[N.C. Gen. Stat. §§ 58-50-105 through 58-50-150.]

§§ 58-50-105 through 58-50-150: North Carolina Small Employer Group Health Coverage Reform Act

§ 58-50-105. Purpose and intent.

The purpose and intent of this Act is to promote the availability of accident and health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group accident and health insurance marketplace. (1991, c. 630, s. 1.)

§ 58-50-110. Definitions.

As used in this Act:

(1) Repealed by Session Laws 2001-334, s. 12.1, effective August 3, 2001.

(1a) "Actuarial certification" means a written statement by a member of the 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 Article 68 of this Chapter, 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(2) Repealed by Session Laws 1993, c. 529, s. 3.3.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, geographic location, and industry.

(6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.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

(10a) "Grandfathered health plan" means a health benefit plan providing coverage considered grandfathered health coverage described in 45 C.F.R. § 147.140(a).

(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 include benefits described in G.S. 58-68-25(b).

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

(12a) "Industry" means a demographic factor used to reflect the financial risk associated with a specific industry.

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

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

a. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.

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 Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.

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 Repealed by Session Laws 1993, c. 529, s. 3.3.

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

c. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.

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

e. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.

(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 preexisting-condition provision as defined in G.S. 58-68-30.

(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 50 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 subdivision, the term small employer includes self-employed individuals. Effective January 1, 2014, this definition shall apply only to grandfathered group health plans subject to this Act.

(22a) Repealed by Session Laws 2013-357, s. 4(a), effective January 1, 2016.

(22b) "Small employer" means, in connection with a nongrandfathered nontransitional group health plan with respect to a calendar year and a plan year, an employer who meets the definition of small employer under 42 U.S.C. § 18024(b). The number of employees shall be determined using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.

(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. (1991, c. 630, s. 1; 1993, c. 408, ss. 1, 2; c. 529, s. 3.3; 1993 (Reg. Sess., 1994), c. 569, s. 6; 1997-259, s. 2; 1998-211, s. 9; 2001-334, ss. 12.1, 12.2; 2006-154, ss. 5, 6; 2013-357, ss. 2(b), 4(a), (b); 2015-281, s. 12.)

§ 58-50-112. Affiliated companies; HMOs.

For the purposes of this Act, companies that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier except that any insurance company, hospital service plan, or medical service plan that is an affiliate of an HMO located in North Carolina or any HMO located in North Carolina that is an affiliate of an insurance company, a health service corporation, or a medical service corporation may treat the HMO as a separate carrier and each HMO that operates only one HMO in a service area of North Carolina may be considered a separate carrier. (1991, c. 630, s. 1.) § 58-50-113: Repealed by Session Laws 1993, c. 529, s. 3.4.

§ 58-50-115. Health benefit plans subject to Act.

(a) A health benefit plan is subject to this Act if it provides health benefits for small employers and if any of the following conditions are met:

(1) Any part of the premiums or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium;

(2) The health benefit plan is treated by the employer as part of a plan or program for the purpose of sections 106, 125, or 162 of the United States Internal Revenue Code; or

(3) The small employer has permitted payroll deductions for the eligible enrollees for the health benefit plans.

(b) Repealed by Session Laws 1993, c. 529, s. 3.5, effective January 1, 1995.

(c) A health benefit plan is not subject to this Act if it provides health benefits for employers who are employer members of a Path 2 MEWA pursuant [to] Article 50A of this Chapter through a policy issued to the Path 2 MEWA. (1991, c. 630, s. 1; 1993, c. 529, s. 3.5; 2013-357, s. 2(c); 2019-202, s. 4(b).)

§ 58-50-120: Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

§ 58-50-125. Health care plans; formation; approval; offerings.

(a), (a1) Repealed by Session Laws 2013-357, s. 2(e), effective January 1, 2015.

(b) Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

(c) Except as provided under Article 68 of this Chapter, 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.

(d) 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)(4b). 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. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer.

(e) Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

(f) To the extent it is required under this section and G.S. 58-68-40, every small employer carrier shall fairly market all of its small group health benefit plans it offers on a guaranteed issue basis to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits.

