

**GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2005**

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**SENATE BILL 627\***

Short Title: Improve Health Insurance Underwriting.-AB

(Public)

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Sponsors: Senator Thomas.

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Referred to: Commerce.

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March 17, 2005

A BILL TO BE ENTITLED

1 AN ACT TO REQUIRE THAT ASSOCIATION PREMIUM RATES FOR  
2 ACCIDENT AND HEALTH INSURANCE BE ACTUARIALLY SOUND AND  
3 THAT ASSOCIATIONS BE RATED AS A SINGLE GROUP WHEN THE  
4 COVERAGE PROVIDED IS NOT EMPLOYER-BASED, LIMIT AN  
5 INDIVIDUAL ACCIDENT AND HEALTH INSURER'S USE OF AN  
6 INDIVIDUAL'S OWN CLAIMS EXPERIENCE TO DEVELOP THE  
7 INDIVIDUAL'S RENEWAL RATE; EXEMPT A SOLE PROPRIETOR FROM  
8 THE FULL-TIME BASIS FOR THIRTY-HOUR WORKWEEK REQUIREMENTS  
9 TO BE ELIGIBLE FOR LARGE GROUP HEALTH COVERAGE LIKE THE  
10 PROPRIETOR'S FULL-TIME EMPLOYEES; CORRECT AN INADVERTENT  
11 CROSS-REFERENCE IN ORDER TO REAPPLY NEWBORN COVERAGE TO A  
12 MORE COMPREHENSIVE GROUP OF INSURERS; TECHNICALLY  
13 CORRECT AN OMISSION REGARDING PROVISIONS GOVERNING  
14 PREEXISTING CONDITIONS FOR LIMITED HEALTH, SUPPLEMENTAL  
15 HEALTH, AND SPECIFIED DISEASE POLICIES; DECREASE THE TOTAL  
16 NUMBER OF MEMBERS THAT SERVE ON THE SMALL EMPLOYER  
17 REINSURANCE POOL BOARD FROM NINE TO SIX; ALLOW PERSONS  
18 RETROACTIVELY ENROLLED IN MEDICARE PART B THE SAME  
19 SIX-MONTH OPEN ENROLLMENT PERIOD FOR MEDICARE SUPPLEMENT  
20 PLANS AS PERSONS WHO ENROLLED IN MEDICARE PART B WITHOUT A  
21 RETROACTIVE EFFECTIVE DATE OF COVERAGE; TECHNICALLY  
22 CORRECT THE REVOCATION AND SUSPENSION LAW TO INCLUDE A  
23 BENEFICIARY OF A LIFE OR ANNUITY CONTRACT AS A CLAIMANT;  
24 AND AMEND THE UTILIZATION REVIEW LAWS TO CLARIFY THAT SUCH  
25 LAWS PLAINLY APPLY TO INDIVIDUAL INSURANCE COVERAGE AS  
26 WELL AS GROUP COVERAGE.

27  
28 The General Assembly of North Carolina enacts:

29 **SECTION 1.(a)** G.S. 58-51-80(1a) reads as rewritten:

"(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; 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, other than associate 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. The premium rates for each association policy shall be developed, and applied to the certificates thereunder, on an actuarially sound basis.
- c. Repealed by Session Laws 1997-259, s. 8."

**SECTION 1.(b)** G.S. 58-51-95 is amended by adding the following new subsection to read:

**"§ 58-51-95. Approval by Commissioner of forms, classification and rates; hearing; exceptions.**

...

"(g) For policies subject to this section, an individual health insurer shall not increase an individual's renewal premium for continued health insurance coverage under the terms of the individual's health insurance policy based on any health status-related factors in relation to the individual or a dependent of the individual, including:

- (1) Health status.
- (2) Medical condition (including physical and mental illnesses).
- (3) Claims experience.
- (4) Duration from issue.
- (5) Receipt of health care.
- (6) Medical history.
- (7) Genetic information."

**SECTION 2.(a)** G.S. 58-65-60 is amended by adding the following new subsection to read:

1 **"§ 58-65-60. Subscribers' contracts; required and prohibited provisions.**

2 ...

3 "(e3) When determining employee eligibility for a large employer, as defined in  
4 G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an  
5 "employee" for the purpose of obtaining coverage under the employee group health plan  
6 and shall not be held to a minimum workweek requirement as imposed on other eligible  
7 employees."

