North Carolina Statutes
Health Insurance Portability and Accountability

PART A. GROUP MARKET REFORMS

SUBPART 1. PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

§ 58-68-25. Definitions; excepted benefits; employer size rule

(a) Definitions. -- In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

(1) "Bona fide association". -- With respect to health insurance coverage offered in this State, an association that:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does 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).

d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) "COBRA continuation provision". -- Any of the following:

a. *Section 4980B of the Internal Revenue Code of 1986,* other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.

b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.

c. Title XXII of the Public Health Service Act *(42 U.S.C.S. § 300bb,* et seq.,) as requirements for certain group health plans for certain State and local employees.

d. Article 53 of this Chapter or the health insurance continuation law of another state.

(3) "Employee". -- The meaning given the term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) "Employer". -- The meaning given the term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two or more employees.

(5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan". -- Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer.

(6) "Health insurer". -- An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) "Health status-related factor". -- Any of the factors described in *G.S. 58-68-35(a)(1)*.

(8) "Individual health insurance coverage". -- Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) "Individual market". -- The market for health insurance coverage offered to individuals.

(10) "Large employer". -- An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the health insurance plan year.

(11) "Large group market". -- The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) "Medical care". -- Amounts paid for:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

b. Amounts paid for transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision.

c. Amounts paid for insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.

(13) "Network plan". -- Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) "Participant". -- The meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) "Placed for adoption". -- The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) "Small employer". -- The meaning given to the term in *G.S. 58-50-110(22)*.

(17) "Small group market". -- The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer.

(b) Excepted Benefits. -- For the purposes of this Article, "excepted benefits" means benefits under one or more or any combination of the following:

(1) Benefits not subject to requirements. --

a. Coverage only for accident or disability income insurance or any combination of these.

b. Coverage issued as a supplement to liability insurance.

c. Liability insurance, including general liability insurance and automobile liability insurance.

d. Workers' compensation or similar insurance.

e. Automobile medical payment insurance.

f. Credit-only insurance.

g. Coverage for on-site medical clinics.

h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

i. Short-term limited-duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) Benefits not subject to requirements if offered separately. --

a. Limited scope dental or vision benefits.

b. Benefits for long-term care, nursing care, home health care, community-based care, or any combination of these.

c. The other similar, limited benefits as are specified in federal regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits. --

a. Coverage only for a specified disease or illness.

b. Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy. -- Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health insurance plan.

(c) Application of certain rules in determination of employer size. -- For the purposes of this Article:

(1) Application of aggregation rule for employers. -- All persons treated as a single employer under subsection (b), (c), (m), or (o) of *section 414 of the Internal Revenue Code of 1986* shall be treated as one employer.

(2) Employers not in existence in preceding year. -- In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. -- Any reference in this subsection to an employer shall include a reference to any predecessor of the employer.

HISTORY: 1997-259, s. 1(c); 2002-187, s. 5.1.

§ 58-68-30. Increased portability through limitation on preexisting condition exclusions

(a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage. -- Subject to subsection (d) of this section, a group health insurer may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions. -- For the purposes of this Part:

(1) Enrollment date. -- With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment. An individual's enrollment date does not change if the individual receiving benefits under a group health insurance plan changes benefit packages or if the plan changes health insurers.

(2) Late enrollee. -- With respect to coverage under a group health insurance plan, a participant or beneficiary who enrolls under the plan other than during:

a. The first period in which the individual is eligible to enroll under the plan, or

b. A special enrollment period under subsection (f) of this section.

(3) Preexisting condition exclusion. --

a. In general. -- "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

b. Treatment of genetic information. -- Genetic information shall not be treated as a condition described in subdivision (a)(1) of this subsection in the absence of a diagnosis of the condition related to the information.

(4) Waiting period. --

a. With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

b. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.

c. If an individual seeks individual health insurance coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on: (i) the date coverage begins if the application results in coverage; or (ii) the date on which the application is denied by the health insurer or the date on which the offer for coverage lapses if the application does not result in coverage.

(c) Rules Relating to Crediting Previous Coverage. --

(1) Creditable coverage defined. -- For the purposes of this Article, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

a. A self-funded employer group health plan under the Employee Retirement Income Security Act of 1974.

b. Group or individual health insurance coverage.

c. Part A or part B of title XVIII of the Social Security Act.

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

e. Chapter 55 of title 10, United States Code.

f. A medical care program of the Indian Health Service or of a tribal organization.

g. A State health benefits risk pool.

h. A health plan offered under chapter 89 of title 5, United States Code.

i. A public health plan (as defined in federal regulations).

j. A health benefit plan under section 5(e) of the Peace Corps Act *(22 U.S.C. § 2504*(e)).

k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered creditable coverage for purposes of this section and *G.S. 58-51-15(a)(2)*b.

(2) Not counting periods before significant breaks in coverage. --

a. In general. -- A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the en-

rollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

b. Waiting period not treated as a break in coverage. -- For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.

c. Time spent on short term limited duration health insurance not treated as a break in coverage. -- For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision. a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.

d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.

