GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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SENATE BILL 1325*

Short Title: HMO Insolvency. (Public)

Sponsors: Senators Wellons, Dannelly, Harris; Albertson, Carter, Clodfelter, Dalton, Garrou, Kinnaird, Lucas, Martin of Guilford, Miller, Perdue, Purcell, Rucho, Warren, and Weinstein.

Referred to: Judiciary I.

June 14, 2000

1 A BILL TO BE ENTITLED
2 AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE
3 CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING
4 ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR
5 UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE
6 FOR THE ENROLLEES.
7 The General Assembly of North Carolina enacts:
8 Section 1. Article 67 of Chapter 58 of the General Statutes is amended by
9 adding a new section to read:
10 "**§ 58-67-126. Insolvency protection; assessment.**
11 (a) When an HMO in this State is declared insolvent by a court of competent
12 jurisdiction, the Commissioner may levy an assessment on solvent HMOs doing business
13 in this State to pay claims for uncovered expenditures for enrollees who are residents of
14 this State and to provide continuation of coverage for enrollees not covered under G.S.
15 58-67-120, 58-67-125, or 58-67-130. Assessments against an HMO may not exceed two
16 percent (2%) of that HMO's average annual premiums received in North Carolina on
17 policies and contracts during the three calendar years immediately preceding the year in
18 which the insolvent HMO was declared insolvent.

1 (b) To provide the funds necessary to carry out the powers and duties of the
2 Commissioner under this section, the Commissioner shall assess the HMOs at such time
3 and for such amounts, as the Commissioner finds necessary. Assessments not paid within
4 30 days of the written notice shall accrue interest at the rate of one percent (1%) per
5 month, or any part thereof. Assessments shall not be made until necessary to implement
6 the purposes of this section. Computation of assessments under this section shall be made
7 with a reasonable degree of accuracy, recognizing that exact determinations may not
8 always be possible.
9 (c) The Commissioner may use funds obtained under subsection (a) of this section
10 to pay claims for uncovered expenditures for enrollees of an insolvent HMO who are
11 residents of this State, provide for continuation of coverage for enrollees who are
12 residents of this State and are not covered under G.S. 58-67-120, 58-67-125, or 58-67-
13 130, and administrative costs. The Commissioner may by rule prescribe the time,
14 manner, and form for filing claims under this section or may require claims to be allowed
15 by an ancillary receiver or the domestic liquidator or receiver. A receiver or liquidator of
16 an insolvent HMO shall allow a claim in the proceeding in an amount equal to
17 administrative and uncovered expenditures paid under this section.
18 (d) Any person receiving benefits under this section for uncovered expenditures is
19 deemed to have assigned the rights under the covered health care plan certificates to the
20 Commissioner to the extent of the benefits received. The Commissioner may require an
21 assignment to it of such rights by any payee, enrollee, or beneficiary as a condition
22 precedent to the receipt of any rights or benefits conferred by this section upon that
23 person. The Commissioner is subrogated to these rights against the assets of an insolvent
24 HMO held by a receiver or liquidator of another jurisdiction.
25 (e) The assignment of subrogation rights of the Commissioner and allowed claim
26 under this section have the same priority against the assets of the insolvent HMO as those
27 possessed by the person entitled to receive benefits under this section or for similar
28 expenses in the receivership or liquidation.
29 (f) When assessed funds are unused following the completion of the liquidation of
30 an HMO, the Commissioner will distribute on a pro rata basis any unused amounts
31 received under subsection (a) of this section to the HMOs that have been assessed under
32 this section.
33 (g) The aggregate coverage of uncovered expenditures under this section shall not
34 exceed three hundred thousand dollars ($300,000) with respect to one individual.
35 Continuation of coverage for an enrollee shall continue for the duration of the contract
36 period for which premiums have been paid and continuation of coverage for an enrollee
37 who is confined in an inpatient facility shall continue until his or her discharge or
38 expiration of benefits. The Commissioner may provide continuation of coverage on any
39 reasonable basis; including continuation of the HMO contract or substitution of
40 indemnity coverage in a form determined by the Commissioner.
41 (h) The Commissioner may abate or defer, in whole or in part, the assessment of
42 an HMO if, in the Commissioner's opinion, payment of the assessment would endanger
43 the HMO's ability to fulfill its contractual obligations. If an assessment against an HMO

1 is abated or deferred, in whole or in part, the amount by which the assessment is abated
2 or deferred may be assessed against the other HMOs in a manner consistent with the
3 basis for assessments set forth in this section. An HMO that fails to pay an assessment
4 within 30 days after notice is subject to a civil penalty of not more than one thousand
5 dollars ($1,000) per day, or suspension or revocation of its license, or both.
6 (i) It is proper for any HMO, in determining its premium rates and policy owner
7 dividends, to consider the amount reasonably necessary to meet its assessment
8 obligations under this section."
9 Section 2. G.S. 58-30-220(2) reads as rewritten:
10 "(2) Claims or portions of claims for benefits under policies and for losses
11 incurred, including claims of third parties under liability policies; claims
12 of HMO enrollees and HMO enrollees' beneficiaries; beneficiaries,
13 including situations where an enrollee or beneficiary is liable to a health
14 care provider for services provided under the HMO plan; claims for
15 unearned premiums; claims for funds or consideration held under
16 funding agreements, as defined in G.S. 58-7-16; claims under life
17 insurance and annuity policies, whether for death proceeds, annuity
18 proceeds, or investment values; and claims of domestic and foreign
19 guaranty associations, including claims for the reasonable
20 administrative expenses of domestic and foreign guaranty associations;
21 but excluding claims of insurance pools, underwriting associations, or
22 those arising out of reinsurance agreements, claims of other insurers for
23 subrogation, and claims of insurers for payments and settlements under
24 uninsured and underinsured motorist coverages."
25 Section 3. If any section or provision of this act is declared unconstitutional or
26 invalid by the courts, it does not affect the validity of the act as a whole or any part other
27 than the part so declared to be unconstitutional or invalid.
28 Section 4. This act becomes effective January 1, 2001.