GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

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SENATE BILL 301

Short Title: Managed Care Changes/AB. (Public)

Sponsors: Senators Parnell and Carpenter.

Referred to: Pensions and Retirement/Insurance/State Personnel

March 6, 1995

A BILL TO BE ENTITLED

AN ACT RELATING TO MANAGED CARE OPERATIONS.

The General Assembly of North Carolina enacts:

Section 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-6. Other definitions.**

(a) 'Service area' means a geographic area in North Carolina approved by and on file with the Commissioner in which:

(1) An HMO enrolls persons who either work in the service area, reside in the service area, or work and reside in the service area.

(2) An HMO contracts with providers for the provision of primary and specialty health care services to its enrolled membership.

(b) 'Single service HMO' means an organization that undertakes to provide or arrange for the delivery of a single type or single group of health care services to a defined population on a prepaid or capitated basis, except for enrollee's responsibility for copayments or deductibles."

Sec. 2. G.S. 58-67-5(g), G.S. 58-67-10(b)(3a), and G.S. 58-67-10(b)(4) are repealed.

Sec. 3. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-11. Miscellaneous provisions.**

(a) The licensing provisions of this Article do not apply to any single service HMO to the extent that the single service HMO solely contracts with and offers its services through one or more exclusive provider panels or licensed HMOs.

(b) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Nothing in this subsection exempts HMOs or any other person who undertakes to provide or arrange for the delivery of basic health care services to all enrollees on a prepaid basis from complying with all applicable provisions of this Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to an HMO licensed in this State, that person shall be considered a single service HMO for the purposes of G.S. 58-67-20(4), 58-67-25, and 58-67-110.

(c) In addition to the items required by G.S. 58-67-10(c), each applicant for an HMO license shall file a description of its quality assurance, utilization review, and credentialing programs.

(d) As used in this Article, 'certificate of authority' and 'license' have the same meaning.

(e) An HMO license shall continue for the ensuing 12 months after July 1 of each year, unless suspended or revoked as provided in G.S. 58-67-140. Application for renewal of an HMO license must be submitted on or before the first day of March on a form approved by the Commissioner. Upon satisfying himself that an HMO has met all requirements of law, the Commissioner shall forward the renewal license to the HMO. An HMO that does not qualify for a renewal license before July 1 shall cease to do business in this State as of July 1, unless its license is suspended or revoked by the Commissioner before that date.

(f) A master group contract may provide for readjustment of the rate of premium based on the experience thereunder at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience: Provided that any such readjustment after the first year shall not be made any more frequently than once every six months. Any rate adjustment must be preceded by a 45-day notice to the master group contract holder before the effective date of the rate increase or policy benefit revision. A notice of nonrenewal shall be given 45 days before termination.

(g) In addition to the requirements in G.S. 58-67-50, every evidence of coverage shall contain:

(1) A grace period of not fewer than 15 days for the payment of each premium falling due after the first premium, during which time coverage shall remain in effect if payment is made during the grace period and if the group is not delinquent more than twice in any 12-month period.

(2) A claims payment provision that allows a period of at least 180 days during which an enrollee or group may submit a claim form after

delivery of health care, with an exception for an extension of time for absence of legal capacity.

(h) The Commissioner may withdraw approval of an approved form by sending 30-days' advance written notice to the HMO that the form is no longer in compliance with the statutes and rules of this State. The notice shall include the reasons for the Commissioner's withdrawal of approval. Any request for a hearing suspends the Commissioner's withdrawal until an order is issued on the matter.

(i) No action shall be brought to recover on the evidence of coverage before the later of the expiration of any mandatory grievance procedure, or other administrative appeals remedy, or 60 days after a claim form has been submitted in accordance with the requirements of the evidence of coverage.

(j) The provisions of G.S. 58-2-131, 58-2-132, and 58-2-133 apply to examinations under G.S. 58-67-100.

(k) The provisions of G.S. 58-51-25, 58-51-35, 58-51-40, and 58-51-45 apply to HMOs.

(l) An HMO may contract outside its service area for organ and tissue transplants, services not reasonably or sufficiently available in its service area, emergency services, and extraordinary case management."

