GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H **1**

HOUSE BILL 907*

Short Title: Managed Care Act. (Public)

Sponsors: Representative B. Miller.

Referred to: Health and Human Services.

April 13, 1993

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE LICENSING AND REGULATION OF PREFERRED PROVIDER ORGANIZATIONS, EXCLUSIVE PROVIDER PANELS, AND OTHER MANAGED CARE OPERATIONS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-50 is amended by designating the present paragraph as subsection (a) and by adding the following:

"(b) As used in subsection (a) of this section, 'special reimbursement' includes (i) any fee-for-service or discounted fee-for-service arrangement that is mutually satisfactory to the provider and the indemnity insurance company organized under Articles 1 through 64 of this Chapter or (ii) capitation or EPP payment that has been approved by the Commissioner under G.S. 58-50-56.

(c) As used in this Article, 'PPO' includes a preferred provider contract, organization, plan, or arrangement.

(d) As used in this Article, 'EPP' means an exclusive provider panel."

Sec. 2. G.S. 58-50-55(a) reads as rewritten:

"(a) Notwithstanding any other provisions of law, except the second and third paragraphs of G.S. 58-50-30, corporations organized pursuant to Articles 1 through 64 of this Chapter are authorized ~~to enter into preferred provider contracts in addition to all other contracts authorized by Articles 1 through 64 of this Chapter, or~~ to enter cost containment arrangements approved by the Commissioner, with persons, entities or organizations for the purpose of reducing the cost of providing health care services. Such preferred provider contracts may be entered into with licensed institutions and practitioners of all types without regard to specialty of services or limitation to a

specific type of practice. Corporations organized pursuant to Articles 1 through 64 of this Chapter shall apply to the Commissioner for a license to operate a preferred provider organization in order to enter into fee-for-service or discounted fee-for-service contracts, in addition to all other contracts authorized by Articles 1 through 64 of this Chapter."

Sec. 3. G.S. 58-50-55(c) is repealed.

Sec. 4. G.S. 58-55-50 is amended by adding the following:

"(c1) No person shall act as, offer to act as, or hold himself out as a PPO in this State without a valid PPO license issued by the Commissioner."

Sec. 5. G.S. 58-50-55(d) reads as rewritten:

"(d) A person enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan. The preferred provider plan may, however, limit the coverage for health care services obtained from a provider not participating in the plan, except that payments for services rendered by such non-participating providers may not be reduced by more than ~~twenty percent (20%)~~ forty percent (40%) of payments that would be made to participating providers under coverage for the same services. If the schedule of benefits offered in conjunction with the preferred provider plan imposes deductibles, the amount of any annual deductible per enrollee or per family may not exceed five times the amount of the corresponding annual deductible offered in conjunction with the preferred provider panel, nor may the amount of the deductible offered in conjunction with the preferred provider panel exceed two thousand dollars ($2,000) per individual or six thousand dollars ($6,000) for a family. The lifetime maximum amount of coverage offered in conjunction with a preferred provider panel shall not be more than twice the amount of the lifetime coverage offered that is offered in conjunction with the non-participating providers. ~~This percentage limitation shall not require any waiver of copayments or waiver of deductibles in determining payments for services rendered by non-participating providers.~~ Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating ~~providers.~~ providers and shall not contain any requirements, except as provided in this section, that limit the choice of accessing participating or non-participating providers. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating providers. Except as provided in this subsection, such payment may differ from that provided to participating providers in the discretion of the corporation. Non-participating providers may participate in other arrangements with the preferred provider, but will be subject to the provider's approved reimbursement mechanisms including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services."

Sec. 6. (a) Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-51. Preferred provider license requirements.**

(a) Each application for the issuance or renewal of a license shall be made on a form prescribed by the Commissioner.

(b) Applications for issuance of licenses shall include:

(1) All organizational documents, if any, of the PPO and any amendments thereto;
(2) The bylaws, rules, regulations, policies, and procedures that govern the internal operations of the PPO;
(3) The names, addresses, official positions, and professional qualifications of the individuals responsible for the operation of the PPO, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers or management;
(4) A general description of the business operations, including information on staffing levels and activities proposed in this State;
(5) A copy of any contract form made or to be made by the applicant on behalf of or by the PPO with any provider or subcontracted provider;
(6) A copy of any contract or agreement made or to be made by the applicant on behalf of or by the PPO with any person providing management services;
(7) A copy of the applicant's credentialing policies and procedures, quality assurance policies and procedures, and utilization management or review policies and procedures, and internal grievance policies and procedures;
(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this section;
(9) A financial feasibility plan which includes sufficient detail to allow the Commissioner to determine if the proposed operation of the PPO will not have a hazardous effect on the applicant or the citizens of this State that would be participating in the applicant's PPO; and
(10) Such other information as the Commissioner may require to make determinations required in subsection (d) of this section.

