

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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HOUSE BILL 1455*
Committee Substitute Favorable 7/13/98
Committee Substitute #2 Favorable 9/24/98

Short Title: PSO Medicare Licensing.

(Public)

Sponsors:

Referred to:

May 25, 1998

1 A BILL TO BE ENTITLED
2 AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION
3 LICENSING.

4 The General Assembly of North Carolina enacts:

5 Section 1. Chapter 131E of the General Statutes is amended by adding a new
6 Article to read:

7 "ARTICLE 17.

8 "Provider Sponsored Organization Licensing.

9 "**§ 131E-275. General provisions.**

10 (a) The General Assembly acknowledges that section 1855, et seq., of the federal
11 Social Security Act permits provider sponsored organizations that are organized and
12 licensed under State law as risk-bearing entities, or that are otherwise certified as such by
13 the federal government, to be eligible to offer Medicare health insurance or health
14 benefits coverage in each state in which the provider sponsored organization offers a
15 Medicare+Choice plan. The General Assembly declares that provider sponsored
16 organizations are beneficial to North Carolina citizens who are Medicare beneficiaries
17 and should be encouraged, subject to appropriate regulation by the Division of Medical
18 Assistance of the Department of Health and Human Services. The General Assembly

1 further declares that, because provider sponsored organizations provide health care
2 directly and assume responsibility for the provision of health care services to Medicare
3 beneficiaries under the requirements of the federal Medicare program, they require
4 different regulatory oversight to protect the public than health maintenance organizations
5 and insurance companies. The General Assembly further declares that the organizers and
6 operators of provider sponsored organizations which are licensed under the terms of this
7 Article as risk-bearing entities authorized to contract directly with the federal
8 Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or
9 the insurance laws of this State, unless otherwise specified in this Article.

10 It is the intent of the General Assembly to encourage innovative methods by which
11 sponsoring providers can directly or indirectly share substantial financial risk in the PSO
12 in any lawful manner.

13 (b) As set forth in this Article, the Division of Medical Assistance of the
14 Department of Health and Human Services shall be the agency of the State authorized to
15 license provider sponsored organizations to contract with Medicare to provide health care
16 services to Medicare beneficiaries and to engage in the other related activities described
17 in this Article.

18 (c) Each provider sponsored organization shall obtain a license from the Division
19 or shall otherwise be certified by the federal government prior to establishing,
20 maintaining, and operating a health care plan in this State for Medicare+Choice
21 beneficiaries. Nothing in this Article shall be construed to authorize a provider sponsored
22 organization to establish, maintain, or operate a health care plan other than exclusively
23 for Medicare+Choice beneficiaries.

24 **"§ 131E-276. Definitions.**

25 As used in this Article, unless the context clearly implies otherwise, the following
26 definitions apply:

- 27 — (1) 'Affiliated provider' means a health care provider that is affiliated with
28 another provider if, through contract, ownership, or otherwise: (i) one
29 provider directly controls, is controlled by, or is under common control
30 with the other provider; (ii) each provider participates in a lawful
31 combination under which they share substantial financial risk for the
32 organization's operation; (iii) both providers are part of a controlled
33 group of corporations as defined under section 1563 of the Internal
34 Revenue Code of 1986; or (iv) both providers are part of an affiliated
35 service group under section 414 of this Code. Control is presumed if
36 one party directly or indirectly owns, controls, or holds the power to
37 vote, or proxies for, at least fifty-one percent (51%) of the voting or
38 governance rights of another.
- 39 (2) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the
40 Medicare+Choice program who are enrolled with the provider
41 sponsored organization (PSO) under the terms of a contract between the
42 PSO and the Medicare program.

- 1 (3) 'Current assets' means cash, marketable securities, accounts receivable,
2 and other current items that will be converted into cash within 12
3 months.
- 4 (4) 'Current liabilities' means accounts payable and other accrued liabilities,
5 including payroll, claims, and taxes that will need to be paid within 12
6 months.
- 7 (5) 'Current ratio' means the ratio of current assets divided by current
8 liabilities calculated at the end of any accounting period.
- 9 (6) 'Division' means the Division of Medical Assistance of the Department
10 of Health and Human Services.
- 11 (7) 'Emergency services' has the same meaning as defined in G.S. 58-50-
12 61(a)(5).
- 13 (8) 'Health care delivery assets' means any tangible asset that is part of a
14 PSO operation, including hospitals, medical facilities, and their ancillary
15 equipment, and any property that may reasonably be required for the
16 PSO's principal office or for any purposes that may be necessary in the
17 transaction of the business of the PSO.
- 18 (9) 'Health plan contract' or 'Medicare contract' means a PSO's direct
19 contract with the United States Department of Health and Human
20 Services under section 1857 of the federal Social Security Act.
- 21 (10) 'Out-of-network services' means health care items or services that are
22 covered services under a PSO's Medicare contract and that are provided
23 to beneficiaries by health care providers that are not participating
24 providers in the PSO's network of health care providers.
- 25 (11) 'Parent of a sponsoring provider' means the public or private entity that
26 owns or controls a controlling interest in the sponsoring provider or that
27 has the power to appoint a controlling number of the governing board of
28 a sponsoring provider or that has the power to direct the management
29 policy and decisions of the sponsoring provider.
- 30 (12) 'Provider' or 'health care provider' means: (i) any individual that is
31 engaged in the delivery of health care services and that is required by
32 North Carolina law or regulation to be licensed to engage in the delivery
33 of these health care services and is so licensed; (ii) any entity that is
34 engaged in the delivery of health care services and that is required by
35 North Carolina law or regulation to be licensed to engage in the delivery
36 of these health care services and is so licensed; or (iii) any entity that is
37 owned or controlled entirely by individuals or entities described in
38 subparts (i) or (ii) of this definition.
- 39 (13) 'Provider sponsored organization' or 'PSO' means a public or private
40 entity domiciled in this State, including a business corporation, a
41 nonprofit corporation, a partnership, a limited liability company, a
42 professional limited liability company, a professional corporation, a sole
43 proprietorship, a public hospital, a hospital authority, a hospital district,

1 or a body politic: (i) that is established, organized, and operated by
2 sponsoring providers; (ii) in which physicians licensed pursuant to
3 Article 1 of Chapter 90 of the General Statutes or to the laws of any
4 state of the United States comprise no less than fifty percent (50%) of
5 the governing board or body, unless otherwise prohibited by law; and
6 (iii) that provides a substantial proportion of the services under each
7 Medicare contract directly through the sponsoring provider. The
8 requirement in subpart (ii) of this definition shall not preclude a PSO
9 that includes a tax-exempt hospital from adopting a bylaw provision that
10 provides a veto for the tax-exempt hospital over actions of the PSO
11 necessary to maintain the hospital's tax-exempt status. A PSO shall not
12 be out of compliance with the requirement in subpart (ii) due to
13 temporary vacancies on its governing board or body. Subpart (ii) of this
14 subdivision applies only if a hospital licensed under this Chapter or
15 Chapter 122C of the General Statutes is the sponsoring provider or a
16 member of the group of affiliated health care providers that comprises
17 the sponsoring provider.

18 (14) 'Sponsoring providers' of a PSO means the health care provider
19 domiciled in this State that assumes, or group of affiliated health care
20 providers that directly or indirectly shares, substantial financial risk in
21 the PSO and that has at least a majority financial interest in the PSO.

22 (15) 'Substantial proportion of the services' means at least seventy percent
23 (70%), or sixty percent (60%) for PSOs whose beneficiaries reside
24 primarily in rural areas, of the annual health care expenditures.