Sec. 4. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

(a) A health maintenance organization ~~may~~ shall issue a master group contract with the approval of the Commissioner ~~of Insurance~~ provided the contract and the individual certificates issued to members of the group, ~~shall~~ comply in substance to the other provisions of this ~~Article.~~ Article and this Chapter that are applicable to HMOs. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If the master group contract is ~~issued, altered~~ altered or modified, such alteration or modification must be filed and approved before the issuance of the altered or modified form; and the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

(b) ~~For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase "groups of 50" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~ For employer groups, no evidence of individual insurability may be used to exclude from participation in an HMO an employee or dependent of the employee who enrolls:

(1) During the annual enrollment or open enrollment period;

(2) Within 31 days after first becoming eligible for coverage; or
(3) Within 31 days after the occurrence of a qualifying event.

(b1) For purposes of this section and subsection (e) of this section, each of the following is a qualifying event:

(1) The loss of coverage under another employer group health benefit plan due to one of the following, provided that the employee or dependent was covered under the plan when first eligible for enrollment in the HMO:
a. Termination of employment;
b. Termination of the other plan's coverage;
c. Death of a spouse; or
d. Divorce.
(2) The issuance of a court order requiring a spouse or minor child to be covered under the employee's health benefit plan.

(b2) If an HMO uses medical underwriting criteria or forms, the criteria and forms shall be filed with the Commissioner prior to their use.

(c) Except as otherwise provided in this subsection, employer ~~Employer~~ master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented in the following circumstances:

(1) ~~by~~ By any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan. ~~For employer groups of 50 or more persons:~~ In determining whether a preexisting condition provision applies to an eligible employee or to a ~~dependent, all health benefit plans~~ dependent enrolled under an employer group plan, the HMO shall credit the time the person was covered under a previous group health benefit plan if the previous coverage was continuous to a date not more than 60 days before the effective date of the new coverage, exclusive of any applicable waiting period under the new coverage.
(2) For any employee or dependent who enrolls within 31 days after the occurrence of a qualifying event; and
(3) For any employee or dependent who enrolls during a period of open enrollment or within 31 days after first becoming eligible, except as provided in subsections (f) and (g) of this section.

(c1) The following requirements apply when an HMO is the only health benefit plan offered by an employer to its employees for group coverage:

(1) If requested by the employer, the HMO may offer one open enrollment period at the assumption of the group and only offer subsequent annual enrollments. All eligible employees must be notified at the time of the open enrollment that no additional open enrollments are anticipated by the HMO.

(2) Preexisting condition exclusions permitted under subsection (e) of this section shall be applied by the HMO only if requested by the employer.

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours per week. ~~and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.~~ For all employer groups where more than one health benefit plan is available to employees, employees may be added to the plan according to the employer's eligibility requirements for the other plan(s). Preexisting condition limitations may be applied to employees and dependents to the same extent applicable in the other plan(s) if not otherwise prohibited under this Article.

(d1) Open enrollments under this section shall be periods of time no shorter than 10 business days occurring at least every year. During open enrollments all eligible employees and dependents may join or transfer from one type of health benefit plan to another, without providing proof of insurability or being subject to preexisting condition exclusions. Annual enrollments under this section shall be periods of time no shorter than 10 business days that are held once a year. During annual enrollments HMOs shall accept all eligible employees and dependents for membership and may use evidence of insurability to impose preexisting condition exclusions.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under ~~Articles 1 through 67 of~~ this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with ~~(e)(1)~~ subdivision (1) of this subsection must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan.

(f) All master group contracts offered or issued by an HMO must be printed in a typeface at least as large as 10-point modern type, one point leaded, and written in a logical and clear order and form; and contain the following:

(1) A statement on the cover, first, or insert page that the document is a legal contract subject to the jurisdiction of and is in compliance with the statutes and rules of this State.
(2) An index of the major provisions of the document.
(3) A provision that the contract represents the entire agreement between the signatory parties.
(4) A provision outlining the time limits on certain defenses, if any.
(5) A provision concerning the eligibility of members.
(6) A provision explaining the benefits offered.
(7) A provision explaining the limitations and exclusions of coverage.
(8) A provision explaining the mechanism for the payment of claims incurred and submitted by or on behalf of the member under the benefit plan.
(9) A provision explaining the grievance and complaint procedure.
(10) A provision explaining the rights of continuation and conversion in Article 53 of this Chapter and under any federal law."