(c) A PPO shall file a notice describing in detail any significant modification of the operations set out in the information required in this section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Modifications to be included in this requirement include, but are not limited to, material changes in the provider network, credentialing process, or contracts with providers. Every PPO shall file with the Commissioner all subsequent changes in the information or forms that are required by this section to be filed with the Commissioner.

(d) Before issuing any license, the Commissioner may make such examinations or investigations he deems to be necessary, including the requirement that a site visit be conducted prior to the approval of a license to operate a PPO. The site visit will be

scheduled within 45 days after the application for a license. The cost of the prelicensing site visit, if any, will be paid by the applicant.

(e) The Commissioner shall issue a license to the applicant to operate a PPO upon receiving sufficient information that the PPO will operate in compliance with the statutes and rules of this State and upon being satisfied that the operation of the PPO will not have a hazardous financial result on the applicant.

(f) The Commissioner may deny, suspend, or revoke a license to operate a PPO if the Commissioner finds that the PPO:

(1) Is being operated by an insolvent insurer;

(2) Is using such methods and practices in the conduct of its business as to render its further transaction of business in this State hazardous or injurious to its participants or to the public;

(3) Is operating in violation of any applicable statutes or rules of this State, or has violated any lawful order of the Commissioner; or

(4) Has refused to produce materials or files for examination pursuant to G.S. 58-131."

(b) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-52. Prohibited practices.**

(a) No PPO or representative thereof shall cause or knowingly permit the use of advertising that is untrue or misleading or any solicitation that is untrue or misleading. For the purposes of this Article:

(1) A statement or item of information is untrue if it does not conform to fact in any respect that is or may be significant to a person considering contracting with the PPO;

(2) Article 63 of this Chapter applies to PPOs, except to the extent that the Commissioner determines that the nature of PPOs renders that Article clearly inappropriate; and

(3) No PPO may use in its name, contracts, or literature any of the words 'health maintenance organization', 'HMO', 'HMO-like', 'capitation', 'withholds', or any other of the words descriptive of a health maintenance organization or deceptively similar to the name or business of a health maintenance organization, nor may it hold itself out or represent itself as being an insurance company."

(c) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-53. Powers of PPOs.**

PPOs may contract with providers on a fee-for-service, or discounted fee-for-service basis for the provision of health care in conjunction with:

(1) An indemnity health insurance company organized under Articles 1 through 64 for the provision of health insurance;

(2) A hospital or medical service corporation organized under Article 65 of this Chapter for the provision of health care;

(3) A self-insured, single employer, or an employee benefit plan preempted from State insurance regulation by The Employee Retirement Income Security Act of 1974, for the provision of health care to its employees and dependents; or

(4) The contracting with any person for the performance on its behalf of certain functions such as marketing, management information systems, quality assurance and utilization review, and other similar services. However, if the PPO subcontracts any element of its business to a third party, the PPO will still retain the responsibility for regular monitoring of the delegated responsibilities and the regulatory compliance of its total operations."

(d) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-56. Exclusive provider panels.**

(a) No person may establish or operate an exclusive provider panel (EPP) in this State or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with an EPP without first obtaining a license from the Commissioner to operate an EPP, as a line of business of an insurer organized under Articles 1 through 64 of this Chapter.

(b) Insurers organized under Articles 1 through 64 of this Chapter may apply for a license to operate an EPP as a line of business by submitting to the Commissioner:

(1) An application on a form approved by the Commissioner and executed by an officer of the applicant insurer;

(2) A copy of the basic organizational documents of the EPP, if any, and all amendments thereto;

(3) A copy of the bylaws, rules, and regulations or similar documents regulating the internal conduct of the EPP, if any;

(4) A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the proposed EPP;

(5) A copy of any contract or subcontract form made or to be made between any class of providers and the proposed EPP and a copy of any contract made by or on behalf of the proposed EPP and any third party for the purpose of providing marketing or administrative services to the proposed EPP;

(6) A statement generally describing the proposed EPP, its health care delivery system, and personnel;

(7) A copy of the group or individual contract and evidences of coverage that will be issued in conjunction with the proposed EPP;

(8) A financial statement and financial feasibility plan, satisfactory to the Commissioner, showing the financial impact of the proposed EPP line of business on the applicant insurer;

(9) A detailed explanation of the premium-rating methodologies to be used in conjunction with the proposed EPP;

(10) A description of the internal grievance procedures to be utilized in conjunction with the proposed EPP;

(11) A description of the credentialing program, utilization management or review program, and the quality assurance program to be used in conjunction with the proposed EPP; and

(12) Such other information the Commissioner requires to determine the potential compliance of the proposed EPP with applicable rules and statutes of this State.