(g) Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

(h) The provisions of subsection (d) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan. (1991, c. 630, s. 1; c. 761, s. 10; 1993, c. 529, s. 3.6; 1997-259, ss. 3, 4; 2006-154, ss. 1, 2, 9, 10, 14; 2013-357, ss. 2(d), (e).) §§ 58-50-126, 58-50-127: Repealed by Session Laws 2013-357, s. 2(a), effective January 1, 2014.

§ 58-50-130. Required health care plan provisions.

(a) Health benefit plans covering small employers are subject to the following provisions:

(1) to (4) Repealed by Session Laws 1997-259, s. 5, effective July 14, 1997.

(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.

(4b) Late enrollees may only 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 that period in the health benefit plan held at the time by the small employer.

(5) 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 who employ fewer than 20 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:

a. Provides direct coverage of health expenses payable to an individual.

b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

c. Has an annual aggregate attachment point lower than the greater of one of the following:

1. One hundred twenty percent (120%) of expected claims.

2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012. Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis.

(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), (8) Repealed by Session Laws 1997-259, s. 5.

(9) The health benefit plan must meet the applicable requirements of Article 68 of this Chapter.

(b) For all small employer health benefit plans that are grandfathered health benefit plans and that are subject to this section, the premium rates are subject to all of the following provisions:

(1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined

under subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection, or industry as determined under subdivision (9) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than twenty-five percent (25%) for any reason, including differences in administrative costs and claims experience.

(2) Rating factors related to age, gender, number of family members covered, geographic location, or industry may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review.

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

a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period.

b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

c. Any adjustment because of change in coverage or change in case characteristics of the small employer group.

(4), (5) Repealed by Session Laws 1995, c. 238, s. 1.

(6) Unless the small employer carrier uses composite rating, the small employer carrier shall use the following age brackets:

a. Younger than 15 years;

b. 15 to 19 years;

c. 20 to 24 years;

d. 25 to 29 years;

e. 30 to 34 years;

f. 35 to 39 years;

g. 40 to 44 years;

h. 45 to 49 years;

i. 50 to 54 years;

j. 55 to 59 years; k. 60 to 64 years;

l. 65 years. Carriers may combine, but shall not split, complete age brackets for the purposes of determining rates under this subsection. Small employer carriers shall be permitted to develop separate rates for individuals aged 65 years and older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor.

(7) A carrier shall define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas, and shall be revenue neutral to the small employer carrier.

(8) The Department may adopt rules to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those rules shall include consideration of differences based on all of the following:

a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs.

b. Except as provided for in sub-subdivision a. of this subdivision, differences in rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates because of the case characteristics of groups assumed to select particular health benefit plans.

c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers.

(9) In any case where the small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification divided by the lowest rate factor associated with any other industry classification shall not exceed 1.2.

(b1) For all small employer health benefit plans that are not grandfathered health benefit plans and that are subject to this section, the premium rates are subject to all of the following provisions:

(1) A small employer carrier shall use a method to develop premiums for small employer group health benefit plans that are not grandfathered health plans which spreads financial risk across a large population and allows adjustments for only the following factors:

a. Age, except that the rate shall not vary by more than the ratio of three to one (3:1) for adults.

b. Whether the plan or coverage covers individual or family.

c. Geographic rating areas.

d. Tobacco use, except that the rate shall not vary by more than the ratio of one and two-tenths to one (1.2:1) due to tobacco use. With respect to family coverage under a health benefit plan, the rating variations for age and tobacco use shall be applied based on the portion of premium that is attributable to each family member covered under the plan.

(2) A small employer carrier shall consider the claims experience of all enrollees in all small employer group health benefit plans that are not grandfathered health plans offered by the insurer in the small employer group market in this State to be members of a single risk pool. No small employer carrier shall consider claims experience of grandfathered health plans in developing the single risk pool.

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

(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 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.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction. Nothing in this section affects the Commissioner's authority to approve rates before their use under G.S. 58-65-60(e) or G.S. 58-67-50(c).

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons

residing in this State on or after January 1, 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan.

