

# HEALTH INSURANCE FOR LARGE BUSINESSES

### What is it?

The North Carolina General Assembly has enacted special insurance laws that apply to large employers that offer health insurance to their employees. These laws give certain protections to employees who work for these large employers. A large employer is defined in state law as having 51 or more employees.

### Who is it for?

These laws are for employees of large employers who purchase health insurance or HMO plans for their employees. This chapter does not apply to self-funded (ERISA) plans. For information on ERISA, see the next chapter.

A large employer that offers health insurance to any employee must offer it to all eligible employees. An “eligible employee” is a worker with a normal workweek of 30 or more hours. Eligible employees do not include part-time, temporary, or seasonal workers, or those who have been hired on a substitute basis. Employers can choose to offer health insurance coverage to these other employees, but are not required under state law to do so.

### BENEFITS

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The health insurance plans of large employers must cover the mandated benefits listed in Chapter 24, “Consumer Protections.” Except for these mandated benefits, large employers are not required to offer any specific benefits in their plans.

### ELIGIBILITY

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A large employer offering health insurance to any employee must offer it to all eligible employees. An eligible employee is defined as a non-seasonal, full-time worker with a normal workweek of 30 or more hours. Employees must be added to the group coverage no later than 90 days after the first date of employment [N.C.G.S. § 58-51-80(c)].

## GUARANTEED ISSUANCE AND RENEWABILITY

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Insurance companies are not required to offer policies to large businesses. Thus, unlike small employers, large employers have no legally guaranteed right to obtain insurance coverage. As a practical matter, however, large employers generally do not have problems finding insurers or HMOs that will provide coverage. If large employers do not offer their employees health insurance, it is usually not because they can't find a company to offer insurance coverage; it is more likely because they can't find affordable insurance.

While insurers are not required to initially offer health insurance to a large group, they are generally required to renew coverage once an employer purchases coverage. Insurers must continue to provide coverage at the employer's option, unless the employer fails to pay premiums, commits fraud, or meets one of the other limited exceptions to the guaranteed renewability rules.

## LIMITATIONS AND EXCLUSIONS

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Health insurers cannot “medically underwrite — that is, exclude you from coverage or charge you a higher premium based on your health status, medical condition, claims experience, genetic information, disability, or perceived health risk — if you sign up for your employer's health plan within the open-enrollment time period (often 30 or 31 days after you first become eligible).

Thus, for example, insurers cannot deny your health insurance coverage or charge a higher premium if you have cancer, a mental illness, or have been a victim of domestic violence. However, if you are a late enrollee — that is, you turn down coverage at first and later sign up for your employer's health plan — you can be subject to medical underwriting. Also, if you purchase an individual policy to supplement your employment-based policy, the supplemental policy can be subject to medical underwriting.

Even if you elect your employer's health plan when you are first eligible, the plan may refuse to pay benefits for pre-existing conditions for up to twelve months. (Pre-existing conditions are defined as “a condition, whether physical or mental...for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.”) [N.C.G.S. § 58-68-30(a)(1)]. However, if you are a late enrollee, plans can impose pre-existing condition limitations of up to 18 months.

Once you have met the requirements of the pre-existing condition waiting period, the insurance company cannot impose a new waiting period, even if your employer changes insurance carriers or you change jobs, as long as you had health insurance within 63 days of the time your new coverage begins. If you met only part of the pre-existing waiting period under a prior health insurance plan, you will be given credit for that time as long as you change plans and have less than a 63-day break in coverage. Note: Prior health insurance plans include health insurance offered

through small or large employers, ERISA plans, individual health insurance coverage, Medicare, Medicaid, NC Health Choice, or a medical care program of the Indian Health Services. Individuals who were previously covered by one of these plans for at least 12 months, and who obtained new coverage within 63 days of when the prior coverage ended, cannot be subject to a pre-existing condition exclusion—even if the prior coverage did not have any exclusionary periods.

Additional protections apply for newborns, children who were adopted, and pregnant women. Insurers may not impose pre-existing condition exclusions on newborns if they are insured within 30 days of birth. Similarly, insurers cannot impose pre-existing condition exclusions on children who were placed for adoption, if they are insured within 30 days after the date of the adoption. In addition, insurers may not impose pre-existing condition exclusions on pregnancy, regardless of whether the woman was previously covered by insurance. In other words, if an insurer normally covers the medical costs associated with pregnancy and delivery, then the insurers must cover the pregnancy-related costs of all new enrollees, whether or not the pregnant women had health insurance coverage in the past.

## **NOTICE AND ENROLLMENT**

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In general, all insurance companies and HMOs must furnish participants and beneficiaries with a description of the health insurance plan, which includes their rights, benefits, and responsibilities under the plan. If material changes are made to the plan, information about these provisions must also be provided.

## **PREMIUMS**

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The NC Department of Insurance has no authority to regulate large-group insurance rates. Typically, insurers can adjust the premiums only once at the end of a year of the first year of coverage, and then not more frequently than once every six months. The new rates will not become effective unless the insurer has given the enrollees at least 45 days advance notice [N.C.G.S. § 58-51-80(g)].

## **ADMINISTRATION**

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The NC Department of Insurance has the legal authority to regulate insurance carriers and Health Maintenance Organizations (HMOs). In general, the Department insures that the plans are financially solvent, meet certain quality standards, and have certain procedural safeguards.

## **SOURCES OF LAW**

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State law:	N.C.G.S. § 58-51-80, 58-68-25 <i>et seq.</i> (governs health insurance portability)
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## FOR MORE INFORMATION

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