coverage for minimum hospital stay following birth.**

(a) Definitions. – As used in this section:

(1) 'Attending providers' includes:

a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and

b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any of the following kinds of insurance:

a. Accident,

b. Credit,

c. Disability income,

d. Long-term or nursing home care,

e. Medicare supplement,

f. Specified disease,

g. Dental or vision,

h. Coverage issued as a supplement to liability insurance,

i. Workers' compensation,

j. Medical payments under automobile or homeowners, and
k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(3) 'Insurer' means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) In General. – Except as provided in subsection (c), an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. – Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

(1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and
(2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections(d) and (e) of this section.

(d) Postdelivery Follow-Up Care. – In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

(1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
(2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. – As used in subsection (d) of this section, 'timely postdelivery care' means health care that is provided:

(1) Following the discharge of a mother and her newborn child from the inpatient setting; and

(2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. – An insurer shall not:

(1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;

(2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or

(4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. – Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

(1) Give birth in a hospital; or

(2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. – Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section."

Section 20. G.S. 58-3-170 reads as rewritten:

"**§ 58-3-170. Requirements for maternity coverage.**

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

~~(a1) A health benefit plan that provides maternity coverage shall provide coverage for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by caesarean section.~~

(b) As used in this section, 'health benefit plans' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health

maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 21. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) Definitions. – As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) Coverage of Physical Illness. – No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) Coverage of Mental Illness. – A policy that covers both physical illness or injury and mental illness may not impose a lesser lifetime or annual dollar limitation on the mental health benefits than on the physical illness or injury benefits, subject to the following:

(1) A lifetime limit or annual limit may be made applicable to all benefits under the policy, without distinguishing the mental health benefits.

(2) If the policy contains lifetime limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose a lifetime limit on the mental health benefits that is based on a weighted average of the respective lifetime limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(3) If the policy contains annual limits only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the policy, the insurer may impose an annual limit on the mental health benefits that is based on a weighted average of the respective annual limits on the selected physical illness and injury benefits. The weighted average

1 shall be calculated in accordance with rules adopted by the
2 Commissioner.
3 (4) Except as otherwise provided in this section, the policy may
4 distinguish between mental illness benefits and physical injury or
5 illness benefits with respect to other terms of the policy, including
6 coinsurance, limits on provider visits or days of coverage, and
7 requirements relating to medical necessity.
8 (5) If the insurer offers two or more benefit package options under a
9 policy, each package must comply with this subsection.
10 (6) This subsection does not apply to a policy if the insurer can
11 demonstrate to the Commissioner that compliance will increase the
12 cost of the policy by one percent (1%) or more.
13 (7) This subsection expires October 1, 2001, but the expiration does not
14 affect services rendered before that date.
15 (c) Mental illness or chemical dependency coverage not required. – Nothing in this
16 section ~~prevents any insurance company from excluding from coverage any physical~~
17 ~~illness or injury or mental illness or chemical dependency which has existed previous to~~
18 ~~coverage of the individual by the insurance company or from refusing to issue or deliver~~
19 ~~to that individual any policy because of the underwriting of any physical condition~~
20 ~~whether or not related to~~ requires an insurer to offer coverage for mental illness or
21 chemical dependency.
22 (d) Applicability. – ~~This~~ Subsection (b1) of this section applies only to group health
23 insurance contracts covering more than 50 employees. The remainder of this section
24 applies only to group health insurance contracts covering 20 or more employees. For
25 purposes of this section, 'group health insurance contracts' include MEWAs, as defined
26 in G.S. 58-49-30(a)."
27 Section 22. G.S. 58-65-90 reads as rewritten:
28 **"§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**
29 (a) Definitions. – As used in this section, the term:
30 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-
31 3(21); and
32 (2) 'Chemical dependency' has the same meaning as defined in G.S. 58-
33 65-75
34 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders
35 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of
36 those manuals.
37 (b) Coverage of Physical Illness. – No ~~hospital, medical, dental or health~~ service
38 corporation governed by this Chapter shall, solely because an individual to be insured has
39 or had a mental illness or chemical dependency:
40 (1) Refuse to issue or deliver to that individual any individual or group
41 ~~hospital, dental, medical or health service~~ subscriber contract in this
42 State that affords benefits or coverage for medical treatment or
43 service for physical illness or injury;

1 (2) Have a higher premium rate or charge for physical illness or injury
2 coverages or benefits for that individual; or
3 (3) Reduce physical illness or injury coverages or benefits for that
4 individual.
5 (b1) Coverage of Mental Illness. – A subscriber contract that covers both physical
6 illness or injury and mental illness may not impose a lesser lifetime or annual dollar
7 limitation on the mental health benefits than on the physical illness or injury benefits,
8 subject to the following:
9 (1) A lifetime limit or annual limit may be made applicable to all
10 benefits under the subscriber contract, without distinguishing the
11 mental health benefits.
12 (2) If the subscriber contract contains lifetime limits only on selected
13 physical illness or injury benefits, and these benefits do not represent
14 substantially all of the physical illness and injury benefits under the
15 subscriber contract, the service corporation may impose a lifetime
16 limit on the mental health benefits that is based on a weighted
17 average of the respective lifetime limits on the selected physical
18 illness and injury benefits. The weighted average shall be calculated
19 in accordance with rules adopted by the Commissioner.
20 (3) If the subscriber contract contains annual limits only on selected
21 physical illness and injury benefits, and these benefits do not
22 represent substantially all of the physical illness and injury benefits
23 under the subscriber contract, the service corporation may impose an
24 annual limit on the mental health benefits that is based on a weighted
25 average of the respective annual limits on the selected physical
26 illness and injury benefits. The weighted average shall be calculated
27 in accordance with rules adopted by the Commissioner.
28 (4) Except as otherwise provided in this section, the subscriber contract
29 may distinguish between mental illness benefits and physical injury
30 or illness benefits with respect to other terms of the subscriber
31 contract, including coinsurance, limits on provider visits or days of
32 coverage, and requirements relating to medical necessity.
33 (5) If the service corporation offers two or more benefit package options
34 under a subscriber contract, each package must comply with this
35 subsection.
36 (6) This subsection does not apply to a subscriber contract if the service
37 corporation can demonstrate to the Commissioner that compliance
38 will increase the cost of the subscriber contract by one percent (1%)
39 or more.
40 (7) This subsection expires October 1, 2001, but the expiration does not
41 affect services rendered before that date.
42 (c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing in
43 this section ~~prevents any hospital or medical plan from excluding from coverage any~~