(c) Before issuing a license to operate an EPP to an insurer, the Commissioner may make such examinations and investigations, at the applicant's expense, as he deems to be reasonable and expedient. The Commissioner shall issue a license to operate an EPP to an insurer upon being satisfied on the following:

(1) The applicant is a bona fide insurer;

(2) The applicant has submitted sufficient documentation in subsection (b) of this section to assure the Commissioner that the proposed EPP will operate in compliance with the statutes and rules of this State;

(3) The operations of the proposed EPP as a line of business of the applicant insurer will not have a hazardous effect on the solvency of the applicant insurer; and

(4) The rates and benefits of the proposed EPP are fair and reasonable.

(d) An insurer operating a duly licensed EPP shall file a notice describing any significant modification of the operation set out in the information required in subsection (b) of this section. Such notices shall be filed with the Commissioner before the modification. If the Commissioner does not disapprove within 90 days after the filing, the modification shall be deemed to be approved. Changes subject to this section include changes in provider contract forms and any other changes described in adopted rules. Every EPP shall promptly report to the Commissioner when it knows of the potential of changes, deletions, or additions to the contracted provider panel that would be greater than ten percent (10%) of the total providers participating in the EPP or any other significant changes in the provider panel that would impair the EPP's ability to arrange for the delivery of medical services.

(e) The license to operate an EPP as a line of business of an insurer is subject to renewal on the first day of July of each year. Requests for renewal of such licenses will be made to the Commissioner on forms approved by the Commissioner and will be subject to the continued operations of the EPP and its duly licensed insurer in compliance with the statutes and rules of this State.

(f) The Commissioner may suspend or revoke any license to operate an EPP if he finds that any of the following conditions exist:

(1) The EPP is operating in significant contravention or in a manner contrary to that described in and reasonably inferred from information submitted in the application process or subsequent amendments thereof or any other information submitted to the Commissioner concerning the operations of an EPP or its duly licensed affiliate insurer;

(2) Contracts, benefits, or schedules of premiums are issued by an EPP which have not been approved by the Commissioner prior to their use;
(3) The insurer licensed to operate an EPP or the EPP has represented itself in an untrue, unfair, deceptive, misleading, or misrepresentative manner;
(4) The continued operation of the EPP would be hazardous to the citizens of the State or the duly licensed affiliate insurer; or
(5) The duly licensed affiliate insurer has otherwise failed to substantially comply with applicable statutes or rules.

(g) When the license to operate an EPP is suspended, the EPP and its duly licensed affiliate insurer shall not contract to cover any additional groups or individuals except newborn children or other newly acquired dependents of existing covered employees or spouses thereof of participating employer groups in an EPP, and shall not engage in any sales, marketing, or soliciting activities for an EPP.

(h) When the license to operate an EPP is revoked, the duly licensed affiliate insurer shall proceed immediately following the effective date of the notice to terminate the affairs of its EPP and shall conduct no further EPP business except as approved by the Commissioner which shall be essential to the orderly conclusion of the EPP's affairs.

(i) Any person that operates an EPP in this State without a license issued by the Commissioner is subject to G.S. 58-2-70.

(j) This section does not apply to any EPP to the extent that the Employee Retirement Income Security Act of 1974 preempts State regulation.

(k) The Commissioner may adopt rules governing the operations of EPPs."

(e) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-57. Prohibited practices of exclusive provider panels.**

(a) No EPP may be offered in conjunction with a benefit plan in which:
(1) The policy requires that a covered person pay more than a forty percent (40%) differential between the exclusive provider panel benefit and the non-participating provider benefit;
(2) The non-participating provider deductible is more than five times greater than the exclusive provider panel deductible;
(3) The annual individual out of plan deductible shall not exceed two thousand dollars ($2,000) and the total family out of plan deductible can not exceed three times that of the individual out-of-plan deductible;
(4) The out of plan maximum lifetime benefit may not be less than one-half of the in plan maximum life time benefit; and
(5) Where the exclusive provider panel includes copayments, the difference between the in-plan and out-of-plan copayment shall not exceed fifty dollars ($50.00) or one hundred percent (100%)."

(f) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-160. Managed Care Operations Act; finding; purpose; scope.**

(a) This section and G.S. 58-50-165 through G.S. 58-50-205 are known and may be cited as the 'Managed Care Operations Act', referred to in those sections as 'this Act'.

(b) The General Assembly finds that in order to deliver high quality, cost-effective health care benefits, the health insurance industry has by necessity evolved to contain elements of managed care, which include utilization management, quality assurance, provider contracting, and provider credentialing. The purpose of this Act is to provide a uniform set of standards to govern the development, implementation, and operation of all types of managed care plans providing health care benefits to individuals in North Carolina and to ensure that the quality of care and quality of service provided is preserved and enhanced.

(c) This Act applies to all preferred provider organizations licensed under G.S. 58-50-55 and G.S. 58-65-140; all exclusive provider panels organized under G.S. 58-50-58 and G.S. 58-65-143; all utilization review companies; all exclusive provider panels; all insurance companies organized under Articles 1 through 64, and corporations organized under Article 65 of this Chapter that meet the definition of a managed care plan used in this Act. This Act does not apply to any employee benefit plan to the extent that the Employee Retirement Income Security Act of 1974 preempts State regulation."