25 **"§ 131E-277. Direct or indirect sharing of substantial financial risk.**

26 In order for sponsoring providers to directly or indirectly share substantial financial
27 risk in the PSO, the PSO shall do one or more of the following:

28 (1) Provide services under its Medicare contract at a capitated rate;
29 (2) Provide designated services or classes of services under its Medicare
30 contract for a predetermined percentage of premium or revenue from the
31 Medicare program;

32 (3) Use significant financial incentives for its sponsoring providers, as a
33 group to achieve specified cost-containment and utilization management
34 goals either by:

35 a. Withholding from all sponsoring providers a substantial amount
36 of the compensation due to them, with distribution of that amount
37 to the sponsoring providers based on performance of all
38 sponsoring providers in meeting the cost-containment goals of
39 the network as a whole; or

40 b. Establishing overall cost or utilization targets for the PSO, with
41 the sponsoring providers subject to subsequent substantial
42 financial rewards or penalties based on group performance in
43 meeting the targets; or

1 (4) Agree to provide a complex or extended course of treatment that
2 requires the substantial coordination of care by sponsoring providers in
3 different specialties offering a complementary mix of services, for a
4 fixed, predetermined payment, when the costs of that course of
5 treatment for any individual patient can vary greatly due to the
6 individual patient's treatment or other factors; or

7 (5) Agree to any other arrangement that the Division determines to provide
8 for the sharing of substantial financial risk by the sponsoring providers.

9 **"§ 131E-278. Applicability of other laws.**

10 Unless otherwise required by federal law, provider sponsored organizations licensed
11 pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of
12 the General Statutes. Plan contracts, provider contracts, and other arrangements related
13 to the provision of covered services by these licensed networks or by health care
14 providers of these PSOs when operating through these PSOs shall likewise be exempt
15 from regulation under Chapter 58 of the General Statutes.

16 **"§ 131E-279. Approval.**

17 (a) Unless otherwise required by federal law, the Division shall be the agency of
18 the State that shall license provider sponsored organizations that seek to contract with the
19 federal government to provide health care services directly to Medicare beneficiaries
20 under the Medicare+Choice program.

21 (b) Provider sponsored organizations which have been granted a waiver pursuant
22 to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's
23 Medicare contract shall be deemed by the State to be licensed under this Article for so
24 long as the waiver or Medicare contract remains in effect. The foregoing shall not limit
25 the Division's authority to regulate such PSOs and their respective sponsoring providers
26 and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the
27 PSO's Medicare contract.

28 (c) The Division shall license a PSO as a risk-bearing entity eligible to offer health
29 benefits coverage in this State to Medicare beneficiaries if the PSO complies with the
30 requirements of this Article. This license shall be granted or denied by the Division not
31 longer than 90 days after the receipt of a substantially complete application for licensing.
32 Within 45 days after the Division receives an application for licensing, the Division shall
33 either notify the applicant that the application is substantially complete, or clearly and
34 accurately specify in writing to the applicant all additional specific information required
35 by the applicant to make the application a substantially completed application. This
36 agency response shall set forth a date and time for a meeting within 30 days after it is sent
37 to the applicant, at which a representative of the Division will explain with particularity
38 the additional information required by the Division in the response to make the
39 application substantially complete. The Division shall be bound by the response unless
40 the Division determines that it must be modified in order to meet the purposes of this
41 Article. The Division shall not delegate the authority to modify the response. If an
42 applicant provides the additional information set forth in the response, the application
43 shall be considered substantially complete. If the Division has not acted on an

1 application within 90 days after it is deemed substantially complete, the Division shall
2 immediately issue a license to the applicant, and the applicant shall be considered to have
3 been licensed by the Division. Any reapplication which corrects the deficiencies which
4 were specified by the Division in the response shall be approved by the Division.

5 (d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any
6 successor thereof, the date of receipt by the State of a substantially complete application,
7 the date the Division receives the applicant's written response to the agency response or
8 an earlier date considered by the Division shall be considered to be that date. The
9 foregoing shall not limit the Division's authority to consider an application not
10 substantially complete under subsection (c) of this section if the applicant's response to
11 the response does not provide substantially the information specified in the response.

12 (e) A license shall be denied only after the Division complies with the
13 requirements of G.S. 131E-305.

14 **"§ 131E-280. Applicants for license.**

15 Each application for licensing as a provider sponsored organization authorized to do
16 business in North Carolina shall be certified by an officer or authorized representative of
17 the applicant, shall be in a form prescribed by the Division, and shall be set forth or be
18 accompanied by the following:

- 19 (1) A copy of the basic organizational document, if any, of the applicant
20 and each sponsoring organization that holds greater than a five percent
21 (5%) interest in the PSO, such as the articles of incorporation, articles of
22 organization, partnership agreement, trust agreement, or other
23 applicable documents, and all amendments thereto;
- 24 (2) A copy of the respective bylaws, rules and regulations, or similar
25 documents, if any, regulating the conduct of the internal affairs of the
26 applicant and each sponsoring provider which holds greater than a five
27 percent (5%) interest in the PSO;
- 28 (3) Copies of the document evidencing the arrangements between the
29 applicant and each sponsoring provider that create the relationships and
30 obligations described in G.S. 131E-276(1);
- 31 (4) A list of the names, addresses, and official positions of persons who are
32 to be responsible for the conduct of the affairs of the applicant and of
33 each sponsoring provider that holds greater than a five percent (5%)
34 interest in the PSO, respectively, including all members of the
35 respective boards of directors, boards of trustees, executive committees,
36 or other governing boards or committees, the principal officers in the
37 case of a corporation, and the partners or members in the case of a
38 partnership or association;
- 39 (5) A copy of any contract form made or to be made between any class of
40 providers and the PSO and a copy of any contract form made or to be
41 made between third-party administrators, marketing consultants, or
42 persons listed in subdivision (3) of this subsection and the PSO;

- 1 (6) A statement generally describing the provider sponsored organization,
2 its sponsoring providers, its health care plan or plans, facilities, and
3 personnel and certifying that its medical director or other person
4 charged with determining and overseeing the PSO's medical policies is a
5 medical doctor holding an unrestricted license to practice medicine
6 under Article 1 of Chapter 90 of the General Statutes;
- 7 (7) A copy of the hospital license of each sponsoring provider that is a
8 hospital, a copy of the license to practice medicine of each sponsoring
9 provider or owner of a sponsoring provider that is a licensed physician,
10 and a copy of the health care service or facility license held by any other
11 licensed sponsoring provider;
- 12 (8) Financial statements showing the applicant's assets, liabilities, sources
13 of financial support, and the financial statements of each sponsoring
14 provider that holds greater than a five percent (5%) interest in the PSO
15 showing the sponsoring provider's assets, liabilities, and sources of
16 support. If the applicant's or any such sponsoring provider's financial
17 affairs are audited by independent certified public accountants, a copy
18 of the applicant's or sponsoring provider's most recent regular certified
19 financial statement shall be considered to satisfy this requirement unless
20 the Division directs that additional or more recent financial information
21 is required for the proper administration of this Article;
- 22 (9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-
23 297, 131E-298, and 131E-299 are guaranteed by one or more
24 guarantors:
- 25 a. Documentation that each guarantor meets the following
26 requirements:
- 27 1. The guarantor is a legal entity authorized to conduct
28 business in North Carolina.
- 29 2. The guarantor is not under federal bankruptcy or State
30 receivership or rehabilitation proceedings.
- 31 3. The guarantor has a net worth, not including other
32 guarantees, intangibles, and restricted reserves, equal to
33 three times the amount of the PSO's guarantee.
- 34 b. Financial statements showing each guarantor's assets, liabilities,
35 and source of financial support.
- 36 c. If a guarantor's financial affairs are audited by independent
37 certified public accountants, a copy of the guarantor's most recent
38 regular audited financial statement shall be considered to satisfy
39 this requirement unless the Division directs that additional or
40 more recent financial information is required for the proper
41 administration of this Article.
- 42 d. The guarantee document, including a statement of the financial
43 obligation covered by the guarantee, an agreement to

1 unconditionally fulfill the financial obligations covered by the
2 guarantee, an agreement not to subordinate the guarantee to any
3 other claim on the resources of the guarantor and a declaration
4 that the guarantor must act on a timely basis to satisfy the
5 financial obligations covered by the guarantee.

6 (10) A financial plan, satisfactory to the Division, covering the first 12
7 months of operation under the PSO's Medicare contract and which
8 meets the requirements of G.S. 131E-283. If the financial plan projects
9 losses, the financial plan must cover the period through 12 months
10 beyond the projected breakeven;

11 (11) A statement reasonably describing the geographic area or areas to be
12 served;

13 (12) A description of the procedures to be implemented to meet the
14 protection against insolvency requirements of G.S. 131E-298; and

15 (13) Any other information the Division may require to make the
16 determinations required in G.S. 131E-282.