8 **SECTION 2.(b)** G.S. 58-67-85 is amended by adding the following new  
9 subsection to read:

10 **"§ 58-67-85. Master group contracts, filing requirement; required and prohibited**  
11 **provisions.**

12 ...

13 "(d1) When determining employee eligibility for a large employer, as defined in  
14 G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an  
15 "employee" for the purpose of obtaining coverage under the employee group health plan  
16 and shall not be held to a minimum workweek requirement as imposed on other eligible  
17 employees."

18 **SECTION 2.(c)** G.S. 58-51-80(c) reads as rewritten:

19 **"§ 58-51-80. Group accident and health insurance defined.**

20 ...

21 "(c) The term "employees" as used in this section shall be deemed to include, for  
22 the purposes of insurance hereunder, employees of a single employer, the officers,  
23 managers, and employees of the employer and of subsidiary or affiliated corporations of  
24 a corporation employer, and the individual proprietors, partners, and employees of  
25 individuals and firms of which the business is controlled by the insured employer  
26 through stock ownership, contract or otherwise. With the exception of disability income  
27 insurance, employees shall be added to the group coverage no later than 90 days after  
28 their first day of employment. Employment shall be considered continuous and not be  
29 considered broken except for unexcused absences from work for reasons other than  
30 illness or injury. The term "employee" is defined as a nonseasonal person who works on  
31 a full-time basis, with a normal work week of 30 or more hours and who is otherwise  
32 eligible for coverage, but does not include a person who works on a part-time,  
33 temporary, or substitute basis. The term "employer" as used herein may be deemed to  
34 include the State of North Carolina, any county, municipality or corporation, or the  
35 proper officers, as such, of any unincorporated municipality or any department or  
36 subdivision of the State, county, such corporation, or municipality determined by  
37 conditions pertaining to the employment. When determining employee eligibility for a  
38 large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or  
39 operator shall be defined as an "employee" for the purpose of obtaining coverage under  
40 the employee group health plan and shall not be held to a minimum workweek  
41 requirement as imposed on other eligible employees."

42 **SECTION 3.** G.S. 58-51-30(b) reads as rewritten:

43 **"§ 58-51-30. Policies to cover newborn infants, foster children, and adopted**  
44 **children.**

1       ...

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

21           **SECTION 4.(a)** G.S. 58-51-15(a)(2) reads as rewritten:

22   "**§ 58-51-15. Accident and health policy provisions.**

23       (a) Required Provisions. – Except as provided in subsection (c) of this section  
24 each such policy delivered or issued for delivery to any person in this State shall contain  
25 the provisions specified in this subsection in the substance of the words that appear in  
26 this section. Such provisions shall be preceded individually by the caption appearing in  
27 this subsection or, at the option of the insurer, by such appropriate individual or group  
28 captions or subcaptions as the Commissioner may approve.

29       ...

30       (2) A provision in the substance of the following language:

31           **TIME LIMIT ON CERTAIN DEFENSES:**

- 32           a. After two years from the date of issue or reinstatement of this  
33 policy no misstatements except fraudulent misstatements made  
34 by the applicant in the application for such policy shall be used  
35 to void the policy or deny a claim for loss incurred or disability  
36 (as defined in the policy) commencing after the expiration of  
37 such two-year period.

38           The foregoing policy provision may be used in its entirety  
39 only in major or catastrophe hospitalization policies and major  
40 medical policies each affording benefits of five thousand dollars  
41 (\$5,000) or more for any one sickness or injury; disability  
42 income policies affording benefits of one hundred dollars  
43 (\$100.00) or more per month for not less than 12 months; and

franchise policies. Other policies to which this section applies must delete the words "except fraudulent misstatements."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of G.S. 58-51-15(b), (1), (2), (3), (4) and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

1. Until at least age 50 or,
2. In the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE."

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

- b. This policy contains a provision limiting coverage for preexisting conditions. Preexisting conditions are covered under this policy \_\_\_\_\_ (insert number of months or days, not to exceed one year) after the effective date of coverage. Preexisting conditions mean "those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage." ~~Credit~~ Except for the excepted benefits described in G.S. 58-68-25(b), 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. 58-68-30."

**SECTION 4.(b)** G.S. 58-51-15(h) reads as rewritten:

**"§ 58-51-15. Accident and health policy provisions.**

...

"(h) Preexisting Condition Exclusion Clarification. – Sub-subdivision (a)(2) b. of this section does not apply ~~to~~ to policies issued to eligible individuals under G.S. 58-68-60.