(g) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-165. Definitions.**

(a) 'Capitation' means the practice of prepaying a contracted provider or a group of contracted providers for the health care services of a defined population on a per capita basis.

(b) 'Coinsurance' means the portion of each covered service, calculated as a percentage of the cost of such service, which is to be paid by the enrollee.

(c) 'Copayment' means a fixed dollar payment made by the enrollee, which is collected by the provider at the time the service is delivered.

(d) 'Covered Service' means those health care benefits which enrollee is entitled to and a managed care plan provides or arranges as specified under the enrollee's evidence of coverage, master group contract, or certificate of coverage.

(e) 'Deductible' means the amount of money, specified as a fixed dollar amount, which an individual or family must pay before covered medical services are reimbursed.

(f) 'Enrollee' means an individual who is covered by a managed care plan.

(g) 'Emergency' means an unforeseen illness, or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or unforeseen medical emergencies of a life-threatening nature, or which would result in the serious impairment of bodily functions if treatment were not rendered immediately.

(h) 'Exclusive Provider Panel' (EPP) shall mean a managed care plan organized under G.S. 58-50-56 or G.S. 58-65-143 that provides nonemergency, prepaid, covered health care services only through a contracted panel of participating providers.

(i) 'In-Plan Covered Services' means covered health care services obtained from providers who are employed by, under contract or subcontract with, or referred by the managed care plan, and emergency services.

(j) 'Medical Director' means a duly licensed physician who has been hired or contracted by the managed care plan to monitor the provision of covered services to enrollees.

(k) 'Medically Necessary' or a 'Medical Necessity' means, for the purposes of payment, covered services and supplies that are:

(1) Provided for the diagnosis or care and treatment of a medical condition;

(2) Necessary for and appropriate to the symptoms, diagnosis, or treatment of a medical condition;

(3) Within generally accepted standards of medical care;

(4) Not primarily for the convenience of the member, his family, or the provider; and

(5) Performed in the most cost-effective setting and manner appropriate to treat the patient's medical condition.

(l) 'Out-of-Plan Covered Services' means nonemergency, self-referred, covered health care services obtained from providers who are not otherwise employed by or under contract with the managed care plan; or services obtained from an affiliated specialist without plan authorization.

(m) 'Participating Provider' means a physician or other health care provider, or a group of physicians or health care providers, or a medical facility, program, or agency which has a contractual arrangement with the managed care plan to provide specified covered health care services to enrollees.

(n) 'Plan' means a managed care plan.

(o) 'Point-of-Service Plan' means a plan or insurance product that includes in-plan and out-of-plan covered services, which provide or reimburse at different benefit levels.

(p) 'Preferred Provider Organization' (PPO) means a type of health plan that may be offered by an insurance company, a hospital or medical service corporation, or arranged by a self-funded employer for the sole use of its employees and dependents, which is characterized by all or most of the following features:

(1) Services are provided by a network of contract providers who are paid on a negotiated or discounted fee-for-service basis,

(2) Enrollees are offered incentives to limit care to the panel of contract providers,

(3) Utilization and quality management programs are employed to manage care, and

(4) No transfer of insurance risk to providers through capitated payment arrangements, fee withholds, or other risk-sharing arrangements.

(q) 'Primary Care Physician' means a physician duly licensed to practice medicine in the fields of general and family practice, general internal medicine, or pediatrics.

(r) 'Quality Management (Quality Assurance)' means a program of reviews, studies, evaluations, and other activities employed by the managed care plan for the purpose of monitoring and enhancing quality of health care and services provided to enrollees.

(s) 'Single Service Preferred Provider Organization' means an organization which provides a single specific type, or limited number of related health care services to a health benefit plan or other payor on a fee-for-service basis, or discounted fee-for-service basis.

(t) 'Urgent Care' means services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that in the absence of immediate care the individual could reasonably be expected to suffer an extended illness, prolonged impairment, or require a more hazardous treatment.

(u) 'Utilization Management (Utilization Review)' means those methodologies used by managed care plans and utilization review organizations to improve the quality and maximize the efficiency of the health care delivery system.

(v) 'Withholds, (Risk Reserves, Physician Incentive Pools)' means the contractual practice of withholding a portion of a provider's claim reimbursement, or the setting aside of a preset percentage of premium income that eventually may be payable to the provider(s) based upon a previously established set of utilization review performance standards or claims dollar volumes."

(h) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-170. Requirements for provider contracting.**

(a) A managed care plan may contract for primary care and specialty care within its service area. A managed care plan may also contract for services in accordance with the requirements of G.S. 58-67-5(q)(2), subject to the documentation requirements of this subsection. If an enrollee is sent to the contracted out-of-area provider, the managed care plan shall document in writing that provision of services by such provider is necessary or appropriate to the provision of quality health care services to the enrollee. The documentation will be prepared pursuant to medical case management procedures adopted by the managed care plan.