(3) Method of crediting coverage. --

a. Standard method. -- Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.

b. Election of alternative method. -- A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

c. Health insurer notice. -- In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.

(4) Establishment of period. -- Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations.

(d) Exceptions. --

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

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

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

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

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

(e) Certifications and Disclosure of Coverage. --

(1) Requirement for certification of period of creditable coverage. --

a. In general. -- A group health insurer shall provide the certification described in sub-subdivision b. of this subdivision: (i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, (ii) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii) of this sub-subdivision, whichever is later.

The certification under clause (i) of this sub-subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

b. Certification. -- The certification described in this sub-subdivision is a written certification of: (i) the period of creditable coverage of the individual under the plan and any coverage under the COBRA continuation provision, and (ii) any waiting period and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) Disclosure of information on previous benefits. -- In the case of an election described in sub-subdivision (c)(3)b. of this subsection by a group health insurer, if the health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1) of this subsection:

a. Upon request of the health insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or health insurer information on coverage of classes and categories of health benefits available under the entity's coverage.

b. The entity may charge the requesting plan or health insurer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods. --

(1) Individuals losing other coverage. -- A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. The employee or dependent was covered under an ERISA group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. With respect to the employee's or dependent's coverage described in sub-subdivision a. of this subsection: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under that provision and either the coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; (iii) employer contributions toward the coverage were terminated; (iv) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, there has been loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or (vii) the health insurer terminated coverage under *G.S. 58-68-45(c)(2)*.

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of the applicable event described in sub-subdivision c. of this subdivision.

(2) For dependent beneficiaries. --

a. In general. -- If: (i) a group health insurance plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes the dependent of the individual through marriage, birth, or adoption or placement for adoption.

The plan shall provide for a dependent special enrollment period described in sub-subdivision b. of this subdivision during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

b. Dependent special enrollment period. -- A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

c. No waiting period. -- If an individual seeks to enroll a dependent during the first 30 days of the dependent's special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of a dependent's birth, as of the date of the birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition Exclusion. --

(1) In general. -- A health maintenance organization that does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if:

a. The period is applied uniformly without regard to any health status-related factors.

b. The period does not exceed two months (or three months in the case of a late enrollee).

(2) Affiliation period. --

a. Defined. -- For the purposes of this Subpart, "affiliation period" means a period that, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

b. Beginning. -- The period shall begin on the enrollment date.

c. Runs concurrently with waiting periods. -- An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods. -- A health maintenance organization described in subdivision (1) of this subsection may use alternative methods, as approved by the Commissioner, from those described in that subdivision, to address adverse selection.

HISTORY: 1997-259, s. 1(c); 1998-211, s. 7; 2001-334, s. 9; 2005-224, ss. 1, 4, 2.1, 2.2.

§ 58-68-35. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In Eligibility To Enroll. --

(1) In general. -- Subject to subdivision (2) of this subsection, a group health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the health insurer's plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.

b. Medical condition (including both physical and mental illnesses).

c. Claims experience.

d. Receipt of health care.

e. Medical history.

f. Genetic information.

g. Evidence of insurability (including conditions arising out of acts of domestic violence).

h. Disability.

(2) No application to benefits or exclusions. -- To the extent consistent with *G.S. 58-68-30*, subdivision (1) of this subsection shall not be construed:

a. To require a group health insurance plan to provide particular benefits other than those provided under the terms of the plan, or

b. To prevent the plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan.

(3) Construction. -- For the purposes of subdivision (1) of this subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.

(b) In Premium Contributions. --

(1) In general. -- A group health insurance plan shall not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of individual.

(2) Construction. -- Nothing in subdivision (1) of this subsection shall be construed:

a. To restrict the amount that an employer may be charged for coverage under a group health insurance plan; or

b. To prevent a group health insurer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

§ 58-68-40. Guaranteed availability of coverage for employers in the small group market

(a) Issuance of Coverage in the Small Group Market. --

(1) In general. -- Subject to subsections (c) through (f) of this section, each health insurer that offers health insurance coverage in the small group market in this State:

a. Must accept every small employer that applies for the coverage; and

b. Must accept for enrollment under the coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health insurance plan and shall not place any restriction that is inconsistent with *G.S. 58-68-35* on an eligible individual being a participant or beneficiary.

(2) Eligible individual defined. -- For the purposes of this section, "eligible individual" means, with respect to a health insurer that offers health insurance coverage to a small employer in the small group market, such an individual in relation to the employer as shall be determined:

a. In accordance with the terms of the plan,

b. As provided by the health insurer under rules of the health insurer that are uniformly applicable in this State to small employers in the small group market, and

c. In accordance with all applicable State laws governing the health insurer and the market.

(b) Special Rules for Network Plans. --

(1) In general. -- In the case of a health insurer that offers health insurance coverage in the small group market through a network plan, the health insurer may:

a. Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

b. Within the service area of the network plan, deny coverage to the employers if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and (ii) it is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. -- A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subsection, shall not offer coverage in the small group market within the service area for a period of 180 days after the date the coverage is denied.