~~(1) Policies issued to eligible individuals under G.S. 58-68-60.~~

~~(2) Excepted benefits as described in G.S. 58-68-25(b)."~~

**SECTION 5.** G.S. 58-50-150(b) reads as rewritten:

**"§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.**

...

"(b) ~~Within 30 days after January 1, 1992, the Commissioner shall give notice to all carriers of the time and place for the initial organizational meeting, which shall take~~

1 ~~place within 90 days after the notice from the Commissioner.~~ The members shall select  
2 the initial Board, subject to the Commissioner's approval. The Board shall consist of  
3 nine members. There shall be no more than two members of the Board representing any  
4 one carrier. In determining voting rights at the organizational meeting, each member  
5 shall be entitled to vote in person or by proxy. ~~The voting rights to determine initial~~  
6 ~~Board membership shall be weighted based upon net group health benefit plan premium~~  
7 ~~derived from this State in the previous calendar year. Thereafter, voting~~ Voting rights  
8 shall be based on net group health benefit plan premium derived from small employer  
9 business. The Board shall at all times, to the extent possible, include at least one  
10 domestic insurance company licensed to transact accident and health insurance, one  
11 HMO, one nonprofit hospital or medical service plan. ~~Six~~ Five of the members of the  
12 Board shall be small employer carriers. In approving selection of the Board, the  
13 Commissioner shall assure that all members are fairly represented."

14 **SECTION 6.** G.S. 58-54-45(a) reads as rewritten:

15 "**§ 58-54-45. By reason of disability.**

16 (a) In addition to any rule adopted under this Article that is directly or indirectly  
17 related to open enrollment, an insurer shall at least make standardized Medicare  
18 Supplement Plans A, C, and J available to persons eligible for Medicare by reason of  
19 disability before age 65. This action shall be taken without regard to medical condition,  
20 claims experience, or health status. To be eligible, a person must submit an application  
21 during the six-month period beginning with the first month the person first enrolls in  
22 Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B  
23 due to a retroactive eligibility decision made by the Social Security Administration, the  
24 application must be submitted within a six-month period beginning with the month in  
25 which the person receives notification of the retroactive eligibility decision.

26 ..."

27 **SECTION 7.** G.S. 58-3-100(c) reads as rewritten:

28 "**§ 58-3-100. Insurance company licensing provisions.**

29 ...

30 (c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an  
31 HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30  
32 days after receiving written or electronic notice of the claim, but only if the notice  
33 contains sufficient information for the insurer to identify the specific coverage involved.  
34 Acknowledgement of the claim shall be one of the following:

- 35 (1) A statement made to the claimant or to the claimant's legal  
36 representative advising that the claim is being investigated.
- 37 (2) Payment of the claim.
- 38 (3) A bona fide written offer of settlement.
- 39 (4) A written denial of the claim.

40 A claimant includes an insured, a beneficiary of a life or annuity contract, a health care  
41 provider, or a health care facility that is responsible for directly making the claim with  
42 an insurer, HMO, service corporation, or MEWA. With respect to a claim under an  
43 accident, health, or disability policy, if the acknowledgement sent to the claimant  
44 indicates that the claim remains under investigation, within 45 days after receipt by the

1 insurer of the initial claim, the insurer shall send a claim status report to the insured and  
2 every 45 days thereafter until the claim is paid or denied. The report shall give details  
3 sufficient for the insured to understand why processing of the claim has not been  
4 completed and whether the insurer needs additional information to process the claim. If  
5 the claim acknowledgement includes information about why processing of the claim has  
6 not been completed and indicates whether additional information is needed, it may  
7 satisfy the requirement for the initial claim status report. This subsection does not apply  
8 to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225.

9 ..."

10 **SECTION 8.** G.S. 58-50-61(a) is amended by adding the following new  
11 subdivision to read:

12 "**§ 58-50-61. Utilization review.**

13 (a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this  
14 Article, the term:

15 ...

16 (2a) 'Certificate of coverage' includes a policy of insurance issued to an  
17 individual person or a franchise policy issued pursuant to  
18 G.S. 58-51-90.

19 ..."

20 **SECTION 9.** Sections 1 through 4 of this act become effective January 1,  
21 2005, and apply to policies or certificates issued or renewed on or after that date. The  
22 remainder of this act is effective when it becomes law and applies to policies or  
23 certificates issued or renewed on or after that date.