(i) A small employer carrier shall not modify the premium rate charged to a small group nongrandfathered health benefit plan or a small employer group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date. (1991, c. 630, s. 1; 1993, c. 408, s. 6; c. 529, ss. 3.2, 3.7; 1993 (Reg. Sess., 1994), c. 569, ss. 7, 8; c. 678, ss. 24, 25; 1995, c. 238, s. 1; c. 507, s. 23A.1(b); 1995 (Reg. Sess., 1996), c. 669, s. 1; 1997-259, ss. 5, 6; 1998-211, ss. 9.1, 10; 1999-132, s. 4.1; 2001-334, ss. 3, 12.3; 2006-154, s. 7; 2013-357, ss. 2(f), (g), 3; 2019-202, s. 5(a).)

§ 58-50-131. Premium rates for health benefit plans; approval authority; hearing.

(a) No schedule of premium rates for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premium rates or premium rate amendment has been filed with and approved by the Commissioner. Any schedule of premium rates or premium rate amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premium rates shall not be excessive, unjustified, inadequate, or unfairly discriminatory and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the U.S. Qualifications Standards promulgated by the American Academy of Actuaries pursuant to its Code of Professional Conduct.

(b) The Commissioner shall approve or disapprove a schedule of premium rates within 60 days of receipt of a complete filing. It shall be unlawful to use a schedule of premium rates until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer, shall specify the reasons for disapproval, and shall provide an opportunity for refiling.

(c) The Commissioner shall adopt rules as necessary or proper (i) to prevent the federal preemption of health insurance regulation in the State, (ii) to implement the provisions of this section, and (iii) to establish minimum standards for loss ratios of policies subject to this section in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. The Commissioner shall adopt rules to require the submission of supporting data and any information that the Commissioner considers necessary or proper to determine whether the filed schedule of premium rates meets the standards set forth in this section. (2011-196, s. 4; 2013-199, s. 9.)

§ 58-50-135: Repealed by Session Laws 2013-357, s. 2(a), effective January 1, 2014.

§ 58-50-140: Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

§ 58-50-145: Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

§ 58-50-149. Limit on cessions to the Reinsurance Pool.

In addition to any individual or group previously reinsured in accordance with G.S. 58-50-150(g)(1), the Pool shall only reinsure a health benefit plan issued or delivered for original issue by a reinsuring carrier on or after October 1, 1995, if the health benefit plan provides coverage to a small employer with no more than 25 eligible employees, including self-employed individuals. Notwithstanding any other provision of law, the Pool shall cease to reinsure any individual or group on January 1, 2007. Reinsuring carriers as of that date shall continue to be governed by G.S. 58-50-135(b) and G.S. 58-50-150 until and through the termination of the Pool. (1995, c. 517, s. 29; 2006-154, s. 8.)

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

(a) There is created a nonprofit entity to be known as the North Carolina Small Employer Health Reinsurance Pool. All carriers issuing or providing health benefit plans in this State from January 1, 1992, until the termination of the Pool, except any small employer carrier electing to be a risk-assuming carrier, are members of the Pool.

(b) The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of five members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. Four of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented.

(c) If the initial Board is not elected at the organizational meeting, the Commissioner shall appoint the initial Board within 30 days of the organizational meeting.

(d) As used in this section, "plan of operation" includes articles, bylaws, and operating rules of the Pool. Within 180 days after the appointment of the initial Board, the Board shall submit to the Commissioner a plan of operation and any amendments necessary or suitable to assume the fair, reasonable, and equitable administration of the Pool. The Commissioner shall approve the plan of operation if it assures the fair, reasonable, and equitable administration of the Pool and provides for the proportionate basis in accordance with the provisions of subsections (h) through (o) of this section. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this section shall be made available. If the Board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Commissioner shall adopt and promulgate a plan of operation or amendment, as appropriate. The Commissioner shall amend any plan of operation he adopts, as necessary, after a plan of operation is submitted by the Board and approved by the Commissioner.

(e) The plan of operation shall establish procedures for, among other things:

(1) Handling and accounting of assets and moneys of the Pool, and for an annual financial reporting to the Commissioner.

(2) Filling vacancies on the Board, subject to the Commissioner's approval.

(3) Selecting an administering carrier and setting forth the powers and duties of the administering carrier.

(4) Reinsuring risks in accordance with the provisions of this Act.

(5) Collecting assessments from members subject to assessment to provide for claims reinsured by the Pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(6) Any additional matters in the Board's discretion.