17 **"§ 131E-281. Additional information.**

18 (a) In addition to the information filed under G.S. 131E-280, each application shall
19 include a description of the following:

20 (1) The program to be used to evaluate whether the applicant's network of
21 sponsoring providers and contracted providers is sufficient, in numbers
22 and types of providers, to assure that all health care services will be
23 accessible without unreasonable delay;

24 (2) The program used to evaluate whether the sponsoring providers provide
25 a substantial portion of services under each Medicare contract of the
26 PSO;

27 (3) The program to be used for verifying provider credentials;

28 (4) The utilization review program for the review and control of health care
29 services provided or paid for by the applicant;

30 (5) The quality management program to assure quality of care and health
31 care services managed and provided through the health care plan; and

32 (6) The applicant's network of sponsoring providers and contracted
33 providers and evidence of the ability of that network to provide all
34 health care services other than out-of-network services and emergency
35 services to the applicant's prospective beneficiaries.

36 (b) The Division may promulgate rules and regulations exempting from the filing
37 requirements of subsection (a) of this section those items it deems unnecessary.

38 **"§ 131E-282. Issuance of license.**

39 (a) Before issuing a PSO license, the Division may make an examination or
40 investigation as it deems expedient. The Division shall issue a license after receipt of a
41 substantially complete application and upon satisfaction of the following requirements:

42 (1) The applicant is duly organized as a provider sponsored organization as
43 defined by this Article.

- 1 (2) The PSO has initially a minimum net worth of one million five hundred
2 thousand dollars (\$1,500,000). In the event the PSO submits a financial
3 plan that demonstrates that the PSO does not have to create but has or
4 has available to it an administrative infrastructure that shall reduce the
5 PSO's start-up costs, the Division may lower the initial minimum net
6 worth required to one million dollars (\$1,000,000) or to any lower
7 amount as determined by the Division if the PSO operates primarily in
8 rural areas.
- 9 (3) The PSO shall have at least seven hundred fifty thousand dollars
10 (\$750,000) in cash or equivalents on its balance sheet, except that the
11 Division may permit a PSO operating primarily in rural areas to have a
12 lesser amount held in cash or equivalents on its balance sheets.
- 13 (4) The applicant submits a financial plan satisfactory to the Division which
14 covers the first 12 months of operation of the PSO's Medicare contract
15 and which meets the requirements of G.S. 131E-283. If the plan
16 projects losses, the financial plan shall cover the period through 12
17 months beyond projected breakeven.
- 18 (5) The Division determines that the applicant has sufficient cash flow to
19 meet its obligations as they become due. In making that determination,
20 the Division shall consider the following:
- 21 a. The timeliness of payment;
22 b. The extent to which the current ratio is maintained at one-to-one,
23 or whether there is a change in the current ratio over a period of
24 time; and
25 c. The availability of outside financial resources.
- 26 (b) In calculating the net worth of a PSO, the Division shall admit the following:
- 27 (1) One hundred percent (100%) of the book value of health care delivery
28 assets on the balance sheet of the applicant.
- 29 (2) One hundred percent (100%) of the value of cash and cash equivalents
30 on the balance sheet of the applicant.
- 31 (3) If at least one million dollars (\$1,000,000) of the initial minimum net
32 worth requirement is met by cash or cash equivalents, then one hundred
33 percent (100%) of the book value of the PSO's intangible assets up to
34 twenty percent (20%) of the minimum net worth amount required. If
35 less than one million dollars (\$1,000,000) of the initial minimum net
36 worth requirement is met by cash or cash equivalents or if the Division
37 has used its discretion to reduce the initial net worth requirement below
38 one million five hundred thousand dollars (\$1,500,000), then the
39 Division shall admit one hundred percent (100%) of the book value of
40 intangible assets of the PSO up to ten percent (10%) of the minimum
41 net worth amount required.

1 (4) Standard accounting principles treatment shall be given to other assets
2 of the PSO not used in the delivery of health care for the purposes of
3 meeting the minimum net worth requirement.

4 (5) Deferred acquisition costs shall not be admitted.

5 **"§ 131E-283. Financial plan.**

6 (a) The financial plan shall include the following:

7 (1) A detailed marketing plan;

8 (2) Statements of revenue and expense on an accrual basis;

9 (3) Cash flow statements;

10 (4) Balance sheets; and

11 (5) The assumptions and justifications in support of the financial plan.

12 (b) In the financial plan, the PSO shall demonstrate that it has the resources
13 available to meet the projected losses for the entire period to break even. Except for the
14 use of guaranties as provided in subsection (c) of this section, letters of credit as provided
15 in subsection (e) of this section, and other means as provided in subsection (f) of this
16 section, the resources must be assets on the balance sheet of the PSO in a form that is
17 either cash or convertible to cash in a timely manner, pursuant to the financial plan.

18 (c) Guaranties shall be acceptable as a resource to meet projected losses, under the
19 following conditions:

20 (1) For the first year of the PSO's operation of the PSO's Medicare contract,
21 the guarantor must provide the PSO with cash or cash equivalents to
22 fund the projected losses, as follows:

23 a. Prior to the beginning of the first quarter, in the amount of the
24 projected losses for the first two quarters;

25 b. Prior to the beginning of the second quarter, in the amount of the
26 projected losses through the end of the third quarter; and

27 c. Prior to the beginning of the third quarter, in the amount of the
28 projected losses through the end of the fourth quarter.

29 (2) If the guarantor provides the cash or cash equivalents to the PSO in a
30 timely manner on the above schedule, this funding shall be considered
31 in compliance with the guarantor's commitment to the PSO. In the third
32 quarter, the PSO shall notify the Division if the PSO intends to reduce
33 the period of funding of projected losses. The Division shall notify the
34 PSO within 60 days of receiving the PSO's notice if the reduction is not
35 acceptable.

36 (3) If the above guaranty requirements are not met, the Division may take
37 appropriate action, such as requiring funding of projected losses through
38 means other than a guaranty. The Division retains discretion which
39 shall be reasonably exercised to require other methods or timing of
40 funding, considering factors such as the financial condition of the
41 guarantor and the accuracy of the financial plan.

42 (d) The Division may modify the conditions in subsection (c) of this section in
43 order to clarify the acceptability of guaranty arrangements.

1 (e) An irrevocable, clean, unconditional letter of credit may be used as an
2 acceptable resource to fund projected losses in place of cash or cash equivalents if
3 satisfactory to the Division.

4 (f) If approved by the Division, based on appropriate standards promulgated by
5 the Division, PSOs may use the following to fund projected losses for periods after the
6 first year: lines of credit from regulated financial institutions, legally binding agreements
7 for capital contributions, or other legally binding contracts of a similar level of reliability.

8 (g) The exceptions in subsections (c), (e), and (f) of this section may be used in an
9 appropriate combination or sequence.

10 **"§ 131E-284. Modifications.**

11 (a) A provider sponsored organization shall file a notice describing any significant
12 change in the information required by the Division under G.S. 131E-280. Such notice
13 shall be filed with the Division prior to the change. If the Division does not disapprove
14 within 90 days after the filing, this modification shall be considered approved. Changes
15 subject to the terms of this section include expansion of service area, addition or deletion
16 of sponsoring providers, changes in provider contract forms, and group contract forms
17 when the distribution of risk is significantly changed, and any other changes that the
18 Division describes in properly adopted rules. Every PSO shall report to the Division for
19 the Division's information material changes in the network of sponsoring providers and
20 affiliated providers of services to beneficiaries enrolled with the PSO, the addition or
21 deletion of any Medicare contracts of the PSO or any other information the Division may
22 require. This information shall be filed with the Division within 15 days after
23 implementation of the reported changes. Every PSO shall file with the Division all
24 subsequent changes in the information or forms that are required by this Article to be
25 filed with the Division.

26 (b) The Division may adopt rules exempting from the filing requirements of
27 subsection (a) of this section those items it considers unnecessary.