Sec. 5. Article 67 of Chapter 58 is amended by inserting a new section to read:

"**§ 58-67-86. Right to obtain individual coverage upon termination of group coverage.**

If an HMO is affiliated with one or more licensed health insurance companies, the HMO must provide the opportunity for conversion to a policy issued by one of its affiliates that is a licensed health insurance company for group enrollees who terminate their coverages and move outside of the HMOs service area. If an HMO is not affiliated with one or more licensed health insurance companies, the HMO shall make a good faith effort to contract on reasonable terms with a licensed health insurance company to make conversion coverage available to group enrollees who terminate their coverages and move outside of the HMO's service area. Such conversion policies shall be issued, at a minimum, in compliance with the provisions of Article 53 of this Chapter."

Sec. 6. Article 67 of Chapter 58 of the General Statutes is amended by adding the following:

"**§ 58-67-190. Provider contracting.**

An HMO may contract for primary care and specialty care within its service area. An HMO may also contract for services to be provided outside of its service area if the services are not those of a primary care physician and the contract is in accordance with standard or model contract forms approved by the Commissioner. If an enrollee is sent to the contracted out-of-area provider, the HMO shall document in writing that the provision of services by that provider is necessary or appropriate to the provision of quality health care services and not unduly burdensome to the enrollee. The documentation will be prepared pursuant to medical case management procedures adopted by the HMO."

Sec. 7. G.S. 58-66-1 through G.S. 58-66-40 are recodified as Part 3 of Article 65 of Chapter 58 of the General Statutes. Part 3 shall be titled "Hospital, Medical and Dental Services Corporation Readable Insurance Certificates Act." The section numbers

of Article 66 of Chapter 58 of the General Statutes, recodified as Part 3 of Article 65 of Chapter 58, are redesignated as follows:

Article 66 Old Section #	Part 3 of Article 65 New Section #
§ 58-66-1	**§ 58-65-175**
§ 58-66-5	**§ 58-65-180**
§ 58-66-10	**§ 58-65-185**
§ 58-66-15	**§ 58-65-190**
§ 58-66-20	**§ 58-65-195**
§ 58-66-25	**§ 58-65-200**
§ 58-66-30	**§ 58-65-205**
§ 58-66-35	**§ 58-65-210**
§ 58-66-40	**§ 58-65-215**

The Revisor of Statutes shall make changes to statutory citations in the General Statutes necessitated by the recodification of G.S. 58-66-1 through G.S. 58-66-40.

Sec. 8. G.S. 97-2(21) reads as rewritten:

"(21) Managed care organization. – The term 'managed care organization' means a ~~preferred provider organization~~ managed care plan described in Article 66 of Chapter 58 of the General Statutes or a health maintenance organization regulated under Article 67 of Chapter 58 of the General Statutes."

Sec. 9. Article 66 of Chapter 58 of the General Statutes is retitled "Managed Care Operations" and is amended by inserting the following new sections to read:

"**§ 58-66-60. Finding; purpose; exception.**

(a) 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 review, quality assurance, provider contracting, and provider credentialing. The purpose of this Article 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 and services to individuals in North Carolina and to ensure that the quality of care and quality of service provided are preserved and enhanced.

(b) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes; or to any provider participating in such a prepaid health service or capitation arrangement.

"**§ 58-66-65. Definitions.**

(1) 'Covered services' means those health care services to which an enrollee is entitled, and for which a managed care plan provides or arranges as

specified under the enrollee's evidence of coverage, master group contract, or certificate of coverage.

(2) 'Emergency' means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably result in:

a. The patient's health being placed in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

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

(4) 'Health care provider' or 'provider' includes any person who, under Chapter 90 of the General Statutes, is licensed, registered, or certified to engage in the practice of or performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital as defined by G.S. 131E-76; or a nursing home as defined by G.S. 131E-101.