1 physical illness or injury or mental illness or chemical dependency which has existed
2 previous to coverage of the individual by the hospital or medical plan or from refusing to
3 issue or deliver to that individual any policy because of the underwriting of any physical
4 condition whether or not related to requires a service corporation to offer coverage for
5 mental illness or chemical dependency.
6 (d) Applicability. – This Subsection (b1) of this section applies only to
7 subscriber contracts covering more than 50 employees. The remainder of this section
8 applies only to group contracts covering 20 or more employees."
9 Section 23. G.S. 58-67-75 reads as rewritten:
10 "**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**
11 (a) Definitions. – As used in this section, the term:
12 (1) ‘Mental illness' has the same meaning as defined in G.S. 122C-
13 3(21); and
14 (2) ‘Chemical dependency' has the same meaning as defined in G.S. 58-
15 67-70
16 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders
17 DSM-3-R or the International Classification of Diseases ICD/9/CM, or a later edition of
18 those manuals.
19 (b) Coverage of Physical Illness. – No health maintenance organization governed
20 by this Chapter shall, solely because an individual has or had a mental illness or chemical
21 dependency:
22 (1) Refuse to enroll that individual in any health care plan covering
23 physical illness or injury;
24 (2) Have a higher premium rate or charge for physical illness or injury
25 coverages or benefits for that individual; or
26 (3) Reduce physical illness or injury coverages or benefits for that
27 individual.
28 (b1) Coverage of Mental Illness. – A health care plan that covers both physical
29 illness or injury and mental illness may not impose a lesser lifetime or annual dollar
30 limitation on the mental health benefits than on the physical illness or injury benefits,
31 subject to the following:
32 (1) A lifetime limit or annual limit may be made applicable to all
33 benefits under the plan, without distinguishing the mental health
34 benefits.
35 (2) If the plan contains lifetime limits only on selected physical illness
36 and injury benefits, and these benefits do not represent substantially
37 all of the physical illness and injury benefits under the plan, the
38 HMO may impose a lifetime limit on the mental health benefits that
39 is based on a weighted average of the respective lifetime limits on
40 the selected physical illness and injury benefits. The weighted
41 average shall be calculated in accordance with rules adopted by the
42 Commissioner.

1 (3) If the plan contains annual limits only on selected physical illness
2 and injury benefits, and these benefits do not represent substantially
3 all of the physical illness and injury benefits under the plan, the
4 HMO may impose an annual limit on the mental health benefits that
5 is based on a weighted average of the respective annual limits on the
6 selected physical illness and injury benefits. The weighted average
7 shall be calculated in accordance with rules adopted by the
8 Commissioner.
9 (4) Except as otherwise provided in this section, the plan may
10 distinguish between mental illness benefits and physical injury or
11 illness benefits with respect to other terms of the plan, including
12 coinsurance, limits on provider visits or days of coverage, and
13 requirements relating to medical necessity.
14 (5) If the HMO offers two or more benefit package options under a plan,
15 each package must comply with this subsection.
16 (6) This subsection does not apply to a health benefit plan if the HMO
17 can demonstrate to the Commissioner that compliance will increase
18 the cost of the plan by one percent (1%) or more.
19 (7) This subsection expires October 1, 2001, but the expiration does not
20 affect services rendered before that date.
21 (c) Mental Illness or Chemical Dependency Coverage Not Required. – Nothing in
22 this section prevents any health maintenance organization from excluding from coverage
23 any physical illness or injury or mental illness or chemical dependency which has existed
24 previous to coverage of the individual by the health maintenance organization or from
25 refusing to issue or deliver to that individual any policy because of the underwriting of
26 any physical condition whether or not related to requires an HMO to offer coverage for
27 mental illness or chemical dependency.
28 (d) Applicability. – This Subsection (b1) of this section applies only to group
29 contracts covering more than 50 employees. The remainder of this section applies only
30 to group contracts covering 20 or more employees."
31 Section 24. Sections 1 through 18 of this act apply to all affected contracts that
32 are delivered, issued for delivery, or renewed on and after July 1, 1997. Sections 19, 20,
33 21, 22, and 23 of this act apply to all affected contracts that are delivered, issued for
34 delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal
35 of a contract is presumed to occur on each anniversary of the date on which coverage was
36 first effective on the person or persons covered by the contract.
37 Section 25. This act is effective when it becomes law.