28 **"§ 131E-285. Deposits.**

29 (a) At the time of application, the Division shall require a deposit of one hundred
30 thousand dollars (\$100,000) in cash or securities or a combination thereof for all provider
31 sponsored organizations. The deposits shall be included in the calculations of a PSO's or
32 applicant's net worth.

33 (b) All deposits required by this section shall be restricted to use in the event of
34 insolvency to help assume continuation of services or pay costs associated with
35 receivership or liquidation.

36 **"§ 131E-286. Ongoing financial standards - net worth.**

37 (a) Beginning the first day of operation of the PSO and except as otherwise
38 provided in subsection (d) of this section, every PSO shall maintain a minimum net worth
39 equal to the greatest of the following amounts:

40 (1) One million dollars (\$1,000,000);

41 (2) Two percent (2%) of annual premium revenues as reported on the most
42 recent annual financial statement filed with the Division on the first one
43 hundred fifty million dollars (\$150,000,000) of premium and one

1 percent (1%) of annual premium on the premium in excess of one
2 hundred fifty million dollars (\$150,000,000);

3 (3) An amount equal to the sum of three months uncovered health care
4 expenditures as reported on the most recent financial statement filed
5 with the Division;

6 (4) An amount equal to the sum of:

7 a. Eight percent (8%) of annual health care expenditures paid on a
8 noncapitated basis to nonaffiliated providers as reported on the
9 most recent financial statement filed with the Division; and

10 b. Four percent (4%) of annual health care expenditures paid on a
11 capitated basis to nonaffiliated providers plus annual health care
12 expenditures paid on a noncapitated basis to affiliated providers;
13 and

14 c. Zero percent (0%) of annual health care expenditures paid on a
15 capitated basis to affiliated providers regardless of downstream
16 arrangements from the affiliated provider.

17 (b) In calculating net worth, liabilities shall not include fully subordinated debt or
18 subordinated liabilities. For purposes of this provision, subordinated liabilities are claims
19 liabilities otherwise due to providers that are retained by the PSO to meet net worth
20 requirements and are fully subordinated to all creditors.

21 (c) In calculating net worth for purposes of this section, the items described in
22 G.S. 131E-282(b) shall be admitted, except as follows:

23 (1) For intangible assets, if at least the greater of one million dollars
24 (\$1,000,000) or sixty-seven percent (67%) of the ongoing minimum net
25 worth requirement is met by cash or cash equivalents, then the Division
26 shall admit the book value of intangible assets up to twenty percent
27 (20%) of the minimum net worth amount required. If less than the
28 greater of one million dollars (\$1,000,000) or sixty-seven percent (67%)
29 of the ongoing minimum net worth requirement is met by cash or cash
30 equivalents, then the Division shall admit the book value of intangible
31 assets up to ten percent (10%) of the minimum net worth amount
32 required; and

33 (2) Deferred acquisition costs shall not be admitted.

34 (d) The Division may lower the minimum ongoing net worth threshold, and the
35 amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

36 (e) During the start-up phase of the PSO, the pre-break-even financial plan
37 requirements shall apply. After the point of breakeven, the financial plan requirement
38 shall address cash needs and the financing required for the next three years.

39 (f) If a PSO, or the legal entity of which the PSO is a component, did not earn a
40 net operating surplus during the most recent fiscal year, the PSO shall submit a financial
41 plan, satisfactory to the Division, meeting all of the requirements established for the
42 initial financial plan.

43 "§ 131E-287. Reporting.

1 (a) The PSO shall file with the Division financial information relating to PSO
2 solvency standards described in this Article, according to the following schedule:

- 3 (1) On a quarterly basis until breakeven; and
4 (2) On an annual basis after breakeven, if the PSO has a net operating
5 surplus; or
6 (3) On a quarterly or monthly basis, as specified by the Division, after
7 breakeven, if the PSO does not have a net operating surplus.

8 (b) To the extent not preempted by federal law or otherwise mandated by the
9 Medicare program, the PSO shall annually, on or before the first day of March of each
10 year, file with the Division the following information for the previous calendar year:

- 11 (1) The number of and reasons for grievances and complaints received from
12 Medicare beneficiaries enrolled with the PSO under the PSO's Medicare
13 contract regarding medical treatment. The report shall include the
14 number of covered lives, total number of grievances categorized by
15 reason for the grievance, the number of grievances referred to the
16 second level grievance review, the number of grievances resolved at
17 each level and their resolution, and a description of the actions that are
18 being taken to correct the problems that have been identified through
19 grievances received. Every PSO shall file with the Division, as part of
20 its annual grievance report, a certificate of compliance stating that the
21 PSO has established and follows, for its Medicare contract, grievance
22 procedures that comply with this Article.
- 23 (2) The number of Medicare beneficiaries enrolled with the PSO under the
24 PSO's Medicare contract who terminated their enrollment with the PSO
25 for any reason.
- 26 (3) The number of provider contracts between the PSO and network
27 providers for the provision of covered services to Medicare beneficiaries
28 that were terminated and reasons for termination. This information shall
29 include the number of providers leaving the PSO network and the
30 number of new providers in the network. The report shall show
31 voluntary and involuntary terminations separately.
- 32 (4) Data relating to the utilization, quality, availability, and accessibility of
33 service. The report shall include the following:
- 34 a. Information on the PSO's program to determine the level of
35 network availability, as measured by the numbers and types of
36 network providers, required to provide covered services to
37 covered persons. This information shall include the PSO's
38 methodology under its Medicare+Choice program for:
- 39 1. Establishing performance targets for the numbers and
40 types of providers by specialty, area of practice, or facility
41 type, for each of the following categories: primary care
42 physicians, specialty care physicians, nonphysician health

1 care providers, hospitals, and nonhospital health care
2 facilities.

- 3 2. Determining when changes in PSO Medicare+Choice
4 program enrollees will necessitate changes in the provider
5 network.

6 The report shall also include: the availability performance targets for
7 the previous and current years; the numbers and types of providers
8 currently participating in the PSO's provider network; and an evaluation
9 of actual plan performance against performance targets.

10 b. The PSO's method for arranging or providing health care services
11 from nonnetwork providers, both within and outside of its service
12 area, when network providers are not available to provide
13 covered services.

14 c. Information on the PSO's program under its Medicare+Choice
15 program to determine the level of provider network accessibility
16 necessary to serve its Medicare enrollees. This information shall
17 include the PSO's methodology for establishing performance
18 targets for member access to covered services from primary care
19 physicians, specialty care physicians, nonphysician health care
20 providers, hospitals, and nonhospital health care facilities. The
21 methodology shall establish targets for:

22 1. The proximity of network providers to members, as
23 measured by member driving distance, to access primary
24 care, specialty care, hospital-based services, and services
25 of nonhospital facilities.

26 2. Expected waiting time for appointments for urgent care,
27 acute care, specialty care, and routine services for
28 prevention and wellness.

29 The report shall also include: the accessibility performance
30 targets for the previous and current years; data on actual overall
31 accessibility as measured by driving distance and average
32 appointment waiting time; and an evaluation of actual
33 Medicare+Choice plan performance against performance targets.
34 Measures of actual accessibility may be developed using
35 scientifically valid random sample techniques.

36 d. A statement of the PSO's methods and standards for determining
37 whether in-network services are reasonably available and
38 accessible to a Medicare enrollee for the purpose of determining
39 whether such enrollee should receive the in-network level of
40 coverage for services received from a nonnetwork provider.

41 e. A description of the PSO's program to monitor the adequacy of
42 its network availability and accessibility methodologies and

1 performance targets, Medicare+Choice plan performance, and
2 network provider performance.

3 f. A summary of the PSO's utilization review program activities for
4 the previous calendar year under its Medicare+Choice program.
5 The report shall include the number of: each type of utilization
6 review performed, noncertifications for each type of review, each
7 type of review appealed, and appeals settled in favor of Medicare
8 enrollees. The report shall be accompanied by a certification
9 from the carrier that it has established and follows procedures
10 that comply with this Article.

11 (5) Aggregate financial compensation data, including the percentage of
12 providers paid under a capitation arrangement, discounted fee-for-
13 service or salary, the services included in the capitation payment, and
14 the range of compensation paid by withhold or incentive payments.
15 This information shall be submitted on a form prescribed by the
16 Division.