(5) 'HMO' means a health maintenance organization operating under Article 67 of this Chapter.

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

(7) 'Managed care plan' or 'Plan' means a PPO, a URO, or any arrangement established by a licensed accident and health insurer, service corporation, or HMO that uses PPOs or UROs or that offers or arranges for one or more products that integrate financing and management with the delivery of health care services.

(8) 'Medically necessary services or supplies' means those services or supplies that are:

a. Provided for the diagnosis or care and treatment of a medical condition,

b. Necessary for and appropriate to the symptoms, diagnosis, or treatment of a medical condition,

c. Within generally accepted standards of medical care,

d. Not primarily for the convenience of the enrollee, the enrollee's family, or the provider, and

e. Performed in the most cost-effective setting and manner appropriate to treat the enrollee's medical condition.

(9) 'Out-of-Plan covered services' means nonemergency, self-referred, covered services obtained from nonparticipating providers; or services obtained from an affiliated specialist without Plan authorization.

(10) 'Participating provider' means a health care provider, a group of health care providers, or a medical facility, program, or agency that is employed by or under contract with a Plan to provide specified covered health care services to enrollees.

(11) 'PPO' means a preferred provider organization or arrangement that is offered by a licensed insurance company, HMO, or service corporation, in which: there is no transfer of insurance risk to health care providers through capitated payment arrangements, fee withholds, bonuses, or other risk-sharing arrangements; health care services are provided by participating providers who are paid on negotiated or discounted fee-for-service bases; and either or both of the following features are present:

a. Utilization review and quality assurance programs are used to manage the provision of covered services.

b. Enrollees are given incentives to limit the receipt of covered services to those furnished by participating providers.

(12) 'Quality assurance' means a program of reviews, studies, evaluations, and other activities employed by a Plan for the purpose of monitoring and enhancing quality of health care and services provided to enrollees.

(13) 'Service corporation' means a medical, hospital, or dental service corporation operating under Article 65 of this Chapter.

(14) 'URO' means an entity that performs utilization review.

(15) 'Utilization review' means those methodologies used to improve the quality and maximize the efficiency of the health care delivery system, including precertification, concurrent review, discharge planning, claims review activities, and claims audit activities.

"**§ 58-66-70. Provider contracting.**

(a) Each Plan shall execute a written contract with all providers listed by the Plan as participating providers; except those providers employed by or under contract with intermediary provider organizations contracting with the Plan. Each contract shall be completely executed and each provider shall be credentialed before the provider is listed as a participating provider in the Plan's provider directory, marketing materials, enrollee materials, or in response to a request for proposal or other inquiry from an employer or employer organization.

(b) All contracts shall, at a minimum, contain provisions:

(1) Requiring the provider to maintain the confidentiality of enrollees' medical information.

(2) Requiring the provider not to discriminate on the basis of race, color, national origin, gender, age, religion, marital status, or health status.

(3) Requiring the Plan to make available to the provider a grievance and appeal process.

(4) Requiring the Plan to make available to the provider a description of the Plan's terms, definitions, and methods of operation applicable to the provision of covered services to enrollees.

(5) Allowing the Plan to terminate the contract when the Plan reasonably determines that continuation of the contract may adversely affect enrollee care.

(6) Whereby the provider warrants that the provider is:

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

b. Covered by adequate levels of general and professional liability insurance or self-funded coverage; and

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

(7) Whereby the provider agrees to notify the Plan immediately of any changes in the status of the provider's license, certification, liability coverage, or hospital privilege status.

(8) Requiring the provider to participate in and fully cooperate with the Plan's utilization review, quality assurance, and credentialing programs.

(9) Requiring the provider to maintain adequate medical records; to make such records available to the Plan for the purpose of conducting its utilization review, quality assurance, and credentialing programs; and to make such records available to the Commissioner in conjunction with an examination of the affairs of the Plan or an investigation of enrollee grievances or complaints.