(c) Application of Financial Capacity Limits. --

(1) In general. -- A health insurer may deny health insurance coverage in the small group market if the health insurer has demonstrated to the Commissioner that:

a. It does not have the financial reserves necessary to underwrite additional coverage; and

b. It is applying this subdivision uniformly to all employers in the small group market in the State consistent with this Chapter and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.

(2) 180-day suspension upon denial of coverage. -- A health insurer upon denying health insurance coverage in accordance with subdivision (1) of this subsection shall not offer coverage in the small group market in the State for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later. The Commissioner may apply this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules. --

(1) In general. -- Subsection (a) of this section does not preclude a health insurer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health insurance plan in the small group market, as allowed under this Chapter.

(2) Rules defined. -- For the purposes of subdivision (1) of this subsection:

a. "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

b. "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(e) Exception for Coverage. -- Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in *G.S. 58-50-110(21a)*, except as otherwise provided for the basic and standard health care plans or other plans under *G.S. 58-50-126* under the North Carolina Small Employer Group Health Coverage Reform Act.

§ 58-68-45. Guaranteed renewability of coverage for employers in the group market

(a) In General. -- Except as provided in this section, if a health insurer offers health insurance coverage in the small or large group market, the health insurer must renew or continue in force the coverage at the option of the employer.

(b) General Exceptions. -- A health insurer may nonrenew or discontinue health insurance coverage in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. -- The policyholder has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. -- The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. -- The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under *G.S. 58-68-40(d)* in the case of the small group market or pursuant to this Chapter in the case of the large group market.

(4) Termination of coverage. -- The health insurer is ceasing to offer coverage in the market in accordance with subsection (c) of this section and this Chapter.

(5) Movement outside service area. -- In the case of a health insurer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the network plan who lives, resides, or works in the service area of the health insurer or in the area for which the health insurer is authorized to do business and, in the case of the small group market, the health insurer would deny enrollment with respect to the network plan under *G.S. 58-68-40(c)(1)*a.

(6) Association membership ceases. -- In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for Uniform Termination of Coverage. --

(1) Particular type of coverage not offered. -- In any case in which a health insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of the type may be discontinued by the health insurer in accordance with this Chapter in the market only if:

a. The health insurer provides notice to each policyholder provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least 90 days before the date of the discontinuation of the coverage;

b. The health insurer offers to each policyholder provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health insurer to a group health insurance plan in the market; and

c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(2) Discontinuance of all coverage. --

a. In general. -- In any case in which a health insurer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the health insurer only in accordance with this Chapter and if: (i) the health insurer provides notice to the Commissioner and to each policyholder and to the participants and beneficiaries covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of the coverage; and (ii) all health insurance

issued or delivered for issuance in this State in the market or markets are discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

b. Prohibition on market reentry. -- In the case of a discontinuation under sub-subdivision a. of this subdivision in a market, the health insurer shall not provide for the issuance of any health insurance coverage in that market in this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. -- At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health insurance plan:

(1) In the large group market; or

(2) In the small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with this Chapter and effective on a uniform basis among group health insurance plans with that product.

(e) Application to Coverage Offered Only Through Associations. -- In applying this section in the case of health insurance coverage that is made available by a health insurer in the small or large group market to employers only through one or more associations, a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer.

§ 58-68-50. Disclosure of information

(a) Disclosure of Information by Health Insurers. -- In connection with the offering of any health insurance coverage to a small employer, a health insurer:

(1) Shall make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b) of this section, and

(2) Shall upon request of the small employer, provide the information.

(b) Information Described. --

(1) In general. -- Subject to subdivision (3) of this subsection, with respect to a health insurer offering health insurance coverage to a small employer, information described in this subsection is information concerning:

a. The provisions of the coverage concerning the health insurer's right to change premium rates and the factors that may affect changes in premium rates;

b. The provisions of the coverage relating to renewability of coverage;

c. The provisions of the coverage relating to any preexisting condition exclusion; and

d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Form of information. -- Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be

sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) Exception. -- A health insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

§ 58-68-55. Exclusion of certain plans

(a) Exception for Certain Benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance coverage in relation to its provision of excepted benefits described in *G.S. 58-68-25(b)(1)*.

(b) Exception for Certain Benefits if Certain Conditions Met. --

(1) Limited, excepted benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in *G.S. 58-68-25(b)(2)* if the benefits:

a. Are provided under a separate policy, certificate, or contract of insurance; or

b. Are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits. -- The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in *G.S. 58-68-25(b)(3)* if all of the following conditions are met:

a. The benefits are provided under a separate policy, certificate, or contract of insurance.

b. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health insurance plan maintained by the same policyholder.

c. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health insurance plan maintained by the same policyholder.

(3) Supplemental, excepted benefits. -- The requirements of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in *G.S. 58-68-25(b)(4)* if the benefits are provided under a separate policy, certificate, or contract of insurance.