

HEALTH INSURANCE FOR SMALL BUSINESSES

What is it?

The North Carolina General Assembly enacted special laws that make it easier for small employers to purchase health insurance for their employees. Any insurance carrier or health maintenance organization (HMO) that markets small group health insurance in North Carolina must offer all of its small group plans to small employers with between 2 and 50 employees. Insurers are required to offer employers with only one person (self-employed) a choice of two standardized benefits plans, called the “Standard” and “Basic” plans (described more fully in this chapter). These insurance products are available to any small employer who requests them and agrees to make the required premium payments and to satisfy the other requirements of the plan.

Who is it for?

These laws provide protections to “small employers.” A small employer includes any self-employed individual or any business with 50 or fewer employees for more than 50% of its working days in the preceding calendar quarter. Any small employer offering health insurance must offer it to all eligible employees, defined as employees who work at least 30 hours a week on a full-time basis. Insurance companies that provide policies to the small-employer market must offer coverage to all eligible employees and their dependents.

INTRODUCTION

Many small employers do not offer health insurance coverage because of the cost — premiums for small employers are generally more expensive than a large employer’s premiums for a similar benefits package. In addition, in the past some small employers were unable to purchase coverage for their employees because of the health status of one or more of their employees.

The North Carolina General Assembly and Congress changed the laws to make it easier for small employers to purchase health insurance. All insurance carriers and HMOs that market small-group health insurance in North Carolina must make all their small group plans available to any small employer with two or more employees on a guaranteed-issue basis. That means no small group can be turned down because of the health status or use of health services of any of its employees. Self-employed individuals (with only one employee) must be offered two plans: a Standard Benefit Plan and a lower-cost Basic Benefit Plan.

In addition to guaranteed issue, the law guarantees renewability. That means that insurers must generally renew coverage for small groups, regardless of the claims experience of that small employer group. The law also limits the ability of insurance companies to charge differential premium rates to different types of employers.

BENEFITS

Insurers that offer health coverage in the small group market must offer the standard and basic benefit plan, in addition to any other plans they choose to offer. The standard and basic plans are described below.

Standard Benefit Plan

The Standard Benefit Plan is a major medical plan providing coverage for both hospitalizations and outpatient care. Coverage may be offered through a traditional major medical plan or through an HMO. Under the Standard major medical plan, benefits begin to be paid after a deductible of \$500 per individual (\$1,500 per family) is met. After the annual deductible is met, the plan generally pays for 80% of eligible medical expenses and the person insured pays 20% (although some services, like outpatient mental health and substance abuse, have more limited coverage). There is an annual out-of-pocket limit of \$2,000 per individual (\$4,000 per family) — that is, after you spend \$2,000 out of your own pocket in one year (not counting your deductible) on medical expenses, all other expenses are fully covered. The Standard indemnity plan has a lifetime limit for all services of \$1,000,000. Coverage of mental health and substance abuse services is generally limited to \$10,000 over the insured's lifetime. Coverage of specific types of therapy services, such as physical therapy, mental health, substance abuse or chiropractic, is limited to a certain number of visits per year.

The standard HMO plan does not have an annual deductible or lifetime limit for medical services. Instead, it has different levels of co-pays that must be paid for health services, such as \$15 for an office visit or \$250 for a hospital admission. While the standard HMO plan does not have specific annual or lifetime limits, coverage of mental health, substance abuse, and some therapy services is limited to a specified number of visits.

Basic Benefit Plan

The Basic benefit plan offers fewer benefits, but it is less expensive. It has a higher annual deductible, higher co-payments, and less coverage of preventive services. As with the standard plan, it may be offered through a traditional major medical plan or through an HMO.

Under the Basic indemnity plan, benefits begin to be paid after a deductible of \$1,000 per individual (or a maximum of \$3,000 for a family) is met. After the deductible is met, the plan generally pays 60% for covered medical services and the insured person pays 40% (although some services, like mental health and substance

abuse, have more limited coverage). There is a maximum out-of-pocket limit of \$3,000 per covered person (not counting the deductible), with no family maximum. The Basic indemnity plan offers an annual maximum benefit of \$100,000 per insured person, or \$1,000,000 lifetime maximum. Coverage of mental health and substance abuse services has a lifetime limit of \$10,000. As with the standard plan and basic HMO plans, there are visit limits for certain therapy services.