17 The name, or group or institutional name, of an individual provider may not be
18 disclosed pursuant to this subsection. No civil liability shall arise from compliance with
19 the provisions of this subsection, provided that the acts or omissions are made in good
20 faith and do not constitute gross negligence, willful or wanton misconduct, or intentional
21 wrongdoing.

22 (c) Disclosure Requirements. – To the extent not otherwise prohibited by federal
23 law or under the terms of the PSO's Medicare contract, each PSO shall provide the
24 following applicable information to Medicare beneficiaries enrolled with the PSO under
25 the PSO's Medicare contract and bona fide prospective enrollees upon request:

26 (1) The evidence of coverage under the Medicare+Choice plan provided by
27 the PSO to Medicare beneficiaries under the terms of the PSO's
28 Medicare contract;

29 (2) An explanation of the utilization review criteria and treatment protocol
30 under which treatments are provided for conditions specified by the
31 prospective enrollee. This explanation shall be in writing if so
32 requested;

33 (3) If denied a recommended treatment, written reasons for the denial and
34 an explanation of the utilization review criteria or treatment protocol
35 upon which the denial was based;

36 (4) The plan's restrictive formularies or prior approval requirements for
37 obtaining prescription drugs, whether a particular drug or therapeutic
38 class of drugs is excluded from its formulary, and the circumstances
39 under which a nonformulary drug may be covered; and

40 (5) The procedures and medically based criteria under the PSO's Medicare
41 contract for determining whether a specified procedure, test, or
42 treatment is experimental.

1 (d) Effective January 1, 1999, PSOs shall make the reports that are required under
2 subsection (b) of this section and that have been filed with the Division available on their
3 business premises and shall provide any Medicare beneficiary enrolled with the PSO
4 access to them upon request, unless otherwise prohibited by federal law or under the
5 terms of the PSO's Medicare contract.

6 (e) Every PSO licensed under this Article shall annually on or before the first day
7 of March of each year, file with the Division a sworn statement verified by at least two of
8 the principal officers of the PSO showing its condition on the thirty-first day of
9 December, then next preceding; which shall be in such form as the Division shall
10 prescribe. In case the PSO fails to file the annual statement as herein required, the
11 Division is authorized to suspend the license issued to the PSO until the statement shall
12 be properly filed.

13 (f) A PSO shall report to the Division the efforts it has undertaken to foster
14 measurable improvements in the health status of the community's Medicare population,
15 increase access to health care for noncovered benefits, and address critical health care
16 needs of the community's Medicare population.

17 **"§ 131E-288. Liquidity.**

18 (a) Each PSO shall have sufficient cash flow to meet its obligations as they
19 become due. In determining the ability of a PSO to meet this requirement, the Division
20 shall consider the following:

21 (1) The timeliness of payment;

22 (2) The extent to which the current ratio is maintained at one-to-one or
23 whether there is a change in the current ratio over a period of time; and

24 (3) The availability of outside financial resources.

25 (b) The following corresponding remedies apply:

26 (1) If the PSO fails to pay obligations as they become due, the Division
27 shall require the PSO to initiate corrective action to pay all overdue
28 obligations.

29 (2) The Division may require the PSO to initiate corrective action if either
30 of the following is evident: (i) the current ratio declines significantly;
31 or (ii) there is a continued downward trend in the current ratio. The
32 corrective action may include a change in the distribution of assets, a
33 reduction of liabilities, or alternative arrangements to secure additional
34 funding requirements to restore the current ratio to one-to-one.

35 (3) If there is a change in the availability of the outside resources, the
36 Division shall require the PSO to obtain funding from alternative
37 financial resources.

38 (c) Nothing in the foregoing liquidity requirements shall be interpreted to require
39 the PSO to maintain a current ratio of one-to-one if the PSO can demonstrate to the
40 Division that it is able to pay its obligations as they become due and the current ratio
41 maintained by the PSO has neither declined significantly nor is on a continued downward
42 trend.

43 **"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.**

1 (a) Except as otherwise provided in subsection (b) of this section, each PSO shall,
2 on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the
3 greater of:

4 (1) Seven hundred fifty thousand dollars (\$750,000) cash or cash
5 equivalents; or

6 (2) Forty percent (40%) of the minimum net worth required.

7 (b) The Division may lower the threshold for minimum net worth held in cash or
8 cash equivalents by PSOs that operate primarily in rural areas.

9 (c) Cash or cash equivalents held to meet the net worth requirement shall be
10 current assets of the PSO.

11 **"§ 131E-290. Prohibited practice.**

12 (a) No provider sponsored organization or sponsoring provider, unless licensed as
13 an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or
14 literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words
15 descriptive of the insurance, casualty, or surety business or deceptively similar to the
16 name or description of any insurance or surety corporation doing business in this State.

17 (b) No provider sponsored organization or sponsoring provider shall engage in any
18 activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

19 (c) Unless otherwise preempted by federal law or mandated by the Medicare
20 program, a PSO shall not discriminate with respect to participation, reimbursement, or
21 indemnification as to any provider who is acting within the scope of the provider's license
22 or certification under applicable State law, solely on the basis of that license or
23 certification. This subsection does not preclude a PSO from including providers only to
24 the extent necessary to meet the needs of the organization's enrollees or from establishing
25 any measure designed to maintain quality and control costs consistent with the
26 responsibilities of the organization.

27 **"§ 131E-291. Collaboration with local health departments.**

28 A provider sponsored organization and a local health department shall collaborate and
29 cooperate within available resources regarding health promotion and disease prevention
30 efforts that are necessary to protect the public health.

31 **"§ 131E-292. Coverage.**

32 (a) Provider sponsored organizations subject to this Article shall provide coverage
33 for the medically appropriate and necessary services specified under the PSO's Medicare
34 contract.

35 (b) In the event a PSO's Medicare contract or federal law, regulations, or rules
36 governing coverage by the PSO of items or services to Medicare beneficiaries permits a
37 PSO, sponsoring provider, or participating provider to object on moral or religious
38 grounds to providing an item or service to Medicare beneficiaries, it is the policy of this
39 State to permit this objection and allow the participating provider to refuse to provide the
40 item or service.

41 **"§ 131E-293. Rates.**

1 Rates charged by provider sponsored organizations to the Medicare program and
2 charges by PSOs and sponsoring providers for items or services to beneficiaries shall be
3 governed by the terms of the PSO's Medicare contract.

4 **"§ 131E-294. Additional consumer protection and quality standards.**

5 Unless otherwise preempted by federal law or mandated by the Medicare program,
6 the Division shall apply to provider sponsored organizations the same standards and
7 requirements that the Department of Insurance applies to health maintenance
8 organizations under Chapter 58 of the General Statutes with respect to the following
9 consumer protection and quality matters:

- 10 (1) Quality management programs (11 NCAC 20.0500, et seq.);
- 11 (2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
- 12 (3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the
13 General Statutes);
- 14 (4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120, 58-63-15(7), and
15 58-67-75);
- 16 (5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
- 17 (6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
- 18 (7) Data reporting requirements under G.S. 58-67-50(e).

19 **"§ 131E-295. Powers of insurers and medical service corporations.**

20 Notwithstanding any provision of the insurance and hospital or medical service
21 corporation laws contained in Articles 1 through 67 of Chapter 58 of the General
22 Statutes, an insurer or a hospital or medical service corporation may contract with a
23 provider sponsored organization to provide insurance or similar protection against the
24 cost of care provided through provider sponsored organizations and their sponsoring
25 providers to beneficiaries and to provide coverage in the event of the failure of the
26 provider sponsored organization or its sponsoring providers to meet its obligations under
27 the PSO's Medicare contract. The beneficiaries of a provider sponsored organization
28 constitute a permissible group under these laws. Among other things, under these
29 contracts, the insurer or hospital or medical service corporation may make benefit
30 payments to provider sponsored organizations for health care services rendered by
31 providers pursuant to the health care plan.

32 **"§ 131E-296. Examinations.**

33 The Division may make an examination of the affairs of any provider sponsored
34 organization and the contracts, agreements, or other arrangements pursuant to its health
35 care plan as often as the Division considers necessary for the protection of the interests of
36 the people of this State but not less frequently than once every three years.