(b) Each HMO shall execute a written contract with all physicians, hospitals, and other health care practitioners listed by the HMO as network or participating providers (except those providers employed by or under contract with intermediary provider organizations contracting with the managed care plan). Such contract shall include the provisions listed in subsection (c) of this section. Each contract shall be fully and completely executed, and each physician or other health care provider shall be credentialed, before the provider is listed as a network or participating provider in the managed care plan's provider directory, marketing materials, member materials, or in response to a request for proposal or other inquiry from an employer or employer organization.

(c) All contracts shall, at a minimum, contain the following provisions:

(1) A provision requiring the provider to maintain the confidentiality of enrollees' medical information;

(2) A provision requiring the provider not to discriminate on the basis of race, color, national origin, sex, age, religion, marital status, or health status;

(3) A provision requiring the managed care plan to make available to the provider a grievance and appeal process;

(4) A provision requiring the managed care plan to make available to the provider a description of the managed care plan's terms, definitions, and methods of operation applicable to the provision of covered services to enrollees;

(5) A provision allowing the managed care plan to terminate the contract when the managed care plan reasonably determines that continuation of the contract may adversely affect enrollee care.

(6) A provision whereby the provider warrants that the provider is:

a. Currently licensed to practice in the fields and jurisdictions listed by the provider in the managed care plan's provider applications;

b. Covered by adequate levels of general and professional liability insurance; and

c. Privileged as a member in good standing of the medical staff of a participating hospital, if applicable.

(7) A provision whereby the provider agrees to notify the managed care plan immediately of any changes in the status of the provider's license, certification(s), liability coverage, or hospital privilege status.

(8) A provision requiring the provider to participate in and cooperate fully with the HMO's utilization management, quality management, and credentialing programs.

(9) A provision requiring the provider to maintain adequate medical records, to make such records available to the managed care plan for the purpose of conducting its utilization management, quality management, and credentialing programs, and to make such records available as required by law to the Commissioner in conjunction with an examination of the affairs of the managed care plan or an investigation of enrollee grievances or complaints.

(10) A provision whereby the provider agrees that all professional decisions, judgments, treatments, and diagnoses, and other professional services delivered to enrollees by the provider are his sole responsibility.

(11) A provision stating that the contract is not assignable by the participating provider without the written consent of the managed care plan;

(12) A provision stating that the contract and attached amendments or exhibits represent the full and complete agreement between the managed care plan and the contract provider, or the subcontracting intermediary contractor and the contracting provider;

(13) A provision applicable to primary care provider contracts requiring the primary care physician provide, or make available 24 hour-per-day, seven day-per-week coverage consistent with the managed care plan's accessibility plan and marketing materials.

(d) This section applies to all provider contracts entered into on or after January 1, 1994; provided, however, that existing contracts may remain in force until providers are recredentialed or recontracted, but no later than January 1, 1996."

(i) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-175. Contracts with intermediary organizations.**

When a managed care plan contracts with an independent practice association, a single service health maintenance, a preferred provider organization, a medical group that subcontracts with other providers, or a hospital-physician organization, the contract shall include the following provisions:

(1) A requirement that each contract between the intermediary organization and participating providers contain all applicable provisions required by G.S. 58-67-190(c);

(2) Acknowledgment that the contract shall not relieve the managed care plan of its responsibility to oversee the provision of health care services to its enrollees and that when the managed care plan delegates responsibility for credentialing, utilization management, quality management, or claims payment to the intermediary organization, the managed care plan shall review annually the intermediary's plans, policies, and procedures pertaining to each of the delegated services or programs;

(3) A requirement that the intermediary organization maintains copies of all of its health care subcontracts at its principal place of business in a manner which facilitates regulatory review, or shall provide access to all such subcontracts and obtain copies to facilitate regulatory review upon 20 business days prior written notice;

(4) A requirement that organization shall:

a. Provide to the managed care plan, upon its request, utilization and claims-paid documentation and information about the timeliness and appropriateness of payment and services received by managed care plan enrollees;

b. Provide access to the Commissioner to all books, records, documentation, and contracts relating to covered services provided to the managed care plan's enrollees as required by law; and

c. Maintain at its principal place of business, for a period of four years, copies of all contracts which it enters into with physicians, hospitals, health care provider organizations, or other health care practitioners for covered services to enrollees.

(5) A provision whereby the intermediary provider organization warrants that the physicians or other health care practitioners it will utilize to provide covered services to enrollees are, or prior to the rendition of services to enrollees will be, properly credentialed by the managed care plan's credentialing processes, or properly credentialed by the credentialing processes of the intermediary provider organization, consistent with the requirements of G.S. 58-67-205."