The Basic HMO plan does not have an annual deductible or lifetime limit for medical services. Instead, it has different levels of co-payment that must be paid for health services. Generally, the required co-payments that the patient must pay are higher in the Basic HMO plan than under the Standard HMO plan. While the Basic HMO plan does not have specific annual or lifetime limits, coverage of mental health, substance abuse, and some therapy services is limited to a specified number of visits.

ELIGIBILITY

In order for a person to be eligible for small-group health insurance, two conditions must be met. First, the person's employer must meet the law's definition of a small business. Then, the employee must be eligible for coverage.

A "small business" includes any self-employed individual or any business with 50 or fewer employees for over 50% of the working days of the business in the preceding calendar quarter. A person must be self-employed to qualify as an individual.

In order for an employee to qualify for coverage under a small-group plan, the employee must work for the small employer on a full-time basis, with a normal work schedule of 30 or more hours per week. Employees who work on a part-time, temporary, or substitute basis are not eligible for coverage.

An insurance company or HMO that offers insurance in the small-group market must offer coverage to all eligible employees and their dependents. Upon request, insurers must also provide small employers a description of all the plans they actively market to small employers, along with a description of the coverage and a quote.

ENROLLMENT

An eligible employee must be given a 30-day period (called an "open enrollment" period) in which to enroll in the plan. If the employer has a probationary period, the employee must be provided the opportunity to enroll within 90 days of the first day of employment. Eligible dependents of the employee also have a 30-day enrollment period.

There are special rules applicable to "late enrollees." Late enrollees are eligible employees or dependents who request health insurance coverage after the initial open enrollment period. Late enrollees may be subject to longer waiting periods and more far-reaching limitations on coverage than those who sign up during an open

enrollment period. More information on limitations applicable to late enrollees is included in the section on limitations and exclusions below. In general, it is better to enroll during an open enrollment period than as a late enrollee.

In any one of the following situations, however, you would not be considered a late enrollee:

- ◆ You were covered under another health benefit plan with comparable coverage at the time you were eligible to enroll with the small-business plan. Note that in order for this protection to apply, you must state at the time of open enrollment that you are declining coverage because you are covered under another employer's health plan. If you later lose that coverage (through the death of a spouse or divorce, or because the other employer stops offering health insurance, or because you lose the other job through which you had coverage), you can enroll with the small-business plan under the terms of the open enrollment period — that is, allowing you to avoid the limitations of a late enrollment. However, you must request enrollment within 30 days of the time you lose your other coverage.
- ◆ Your small-business employer offers the Standard or Basic plan and other plans, and you had previously chosen to be covered under one of the other plans during an open enrollment period. If you later want to switch to the Standard or Basic plan, you are not considered a late enrollee.
- ◆ You elect enrollment within 30 days of becoming an employee of a small employer.
- ◆ A court of law has ordered that coverage must be provided for a spouse or minor dependent child and the request for enrollment is made within 30 days of the court order.
- ◆ You have a newborn or adopted child, and the child is covered within 30 days of the child's birth or adoption.

GUARANTEED ISSUANCE AND RENEWABILITY

Insurance companies and HMOs (“small-employer carriers”) that offer plans in the small-group market must guarantee all plans to all small employers willing to pay the necessary premium. This is called “guaranteed issue.” Under guaranteed-issue protections, the small-employer carrier cannot exclude the coverage of any small employer or of any of its eligible employees or dependents based on their health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability. The only thing the employer must do is to pay the premium and meet the participation and contribution requirements of the small-employer carrier. Individual employees and their dependents cannot be charged more because of their health status.