37 **"§ 131E-297. Hazardous financial condition.**

38 (a) Whenever the financial condition of any provider sponsored organization
39 indicates a condition such that the continued operation of the provider sponsored
40 organization might be hazardous to its beneficiaries, creditors, or the general public, then
41 the Division may order the provider sponsored organization to take any action that may
42 be reasonably necessary to rectify the existing condition, including one or more of the
43 following steps:

- 1 (1) To reduce the total amount of present and potential liability for benefits
2 by reinsurance;
- 3 (2) To reduce the volume of new business being accepted;
- 4 (3) To reduce the expenses by specified methods;
- 5 (4) To suspend or limit the writing of new business for a period of time;
- 6 (5) To require an increase to the provider sponsored organization's net
7 worth by contribution;
- 8 (6) To add or delete sponsoring providers;
- 9 (7) To increase the amount of payments from the PSO which sponsoring
10 providers agree to forego; or
- 11 (8) To require additional guaranties from sponsoring providers or from
12 parents of sponsoring providers.
- 13 (b) If the Division determines that the standards in G.S. 131E-286, 131E-288, and
14 131E-289 do not provide sufficient early warning that the continued operation of any
15 provider sponsored organization might be hazardous to its beneficiaries, creditors, or the
16 general public, the Division may adopt rules to set uniform standards and criteria for such
17 an early warning and to set standards for evaluating the financial condition of any
18 provider sponsored organization, which standards shall be consistent with the purposes
19 expressed in subsection (a) of this section.
- 20 **§ 131E-298. Protection against insolvency.**
- 21 (a) The Division shall require deposits in accordance with the provisions of G.S.
22 131E-285.
- 23 (b) If a provider sponsored organization fails to comply with the net worth
24 requirements of G.S. 131E-286, the Division may take appropriate action to assure that
25 the continued operation of the provider sponsored organization will not be hazardous to
26 the beneficiaries enrolled with the PSO.
- 27 (c) Every provider sponsored organization shall have and maintain at all times an
28 adequate plan for protection against insolvency acceptable to the Division. In
29 determining the adequacy of such a plan, the Division shall consider:
- 30 (1) A reinsurance agreement preapproved by the Division covering excess
31 loss, stop-loss, or catastrophies. The agreement shall provide that the
32 Division will be notified no less than 60 days prior to cancellation or
33 reduction of coverage;
- 34 (2) A conversion policy or policies that will be offered by an insurer to the
35 beneficiaries in the event of the provider sponsored organization's
36 insolvency;
- 37 (3) Legally binding unconditional guaranties by adequately capitalized
38 sponsoring provider or adequately capitalized sponsoring corporations
39 of sponsoring providers;
- 40 (4) Legally binding obligations of sponsoring providers to forego payment
41 for items or services provided by the sponsoring provider in order to
42 avoid the financial insolvency of the PSO;

- 1 (5) Legally binding obligations of sponsoring providers or parents of
2 sponsoring providers to make capital infusions to the PSO; and
3 (6) Any other arrangements offering protection against insolvency that the
4 Division may require.

5 **"§ 131E-299. Hold harmless agreements or special deposit.**

6 (a) Unless the PSO maintains a special deposit in accordance with subsection (b)
7 of this section, each contract between every PSO and a participating provider of health
8 care services shall be in writing and shall set forth that in the event the PSO fails to pay
9 for health care services as set forth in the contract, the Medicare subscriber or beneficiary
10 shall not be liable to the provider for any sums owed by the PSO. No other provisions of
11 these contracts shall, under any circumstances, change the effect of this provision. No
12 participating provider or agent, trustee, or assignee thereof may maintain any action at
13 law against a subscriber or beneficiary to collect sums owed by the PSO.

14 (b) In the event that the participating provider contract has not been reduced to
15 writing or that the contract fails to contain the required prohibition, the PSO shall
16 maintain a special deposit in cash or cash equivalent as follows:

- 17 (1) If at any time uncovered expenditures exceed ten percent (10%) of total
18 health care expenditures the PSO shall either:

- 19 a. Place an uncovered expenditures insolvency deposit with the
20 Division, or with any organization or trustee acceptable to the
21 Division through which a custodial or controlled account is
22 maintained, cash or securities that are acceptable to the Division.
23 This deposit shall at all times have a fair market value in an
24 amount of one hundred twenty percent (120%) of the PSO's
25 outstanding liability for uncovered expenditures for enrollees,
26 including incurred but not reported claims, and shall be
27 calculated as of the first day of the month and maintained for the
28 remainder of the month. If a PSO is not otherwise required to
29 file a quarterly report, it shall file a report within 45 days of the
30 end of the calendar quarter with information sufficient to
31 demonstrate compliance with this section; or
32 b. Maintain adequate insurance or a guaranty arrangement approved
33 in writing by the Division, to pay for any loss to beneficiaries
34 claiming reimbursement due to the insolvency of the PSO. The
35 Division shall approve a guaranty arrangement if the guarantying
36 organization is a sponsoring provider, has been operating for at
37 least 10 years, and has a net worth, including organization-related
38 land, buildings, and equipment of at least fifty million dollars
39 (\$50,000,000), unless the Division finds that the approval of this
40 guaranty may be financially hazardous to beneficiaries.

- 41 (2) The deposit required under sub-subdivision a. of subdivision (1) of this
42 subsection is an admitted asset of the PSO in the determination of net
43 worth. All income from these deposits or trust accounts shall be assets

1 of the PSO and may be withdrawn from the deposit or account quarterly
2 with the approval of the Division;

3 (3) A PSO that has made a deposit may withdraw that deposit or any part of
4 the deposit if (i) a substitute deposit of cash or securities of equal
5 amount and value is made, (ii) the fair market value exceeds the amount
6 of the required deposit, or (iii) the required deposit under this subsection
7 is reduced or eliminated. Deposits, substitutions, or withdrawals may
8 be made only with the prior written approval of the Division;

9 (4) The deposit required under sub-subdivision a. of subdivision (1) of this
10 section is in trust and may be used only as provided under this section.
11 The Division may use the deposit of an insolvent PSO for
12 administrative costs associated with administering the deposit and
13 payment of claims of enrollees of the PSO.

14 (c) Whenever the reimbursements described in this section exceed ten percent
15 (10%) of the PSO's total costs for health care services over the immediately preceding six
16 months, the PSO shall file a written report with the Division containing the information
17 necessary to determine compliance with sub-subdivision a. of subdivision (1) of
18 subsection (b) of this section no later than 30 business days from the first day of the
19 month. Upon an adequate showing by the PSO that the requirements of this section
20 should be waived or reduced, the Division may waive or reduce these requirements to an
21 amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent
22 and purpose of this Article.

23 **"§ 131E-300. Continuation of benefits.**

24 The Division shall require that each PSO have a plan for handling insolvency, which
25 plan allows for continuation of benefits for the duration of the contract period for which
26 premiums have been paid and continuation of benefits to beneficiaries who are confined
27 in an inpatient facility until their discharge or expiration of benefits. In considering such
28 a plan, the Division may require:

29 (1) Insurance to cover the expenses to be paid for benefits after an
30 insolvency;

31 (2) Provisions in provider contracts that obligate the provider to provide
32 services for the duration of the period after the PSO's insolvency for
33 which premium payment has been made and until the beneficiaries'
34 discharge from inpatient facilities;

35 (3) Insolvency reserves as the Division may require;

36 (4) Letters of credit acceptable to the Division;

37 (5) Additional guaranties from a sponsoring provider of the PSO or from
38 the parent of a sponsoring provider;

39 (6) Legally binding obligations of sponsoring providers to forego payment
40 from the PSO for services provided to beneficiaries in order to avoid the
41 insolvency of the PSO; and

42 (7) Any other arrangements to assure that benefits are continued as
43 specified.

"§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Division, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Division shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO, covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Division determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Division shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Division shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Division shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to obtain other coverage. Each PSO to which beneficiaries are so allocated by the Division shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

1 (a) Every PSO shall, when determining liability, include an amount estimated in
2 the aggregate to provide for any unearned premium and for the payment of all claims for
3 health care expenditures that have been incurred, whether reported or unreported, that are
4 unpaid and for which such PSO is or may be liable, and to provide for the expense of
5 adjustment or settlement of such claims.