(j) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-180. Requirements for provider availability and accessibility.**

(a) The plan shall make available to enrollees a sufficient number and range of providers by class, specialty, and geographic location to adequately serve enrollees and to provide them with adequate availability of and access to all health care services covered under the managed care benefit plan. The number and type of providers participating in the managed care network should be reasonably proportionate to and representative of the number and type of providers practicing in the managed care service area, and the travel time to in-plan providers and services should approximate the travel time to those same services as they are generally available in the service area. Where this requirement is not met, the plan must provide convenient and timely access to noncontracted providers, at no additional charge to the member beyond the charge that would have been required for an in-plan provider.

(b) The plan shall develop and adhere to appropriate accessibility standards, policies, and procedures that address:

(1) Provider availability by type, class, and specialty of provider;

(2) Geographic accessibility of primary care physicians, specialty care physicians, hospitals, mental health services and programs, and other types of services covered under the plan's benefits;

(3) Participating physicians' obligation to accept existing and new plan patients;

(4) Waiting time for urgent, routine, and preventive care appointments;

(5) Waiting time in the participating physicians' office or clinic;

(6) After-hours coverage and practice coverage when participating physician will not be available for extended periods of time.

(c) The plan shall make available a method by which enrollees may obtain authorization to use, without financial penalty, such services which are medically necessary, appropriate, and covered under the managed care benefit plan, but are not available, on a timely basis, from or through in-plan providers.

(d) The plan shall make provision to pay, without additional financial penalty to the enrollee, for medically necessary emergency or urgent care provided outside the plan's approved service area.

(e) The plan shall, in its member materials, provide clear instructions on how out-of-plan care and services may be obtained without financial penalty, and how payments for out-of-service area emergency and urgent care are reimbursed."

(k) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-185. Requirements for enrollee complaint and grievance procedure.**

(a) Each plan shall establish and make known to its enrollees and participating providers a formal complaint and grievance procedure. The grievance procedure should be structured to deal with all manner of complaints and problems arising out of, or related to: claims payment, benefit coverage, the patient-provider relationship, utilization management, quality management, the use of out-of-plan and out-of-service area services, and other administrative issues.

(b) All written complaints and all documentation of oral complaints concerning the plan or its providers shall be maintained at the plan's principal place of business in this State in a single location and in a manner which facilitates regulatory review for a period of three years, or from the date of the plan's last market practices examination report, whichever is greater.

(c) The plan's grievance procedure shall be initiated in response to a formal request from a plan enrollee or participating provider. The complaint must be in writing, and must provide a detailed description of the problem which is the subject of the complaint.

(d) The plan's complaint and grievance procedures must incorporate at least two levels of appeal, as specified below:

(1) Level 1 – An administrative review that is undertaken in response to an enrollee's written complaint. The complaint shall be forwarded to the plan's chief administrative or executive officer, or his designee who will:

a. Thoroughly and completely investigate the complaint;

b. Make an informed decision on how the complaint is to be resolved;

c. Communicate in writing the plan's response to the complaint within five business days from receipt of the written complaint;

d. Include, if the complaint is not resolved to the enrollee's benefit, a written notification of the enrollee's right to request a grievance hearing.

(2) Level 2 – A grievance hearing shall be provided as a second level of appeal to the enrollee. The grievance hearing shall be conducted by a grievance committee appointed by the chairman of the plan's board of directors, or other governing body, or by the plan's chief administrative or executive officer, and will follow the general guidelines specified below:

a. The hearing shall be scheduled no later than 30 days from the date of receipt of the request for such a hearing, and the committee shall inform the enrollee in writing of its decision within five business days from the date of the hearing;

b. If medical issues are involved, at least one provider whose specialty relates to the medical issue contained in the complaint shall be appointed to the committee;

c. The committee shall follow general due process guidelines including allowing the enrollee to be present, to be represented by an attorney, to call witnesses, to cross-examine witnesses, and to present evidence during the hearing;

d. Minutes of the hearing shall be made and records retained for a period of not less than three years or until the time of the next market practices examination, whichever is greater.

(3) The description of the plan's grievance procedure provided in its member materials must not state or in any way indicate that the enrollee, by participating in the grievance procedure, forfeits any rights available under the law, or his right to appeal to the Department's Consumer Division."

(l) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-190. Requirements for quality management.**

(a) The plan shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

(b) The plan shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

a. The plan's scope and purpose in quality assurance;

b. The organizational structure responsible for quality assurance activities;

c. Contractual arrangements, where appropriate, for delegation of quality assurance activities;

d. Confidentiality policies and procedures;

e. A system of ongoing evaluation activities;

f. A system of focused evaluation activities;

g. A system for credentialing providers and performing peer review activities; and

h. Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(3) A written statement describing the system of ongoing quality assurance activities including:
a. Problem assessment, identification, selection, and study;
b. Corrective action, monitoring, evaluation, and reassessment; and
c. Interpretation and analysis of patterns of care rendered to individual patients by individual providers.
(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation, and report format; and
(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

(c) The plan shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. The quality assurance program and minutes shall be available to the Commissioner but are not public records.