Similarly, with limited exceptions, the insurance company must renew coverage for all small employers that are policy-holders (“guaranteed renewability”). Some of the exceptions include nonpayment of the premiums; fraud or misrepresentation of the

policy-holder; and noncompliance with certain plan provisions. Renewability is also not guaranteed when the number of enrollees covered under the plan is less than the number or percentage of people insured that the plan requires, or when the small-employer carrier stops writing new business in the small-employer market.

LIMITATIONS AND EXCLUSIONS

Small-employer carriers, like other insurers, may exclude coverage for pre-existing conditions for an insured individual for up to twelve months from the person's initial effective date of coverage. While insurers can exclude people from coverage based on pre-existing conditions, they are not required to do so. Often, the decision about whether to impose a pre-existing condition exclusion is one that is negotiated between the employer and the insurer.

A "pre-existing condition" is defined in North Carolina law as a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately before a person's health insurance coverage becomes effective. That means that the insurance company cannot exclude coverage of a condition for which you were treated, if you received treatment more than six months before the date your coverage became effective. Under state and federal law, pregnancy can never be considered a pre-existing condition. Thus, insurance companies that normally cover pregnancy-related services, cannot exclude coverage for pregnancy even if you started receiving services in the six months before you obtained health insurance coverage.

If you did receive treatment for a health condition within the six months prior to obtaining health insurance coverage, the insurance company may exclude coverage of that condition for up to twelve months. Once you meet the terms of the exclusionary waiting period, you generally cannot be subject to another exclusion as long as you stay continuously insured. To be continuously insured, you cannot have a break in your insurance coverage for more than 63 days. However, you need not maintain coverage with the same insurer to be continuously insured. Thus, you may not be subject to another pre-existing condition exclusion if you change jobs or if your employer changes carriers, as long as you don't have a gap in insurance coverage for more than 63 days.

If you met part of a pre-existing condition exclusion, you must be given credit for that time spent. If, for example, you meet 10 months of a 12-month exclusionary period and then change jobs, you cannot be subject to more than a two-month exclusionary period. Anytime you leave a job that provided health insurance coverage, your employer must give you a certificate that identifies the amount of time you spent under a pre-existing waiting period (if any). This certification will help the new insurer know how much time to give you in credit towards your new pre-existing condition exclusionary period.

Late enrollees may be subject to additional limitations in coverage. If you are a late enrollee, you may be denied all coverage for up to 18 months (a waiting period

before any benefits will be paid), or you may be subject to an 18-month pre-existing condition exclusion (a waiting period before benefits for pre-existing conditions are paid). The total length of all exclusions, however, cannot exceed 18 months. Thus, for example, the insurance company could impose a six-month waiting period for all benefits plus a 12-month exclusion of pre-existing conditions. Once this waiting period is met, you must be covered just like other insured individuals. You cannot then be subjected to an additional pre-existing condition waiting period. Note: you will not be considered a late enrollee if you meet one of the exceptions listed above.

PREMIUMS

Small-employer carriers must use an adjusted community rating system to set premiums for each small employer. In determining premiums for small employers, the insurer can consider the age and gender of all the enrollees; the number of family members covered (an insurance company can charge more for large families than for single individuals); and the geographic area in which the enrollees live. Insurers may also vary the rates charged to small employers with similar characteristics by 20%, based on differences in administrative costs and claims experience. For example, if the average premium for one small employer is \$100/month, the insurer has the flexibility to vary the premiums for other similar small employers from \$80-\$120, based on the employers' claims experience, health status, or other reasons.

Insurers are not allowed to modify the premium rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group has changed by 20% or more, or unless benefits are changed.

ADMINISTRATION

Small business insurance laws are regulated by the North Carolina Department of Insurance.

SOURCES OF LAW

State law(s):	N.C.G.S. § 58-50-100 <i>et seq.</i> (laws on small employer insurance) N.C.G.S. § 58-68-1 <i>et seq.</i> (Health Insurance Portability and Accountability)
State regulation(s):	11 N.C.A.C. §§ 12.1301 through 12.1309

FOR MORE INFORMATION

Small Group Health Insurance Information Hotline
N.C. Department of Insurance
(800) SMALLGP (762-5547)