6 (b) These liabilities shall be computed in accordance with rules adopted by the
7 Division upon reasonable consideration of the ascertained experience and character of the
8 PSO.

9 **"§ 131E-304. Suspension or revocation of license.**

10 (a) The Division may suspend, revoke, or refuse to renew a PSO license if the
11 Division finds that the PSO:

12 (1) Is operating significantly in contravention of its basic organizational
13 document, or in a manner contrary to that described in and reasonably
14 inferred from any other information submitted under G.S. 131E-280,
15 unless amendments to these submissions have been filed with and
16 approved by the Division;

17 (2) Issues evidences of coverage or uses a schedule of premiums for health
18 care services that do not comply with Medicare or Medicaid program
19 requirements as applicable;

20 (3) No longer maintains the financial reserve specified in G.S. 131E-286 or
21 is no longer financially responsible and may reasonably be expected to
22 be unable to meet its obligations to beneficiaries or prospective
23 beneficiaries;

24 (4) Knowingly or repeatedly fails or refuses to comply with any law or rule
25 applicable to the PSO or with any order issued by the Division after
26 notice and opportunity for a hearing;

27 (5) Has knowingly made to the Division any false statement or report;

28 (6) Has sponsoring providers that fail to provide a substantial proportion of
29 the services under any health plan during any 12-month period;

30 (7) Has itself or through any person on its behalf advertised or
31 merchandised its items or services in an untrue, misrepresentative,
32 misleading, or unfair manner;

33 (8) If continuing to operate would be hazardous to beneficiaries; or

34 (9) Has otherwise substantially failed to comply with this Article.

35 (b) A license shall be suspended or revoked only after compliance with G.S. 131E-
36 305.

37 (c) When a PSO license is suspended, the PSO shall not, during the suspension,
38 enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

39 (d) When a PSO license is revoked, the PSO shall proceed, immediately following
40 the effective date of the order of revocation, to wind up its affairs and shall conduct no
41 further business except as may be essential to the orderly conclusion of the affairs of the
42 PSO. The PSO shall engage in no advertising or solicitation. The Division may, by
43 written order, permit any further operation of the PSO that the Division may find to be in

1 the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest
2 practical opportunity to obtain continuing health care coverage.

3 **"§ 131E-305. Administrative procedures.**

4 (a) When the Division has cause to believe that grounds for the denial of an
5 application for a license exist, or that grounds for the suspension or revocation of a
6 license exist, it shall notify the provider sponsored organization in writing specifically
7 stating the grounds for denial, suspension, or revocation and fixing a time of at least 30
8 days thereafter for a hearing on the matter.

9 (b) After this hearing, or upon the failure of the provider sponsored organization to
10 appear at this hearing, the Division shall take the action it considers advisable or make
11 written findings that shall be mailed to the provider sponsored organization. The action
12 of the Division shall be subject to review by the Superior Court of Wake County. The
13 court may, in disposing of the issue before it, modify, affirm, or reverse the order of the
14 Division in whole or in part.

15 (c) The provisions of Chapter 150B of the General Statutes apply to proceedings
16 under this section to the extent that they are not in conflict with subsections (a) and (b) of
17 this section.

18 **"§131E-306. Department of Insurance review and comment.**

19 (a) The Division shall forward to the Department of Insurance each substantially
20 complete application for a PSO license in a timely manner. The Department of Insurance
21 shall review the application with respect to fiscal responsibility and fiduciary
22 responsibility under the following sections:

23 (1) 131E-277. Direct or indirect sharing of substantial financial risk.

24 (2) 131E-282. Issuance of license.

25 (3) 131E-283. Financial plan.

26 (4) 131E-285. Deposits.

27 The Department of Insurance shall forward its comments and recommendations to the
28 Division within 60 days. The Division must review the comments and recommendations
29 of the Department of Insurance that are received within the 60-day period before issuing
30 a PSO license.

31 (b) Each licensed PSO shall submit to the Department of Insurance a copy of each
32 monthly, quarterly, or annual financial solvency statement required by G.S. 131E-287(a)
33 to be submitted to the Division. The Department of Insurance shall review the statements
34 and report its findings and recommendations to the Division. If, based on the information
35 contained in the financial statements, the Department of Insurance determines that the
36 PSO does not comply with G.S. 131E-304(a)(3) and demonstrates to the Division that
37 remedial actions under G.S. 131E-297 are not adequate to remedy the condition, the
38 Department of Insurance may recommend suspension, revocation, or nonrenewal of the
39 PSO's license, and the Division shall implement that recommendation.

40 (c) Any additional information needed by the Department of Insurance for
41 purposes of its review of a PSO's or PSO applicant's solvency pursuant to this section
42 shall be obtained through the Division.

43 **"§ 131E-307. Penalties and enforcement.**

1 (a) The provisions of G.S. 58-2-70, modified to replace the word 'Commissioner'
2 by the word 'Division', applies to this Article. The Division may, in addition to or in lieu
3 of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as
4 so modified, provided that the provider sponsored organization has a reasonable time
5 within which to remedy the defect in its operations that gave rise to the procedure under
6 G.S. 58-2-70.

7 (b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

8 (c) If the Division shall for any reason have cause to believe that any violation of
9 this Article has occurred or is threatened, the Division may give notice to the provider
10 sponsored organization and to the representatives or other persons who appear to be
11 involved in such suspected violation to arrange a conference with the alleged violators or
12 their authorized representatives for the purpose of attempting to ascertain the facts
13 relating to such suspected violation, and, in the event it appears that any violation has
14 occurred or is threatened, to arrive at an adequate and effective means of correcting or
15 preventing such violation.

16 Proceedings under this subsection shall not be governed by any formal procedural
17 requirements and may be conducted in such manner as the Division may deem
18 appropriate under the circumstances.

19 (d) The Division may issue an order directing a provider sponsored organization or
20 a representative of a provider sponsored organization to cease and desist from engaging
21 in any act or practice in violation of the provisions of this Article.

22 Within 30 days after service of the order of cease and desist, the respondent may
23 request a hearing on the question of whether acts or practices in violation of this Article
24 have occurred. These hearings shall be conducted pursuant to Chapter 150B of the
25 General Statutes, and judicial review shall be available as provided by this Chapter.

26 (e) In the case of any violation of the provisions of this Article, if the Division
27 elects not to issue a cease and desist order, or in the event of noncompliance with a cease
28 and desist order issued pursuant to subsection (d) of this section, the Division may
29 institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the
30 Superior Court of Wake County.

31 **"§ 131E-308. Statutory construction and relationship to other laws.**

32 (a) Except as otherwise provided in this Article, provisions of the insurance laws
33 and provisions of hospital or medical service corporation laws shall not be applicable to
34 any provider sponsored organization granted a license under this Article or to its
35 sponsoring providers when operating under such a license. This provision shall not apply
36 to an insurer or hospital or medical service corporation licensed and regulated pursuant to
37 the insurance laws or the hospital or medical service corporation laws of this State except
38 with respect to its provider sponsored organization activities authorized and regulated
39 pursuant to this Article.

40 (b) Solicitation of beneficiaries by a provider sponsored organization granted a
41 license, or its representatives, shall not be construed to violate any provision of law
42 relating to solicitation or advertising by health professionals or health care providers.

1 (c) Any provider sponsored organization licensed under this Article shall not be
2 considered to be a provider of medicine or dentistry and shall be exempt from the
3 provisions of Chapter 90 of the General Statutes relating to the practice of medicine and
4 dentistry; provided, however, that this exemption does not apply to individual providers
5 under contract with or employed by the provider sponsored organization or sponsoring
6 providers or to the sponsoring providers.

7 (d) Except as otherwise limited by this Article, a PSO may organize in the same
8 manner and may exercise the same prerogatives, powers, and privileges as other entities
9 that are organized and existing under the same laws as the PSO.

10 **"§ 131E-309. Filings and reports as public documents.**

11 Except for information that constitutes a bona fide trade secret, proprietary
12 information or competitively sensitive information of a sponsoring provider or parent of a
13 sponsoring provider, all applications, filings, and reports required under this Article shall
14 be treated as public documents.