(f) The Pool has the general powers and authority granted under the laws of this State to insurance companies licensed to transact accident and health insurance except the power to issue coverage directly to enrollees, and, in addition, the specific authority to do all of the following:

(1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the Commissioner's approval, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members.

(3) Take any legal action necessary to avoid the payment of improper, incorrect, or fraudulent claims against the Pool or the coverage reinsured by the Pool.

(4) Issue various reinsurance policies in accordance with the requirements of this section.

(5) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the Pool.

(6) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the Pool's operation.

(7) Assess members in accordance with the provisions of subsections (h) through (o) of this section; and make advance interim assessments that are reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the Pool's fiscal year.

(8) Appoint from among members appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.

(9) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for members and may be carried as admitted assets.

(g) Any member that elects to be a reinsuring carrier may cede, and the Pool shall reinsure the reinsuring carrier, subject to all of the following:

(1) The Pool shall reinsure any basic and standard health care plan originally issued or delivered for original issue by a reinsuring carrier on or after January 1, 1992, under the requirements in G.S. 58-50-125(d). With respect to a basic or standard health care plan, the Pool shall reinsure the level of coverage provided and, with respect to other plans, the Pool shall reinsure the level of coverage provided in the basic or standard health care plan up to, but not exceeding, the level of coverage provided under either the basic or standard health care plans. Small group business of reinsuring carriers in force before January 1, 1992, may not be ceded to the Pool until January 1, 1995, and then only if and when the Board determines that sufficient funding sources are available.

(2) The Pool shall reinsure eligible employees or their dependents or entire small employer groups according to the following:

a. With respect to eligible employees and their dependents who either (i) are employed by a small employer as of the date such employer's coverage by the member begins or (ii) are hired after the beginning of the employer's coverage by the member: The coverage may be reinsured within 60 days after the beginning of the eligible employees' or dependents' coverage under the plan.

b. With respect to eligible employees and their dependents, when the entire employer group is eligible for reinsurance: A small employer carrier may reinsure the entire employer group within 60 days after the beginning of the group's coverage under the plan.

c. With respect to any person reinsured, no reinsurance may be provided for a reinsured employee or dependent until five thousand dollars ($5,000) in benefit payments have been made for services provided during a calendar year for that reinsured employee or dependent, which payments would have been reimbursed through the reinsurance in the absence of the five thousand dollar ($5,000) deductible. The Boards shall review periodically the amount of the deductible and adjust it for inflation. In addition, the member shall retain ten percent (10%) of the next fifty thousand dollars ($50,000) of benefit payments during a calendar year and the Pool shall reinsure the remainder; provided that the members' liability under this section shall not exceed ten thousand dollars ($10,000) in any one calendar year with respect to any one person reinsured. The amount of the member's maximum liability shall be periodically reviewed by the Board and adjusted for inflation, as determined by the Board.

d. Reinsurance may be terminated for each reinsured employee or dependent on any plan anniversary.

e. Premium rates charged for reinsurance by the program to an HMO that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization under 42 U.S.C. § 300 et seq., shall be reduced to reflect the restrictions and requirements of 42 U.S.C. § 300 et seq.

f. Every carrier subject to G.S. 58-50-130 shall apply its case management and claims handling techniques, including but not limited to utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured and nonreinsured business.

g. Except as otherwise provided in this section, premium rates charged by the Pool for coverage reinsured by the Pool for that classification or group with similar case characteristics and coverage shall be established as follows:

1. One and one-half times the rate established by the Pool with respect to the eligible employees and their dependents of a small employer, all of whose coverage is reinsured with the Pool and who are reinsured in accordance with this section.

2. Five times the rate established by the Pool with respect to an eligible employee or dependent who is reinsured in accordance with this section.

(3) The Pool shall reinsure no more than the level of benefits provided in either the basic or standard health care plan established in accordance with G.S. 58-50-125.

(4) The Pool may issue different types and levels of reinsurance coverage, including stop-loss coverage; and the reinsurance premium shall be adjusted to reflect the type and level of reinsurance coverage issued.