(d) The plan shall require the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the plan evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the Commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed to be necessary by the Commissioner, but are not public records.

(f) The plan shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate plan staff.

(g) The requirements of this section may be waived by the Commissioner for any managed care plan that has received accreditation from a nationally recognized accrediting body, satisfactory to the Commissioner; provided, however, that the commissioner may revoke any waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. In making an application for a waiver, the plan shall file with the Commissioner a copy of the initial application for accreditation and initial certification, and all subsequent reapplications and subsequent recertifications."

(m) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-195. Credentialing.**

(a) The plan shall credential, or cause to be credentialed, all physicians and, where appropriate, other health care practitioners before a contract becomes effective and before such providers are listed as participating providers in plan marketing and member materials.

(b) The plan, or an entity to whom the credentialing function has been delegated, shall employ or contract with an individual to whom responsibility for the plan's credentialing program has been delegated. The plan shall employ or contract with a licensed physician who shall have substantial involvement in the plan's credentialing program.

(c) The plan shall develop or adopt a credentialing plan that specifies criteria for participation in the plan and provides policies and procedures for reviewing provider applications.

(d) The plan shall designate a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions.

(e) The plan shall require a credentialing application to be completed, on a form approved by the Commissioner, by each applicant. The application should include, but is not limited to, specifics relating to call coverage, education/training history, professional affiliations, hospital affiliation, level of general and professional liability coverage, Drug Enforcement Administration (DEA) registration number, medical references, medical/legal liability history, and privileges desired.

(f) The plan shall verify the following information provided in the credentialing application, where applicable:

(1) Applicant's license to practice medicine or other health care service in North Carolina;

(2) Applicant's specialty board certification(s) status;

(3) Applicant's general and professional liability coverage;

(4) Applicant's malpractice history and a report from a National Practitioner Data Bank query;

(5) The status of applicant's hospital privileges.

(g) The plan shall maintain full and complete documentation of its credentialing activities including:

(1) A signed and dated credentialing application;

(2) All required verifications;

(3) A signed and dated provider contract;

(4) Responses to professional data base queries;

(5) All correspondence relating to credentialing, if any;

(6) Documentation of credentialing committee action; and

(7) A copy of applicant's notification of acceptance or rejection.

(h) The plan shall recredential all participating providers every two years."

(n) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-200. Utilization management.**

(a) The plan shall have a utilization management program description that describes both delegated and nondelegated activities:

(1) The utilization management program description shall include, at a minimum, policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services; and

(2) A mechanism for updating the utilization management program description on a periodic basis, which is specified by the plan.

(b) The requirements of this section may be waived by the Commissioner for any plan that has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner; provided, however, that the Commissioner may revoke any waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. In making such application for waiver, the plan shall file with the Commissioner a copy of the initial application for accreditation and initial certification and all subsequent reapplications and subsequent recertifications."

(o) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-205. Requirement for claims processing and MIS.**

(a) All plans that process and pay claims shall use an electronic data processing system that has the capability to:

(1) Process and pay all types of provider claims;

(2) Produce an understandable explanation of the benefits form, including in-plan and out-of-plan payment differentials, if applicable;

(3) Support all methods of provider payment utilized by the plan;

(4) Generate a variety of cost and utilization reports for internal use, for clients, and for regulatory review;

(5) Support the plan's quality and utilization management programs; and

(6) Generate a variety of reports to support the plan's quality management program.

(b) All plans that process or pay claims shall comply with the procedures and requirements contained in 11 NCAC 4.0319.

(c) All plans providing utilization management services but not claims payment services shall maintain an automated database sufficient to support their utilization and quality management services and programs, including the ability to generate provider profiles and various utilization summaries and reports."

Sec. 7. Article 65 of Chapter 58 of the General Statutes is amended by adding the following:

"**§ 58-65-142. Exclusive provider panels.**

(a) No person may operate an exclusive provider panel ('EPP') in this State, nor sell or offer to sell or solicit offers to purchase or receive in conjunction with an EPP, advance or periodic consideration without obtaining a license from the Commissioner to operate an EPP as a line of business of a corporation organized under this Article.