15 **"§ 131E-310. Confidentiality of medical information.**

16 Any data or information pertaining to the diagnosis, treatment, or health of any
17 beneficiary or applicant obtained from the person or from any provider by any provider
18 sponsored organization or by any provider acting pursuant to its provider contract with a
19 provider sponsored organization shall be held in confidence and shall not be disclosed to
20 any person except to the extent that it may be necessary to carry out the purposes of this
21 Article; or upon the express consent of the beneficiary or applicant; or pursuant to statute
22 or court order for the production of evidence or the discovery thereof; or in the event of
23 claim or litigation between such person and the provider sponsored organization wherein
24 such data or information is pertinent. A provider sponsored organization shall be entitled
25 to claim any statutory privileges against such disclosure which the provider who
26 furnished such information to the provider sponsored organization is entitled to claim.

27 **"§ 131E-311. Conflicts; severability.**

28 To the extent that the provisions of this Article may be in conflict with any other
29 provision of this Chapter, the provisions of this Article shall prevail and apply with
30 respect to provider sponsored organizations. Notwithstanding the absence of adopted
31 rules, the Division shall continue to process applications for provider sponsored
32 organization licenses as described in this Article. If any section, term, or provision of this
33 Article shall be adjudged invalid for any reason, these judgments shall not affect, impair,
34 or invalidate any other section, term, or provision of this Article, but the remaining
35 sections, terms, and provisions shall be and remain in full force and effect.

36 **"§ 131E-312. Regulations.**

37 This Article shall be self-implementing. No later than six months after the date of
38 enactment of this Article, the Division may adopt rules consistent with this Article to
39 authorize and regulate provider sponsored organizations to contract directly with the
40 federal Medicare program to provide health care services to the beneficiaries of such
41 programs. The Division shall issue permanent rules and, may issue temporary rules, to
42 the extent these rules may be necessary. The Division shall limit its regulation of
43 provider sponsored organizations to the licensing and regulating of these organizations as

1 risk-bearing entities contracting directly with the Medicare program and to the consumer
2 protection and quality standards as provided in G.S. 131E-294 and shall not regulate any
3 matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof.

4 **"§ 131E-313. Utilization review and grievances.**

5 Unless otherwise preempted by federal law or mandated by the Medicare program,
6 the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this
7 Article as if the PSO was an 'insurer' under those sections, except that the Division rather
8 than the Commissioner of Insurance shall regulate a PSO's compliance with those
9 sections."

10 Section 2. G.S. 58-67-10(b) reads as rewritten:

- 11 "(b) (1) It is specifically the intention of this section to permit such persons as
12 were providing health services on a prepaid basis on July 1, 1977, or
13 receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a
14 community health center, to continue to operate in the manner which
15 they have heretofore operated.
- 16 (2) Notwithstanding anything contained in this Article to the contrary, any
17 person can provide health services on a fee for service basis to
18 individuals who are not enrollees of the organization, and to enrollees
19 for services not covered by the contract, provided that the volume of
20 services in this manner shall not be such as to affect the ability of the
21 health maintenance organization to provide on an adequate and timely
22 basis those services to its enrolled members which it has contracted to
23 furnish under the enrollment contract.
- 24 (3) This Article shall not apply to any employee benefit plan to the extent
25 that the Federal Employee Retirement Income Security Act of 1974
26 preempts State regulation thereof.
- 27 (3a) This Article does not apply to any prepaid health service or capitation
28 arrangement implemented or administered by the Department of Health
29 and Human Services or its representatives, pursuant to 42 U.S.C. §
30 1396n or Chapter 108A of the General Statutes, a provider sponsored
31 organization or other organization certified, qualified, or otherwise
32 approved by the Division of Medical Assistance of the Department of
33 Health and Human Services pursuant to Article 17 of Chapter 131E of
34 the General Statutes, or to any provider of health care services
35 participating in such a prepaid health service or capitation arrangement.
36 Article; provided, however, that to the extent this Article applies to any
37 such person acting as a subcontractor to a Health Maintenance
38 Organization licensed in this State, that person shall be considered a
39 single service Health Maintenance Organization for the purpose of G.S.
40 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.
- 41 (4) Except as provided in paragraphs (1), (2), (3), and (3a) of this
42 subsection, the persons to whom these paragraphs are applicable shall
43 be required to comply with all provisions contained in this Article."

1 Section 3. G.S. 90-21.22A reads as rewritten:

2 **"§ 90-21.22A. Medical review committees.**

3 (a) As used in this section, 'medical review committee' means a committee
4 composed of health care providers licensed under this Chapter that is formed for the
5 purpose of evaluating the quality of, cost of, or necessity for health care services,
6 including provider credentialing. 'Medical review committee' does not mean a medical
7 review committee established under G.S. 131E-95.

8 (b) A member of a duly appointed medical review committee who acts without
9 malice or fraud shall not be subject to liability for damages in any civil action on account
10 of any act, statement, or proceeding undertaken, made, or performed within the scope of
11 the functions of the committee.

12 (c) The proceedings of a medical review committee, the records and materials it
13 produces, and the materials it considers shall be confidential and not considered public
14 records within the meaning of ~~G.S. 132-1~~ G.S. 132-1, 131E-309, or G.S. 58-2-100; and
15 shall not be subject to discovery or introduction into evidence in any civil action against a
16 provider of health care services who directly provides services and is licensed under this
17 ~~Chapter or Chapter~~, a PSO licensed under Article 17 of Chapter 131E of the General
18 Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General
19 Statutes or that is owned or operated by the State, which civil action results from matters
20 that are the subject of evaluation and review by the committee. No person who was in
21 attendance at a meeting of the committee shall be required to testify in any civil action as
22 to any evidence or other matters produced or presented during the proceedings of the
23 committee or as to any findings, recommendations, evaluations, opinions, or other actions
24 of the committee or its members. However, information, documents, or records otherwise
25 available are not immune from discovery or use in a civil action merely because they
26 were presented during proceedings of the committee. A member of the committee may
27 testify in a civil action but cannot be asked about his or her testimony before the
28 committee or any opinions formed as a result of the committee hearings.

29 (d) This section applies to a medical review committee, including a medical
30 review committee appointed by one of the entities licensed under Articles 1 through 67 of
31 Chapter 58 of the General Statutes.

32 (e) Subsection (c) of this section does not apply to proceedings initiated under ~~G.S.~~
33 ~~58-50-61 or G.S. 58-50-62.~~ G.S. 58-50-61, 58-50-62, 131E-294, or 131E-294A."

34 Section 4. The Division of Medical Assistance of the Department of Health
35 and Human Services shall report quarterly to the Joint Legislative Health Care Oversight
36 Committee on its regulatory activities in the enforcement of this act and shall provide the
37 Committee with a summary of nonconfidential information on the financial plans and
38 operations of PSOs. The report to the Committee shall include a description and
39 explanation of any regulations or regulatory interpretations that differ from Department
40 of Insurance regulations applicable to HMOs, a summary of the Department of
41 Insurance's comments and recommendations pursuant to G.S. 131E-306, and the
42 Department's response to and action upon those recommendations. The report shall also
43 include PSO efforts to improve community health status. The Committee may request

1 the Department of Insurance to review the Division of Medical Assistance's regulations
2 and regulatory interpretations relating to PSO licensure and monitoring. The Division
3 shall develop processes or methods to measure improvements in health outcomes for
4 Medicare beneficiaries served by managed care organizations and shall report quarterly
5 to the Joint Legislative Health Care Oversight Committee on the development of these
6 standards.

7 Section 5. There is allocated from funds appropriated to the Department of
8 Health and Human Services for the 1998-99 fiscal year the sum of fifty thousand dollars
9 (\$50,000) to be used by the Division of Medical Assistance to implement this act, to the
10 extent these funds are necessary for implementation. Nothing in this act shall obligate
11 the General Assembly to appropriate or allocate additional funds to implement this act.

12 Section 6. Section 5 of this act becomes effective July 1, 1998. The remainder
13 of this act is effective when it becomes law.