(5) The reinsurance premium shall also be adjusted to reflect cost containment features of the plan of operation that have proven to be effective including, but not limited to: preferred provider provisions, utilization review of medical necessity of hospital and physician services, case management benefit alternatives, and other managed care provisions or methods of operation.

(h) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the Pool expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health benefit plan premiums and benefits paid by a member that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments. As used in this section, "net premiums" means health benefit plan premiums for insured plans but does not mean premiums or revenue received by a carrier for Medicare and Medicaid contracts.

(i) Any net losses for the year shall be recouped by assessments of members as follows:

(1) The Board shall determine an equitable assessment formula to recoup assessments of members that takes into consideration both overall market share of small employer carriers that are members of the Pool and the share of new business of the small employer carriers assumed during the preceding calendar year. For the first three years of operation of the Pool, if an assessment is based on an adjustment made, the assessment shall not be less than fifty percent (50%) nor more than one hundred fifty percent (150%) of the amount it would have been if the assessment were based on the proportional relationship of the small employer carrier's total premiums for small employer coverage written in the year to the total premiums of small employer coverage written by all small employer carriers in this State in the year. The Board shall also determine whether the assessment base used to determine assessments shall be made on a transitional basis or shall be permanent. In no event shall assessments exceed four percent (4%) of the total health benefit plan premium earned in this State from health benefit plans covering small employers of members during the calendar year coinciding or ending during the fiscal year of the Pool. The Board may change the assessment formula, including an assessment adjustment formula, if applicable, from time to time as appropriate.

(2) Health benefit plan premiums and benefits paid by a member that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments. For the purposes of this section, health benefit plan premiums earned by MEWAs and other benefit arrangements, to the extent permitted by ERISA, shall be established by adding paid health losses and administrative expenses.

(j) If the assessment level is inadequate, the Board may adjust reinsurance thresholds, retention levels, or consider other forms of reinsurance. After the first three full years of operations the Board shall report to the Commissioner on its experience, the effect on reinsurance and small group rates of individual ceding, and recommendations on additional funding sources, if needed. If legislative or other broader funding alternatives are not found, the Board may enter into negotiations with representatives of health care providers to resolve any deficit through reductions in future years' payment levels for reinsured plans. Any such recommendations shall take into account the findings of the actuarial study provided for in this subsection. An actuarial study shall be undertaken within the first three years of the Pool's operation to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this Act. The study shall be developed by three actuaries appointed by the Commissioner, with one representing risk assuming carriers, one representing reinsuring carriers, and one from within the Department.

(k) Subject to the approval of the Commissioner, the Board may make an adjustment to the assessment formula for any reinsuring carrier that is an HMO approved as a federally qualified HMO by the Secretary of Health and Human Services under 42 U.S.C. § 300 for restrictions placed on them other than those for which an adjustment has already been made in subsection (b)(2) or (b)(5) of this section that are not imposed on other small group carriers.
(l) If assessments exceed actual losses and administrative expenses of the Pool, the excess shall be held at interest and used by the Board to offset future losses or to reduce Pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(m) The Board shall determine annually each member's proportion of participation in the Pool based on financial statements and other reports that the Board considers to be necessary and requires that the member files with the Board. All carriers shall report, to the Board, claims payments made and administrative expenses incurred in this State on an annual basis and on a form prescribed by the Commissioner.

(n) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(o) The Board may abate or defer, in whole or in part, the assessment of a member if, in the Board's opinion, payment of the assessment would endanger the member's ability to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this section. The member receiving the abatement or deferment shall remain liable to the Pool for the deficiency.

(p) Neither the participation in the Pool as members, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its members.

(q) Any person or member made a party to any action, suit, or proceeding because the person or member serves or served on the Board or on a committee or is or was an officer or employee of the Pool shall be held harmless and be indemnified by the Pool against all liability and costs, including the amounts of judgments, settlements, fines, or penalties, and expenses and reasonable attorneys' fees incurred in connection with the action, suit, or proceeding. However, the indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of service or office. Costs and expenses of the indemnification shall be prorated among and paid for by all members.

(r) The Pool is exempt from the taxes imposed by Article 8B of Chapter 105 of the General Statutes. (1991, c. 630, s. 1; 1993, c. 408, s. 7; 2005-223, s. 5; 2006-154, s. 12.)