(b) Corporations organized under this Article may apply for a license to operate an EPP by submitting to the Commissioner:

(1) An application on a form approved by the Commissioner and executed by an officer of the applicant corporation;

(2) A copy of the basic organizational documents of the applicant and all amendments thereto;

(3) A copy of the bylaws, rules, and regulations or similar documents regulating the internal conduct of the applicant;
(4) A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the proposed EPP;
(5) A copy of any contract or subcontract form made or to be made between any class of providers and the proposed EPP and a copy of any contract made by or on behalf of the proposed EPP and any third party for the purpose of providing marketing or administrative services to the proposed EPP;
(6) A statement generally describing the proposed EPP, its health care delivery system, and personnel;
(7) A copy of the group or individual contract and evidences of coverage that will be issued in conjunction with the proposed EPP;
(8) A financial statement and financial feasibility plan, satisfactory to the Commissioner, showing the financial impact of the proposed EPP line of business on the applicant corporation;
(9) A detailed explanation of the premium rating methodologies to be used in conjunction with the proposed EPP;
(10) A description of the internal grievance procedures to be utilized in conjunction with the proposed EPP;
(11) A description of the credentialing program, utilization management or review program, and the quality assurance program to be used in conjunction with the proposed EPP;
(12) Such other information the Commissioner requires to determine the potential compliance of the proposed EPP with the applicable rules and statutes of this State.

(c) Before issuing a license to operate an EPP, the Commissioner may make such examinations and investigations, at the applicant's expense, as he deems expedient. The Commissioner shall issue a license upon being satisfied that:
(1) The applicant is a bona fide corporation organized pursuant to this Article:
(2) The applicant has submitted sufficient documentation in (b) of this section to be assured that the proposed EPP will operate in compliance with the statutes and rules of this State;
(3) The operations of the proposed EPP as a line of business of the applicant corporation will not have a hazardous effect on the solvency of the applicant corporation; and
(4) The rates and benefits of the proposed EPP are fair and reasonable.

(d) A corporation operating a duly licensed EPP shall file a notice describing any significant modification of the operation set out in the information required in subsection (b) of this section. Such notices shall be filed with the Commissioner before the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Changes subject to this section include changes in provider contract forms and any other changes described in

adopted rules. Every EPP shall report to the Commissioner within 48 hours after having knowledge of the potential of changes, deletions, or additions to the contracted provider panel that would be greater than ten percent (10%) of the total providers participating in the EPP or any other significant changes in the provider panel that would impair the EPP's ability to arrange for the delivery of medical services.

(e) Each license is subject to renewal on the first day of July of each year. Requests for renewals shall be made on forms approved by the Commissioner and shall be subject to the continued operations of the EPP and its duly licensed corporation in compliance with the statutes and rules of this State.

(f) The Commissioner may suspend or revoke any license to operate an EPP if he finds that any of the following conditions exist:

(1) The EPP is operating in significant contravention or in a manner contrary to that described in and reasonably inferred from information submitted in the application process or subsequent amendments thereof or any other information submitted to the Commissioner concerning the operations of an EPP or its duly licensed affiliate corporation;

(2) Contracts, benefits, or schedules of premiums are issued in conjunction with the operation of an EPP which have not been approved by the Commissioner prior to their use;

(3) The corporation licensed to operate an EPP or the EPP has represented itself in an untrue, unfair, deceptive, misleading, or misrepresentative manner;

(4) The continued operation of the EPP would be hazardous to the citizens of the State or the duly licensed affiliate corporation;

(5) The duly licensed affiliate corporation has otherwise failed to substantially comply with this Article.

(g) When a license is suspended, the EPP and its duly licensed affiliate corporation shall not contract to cover any additional groups or individuals, except newborn children or other newly acquired dependents of existing covered employees or spouses thereof of participating employee groups in an EPP, and shall not engage in any sales, marketing, or soliciting activities for an EPP.

(h) When a license is revoked, the duly licensed affiliate corporation shall proceed immediately following the effective date of the order to terminate the affairs of its EPP and shall conduct no further EPP business, except that approved by the Commissioner as essential to the orderly conclusion of the EPP's affairs.

(i) Any person that operates an EPP in this State without a license issued by the Commissioner is subject to G.S. 58-2-70.

(j) This section does not apply to any health maintenance organization organized under Article 67 of this Chapter; or to a single employee welfare benefit plan to the extent the Employee Retirement Income Security Act of 1974 preempts State regulation.

"**§ 58-65-143. Prohibited practices of exclusive provider panels.**

(a) No EPP may be offered by a hospital or medical service corporation or its affiliates in which the benefit plan contains:

(1) A difference in coinsurance rates covered by the exclusive provider panel and the non-participating provider shall not exceed 40 percentage points.

(2) A deductible for out-of-plan covered services that is more than five times the deductible for in-plan covered services.

(b) The total out-of-plan deductible shall not exceed two thousand dollars ($2,000) per individual and the total family deductible shall not exceed three times that of the individual.

(c) If the in-plan benefit schedule has a lifetime maximum, the out-of-plan lifetime maximum shall not be less than one-half of the in-plan lifetime maximum.

(d) Where the covered services of the exclusive provider panel contain a copayment, the difference between in-plan and out-of-plan copayments shall not exceed fifty dollars ($50.00) or one hundred percent (100%)."

Sec. 8. This act becomes effective July 1, 1993.