(10) Whereby the provider agrees that all professional decisions, judgments, treatments, diagnoses, and other professional services delivered to enrollees by the provider are the provider's sole responsibility.

(11) That the contract is not assignable by the provider without the written consent of the Plan.

(12) That the contract and any attached amendments and exhibits represent the complete agreement between the Plan and the contracting provider or between the contracting provider and any subcontracting intermediary.

(13) With respect to primary care physician contracts, requiring the primary care physician to provide or make available 24-hour-per-day, seven-day-per-week coverage consistent with the Plan's accessibility plan and marketing materials. 'Primary care physician' means a medical doctor licensed in the fields of general or family practice, general internal medicine, or pediatrics.

"**§ 58-66-75. Contracts with intermediary organizations.**

When a Plan contracts with an intermediary, such as an independent practice association, single service HMO, PPO, medical group that subcontracts with other

providers, or physician-hospital organization, the contract shall include the following provisions:

(1) A requirement that each contract between the intermediary and participating providers contain all applicable provisions required by G.S. 58-66-70.

(2) An acknowledgment that the contract does not relieve the Plan of its responsibility to its enrollees; and that when the Plan delegates responsibility for credentialing, utilization review, quality assurance, or claims payment to the intermediary, the Plan shall conduct an annual review of the intermediary's plans, policies, and procedures for each of the delegated matters.

(3) A requirement that the intermediary:

a. Provide to the Plan, upon its request, utilization review and claims payment documentation; and information about the timeliness and appropriateness of payment and services received by enrollees.

b. Give the Commissioner access to all health care subcontracts and all information and contracts relating to covered services.

c. Retain at its principal place of business, for four years, copies of all contracts with providers to furnish covered services.

(4) A warranty by the intermediary that the providers who will furnish covered services are, or before covered services are furnished will be, credentialed by the Plan's or intermediary's procedures in accordance with G.S. 58-66-95.

"**§ 58-66-80. Provider availability and accessibility.**

(a) Each Plan shall establish, document, and maintain adequate arrangements to provide covered services for its enrollees, without delays detrimental to the enrollees' health and consistent with the standards of a nationally recognized accrediting body satisfactory to the Commissioner, including:

(1) Reasonable proximity of providers and services to the business or residential addresses of the enrollees to avoid unreasonable barriers to accessibility.

(2) Reasonable hours of operation and after-hours services by providers.

(3) Emergency care services available and accessible within the service area 24 hours per day, seven days per week.

(4) Sufficient numbers of providers, administrators, and support staff to assure that all services contracted for will be accessible to enrollees on appropriate bases.

(b) Each plan shall provide a method by which in-plan, covered, medically necessary services or supplies that are not available from or through participating providers are provided to enrollees upon prior authorization or referral by the Plan.

(c) Each Plan shall make provision to pay the usual and customary charges for covered emergency services provided outside the Plan's approved service area.

(d) Each Plan shall provide readable, complete information to enrollees on covered services, limitations, and exclusions, including the procedures for obtaining out-of-plan covered services.

"**§ 58-66-85. Complaint and grievance procedures.**

Each Plan shall have a timely and organized system for resolving enrollees' formal, written complaints and grievances, including:

(1) Procedures for registering and responding to formal, written complaints and grievances in a timely fashion, not to exceed 30 days after the date on which all relevant information is received by the Plan.

(2) Documentation of the substance of complaints, grievances, and actions taken.

(3) Procedures to ensure resolutions of complaints or grievances.

(4) Aggregation and analysis of complaint and grievance data and use of the data for quality improvement.

(5) An appeal process for grievances that includes at least the following:

a. The enrollee has a right to review by a grievance panel.

b. The enrollee has a right to a second review with a different grievance panel.

c. At least one of the levels of review permits the enrollee to appear before the panel.

"**§ 58-66-90. Quality assurance.**

(a) Each Plan or entity to which a quality assurance function has been delegated shall establish procedures to assure that covered services are furnished under reasonable quality care standards consistent with prevailing, professionally recognized medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

(b) Each Plan or entity to which a quality assurance function has been delegated 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 least:

(1) A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of covered services.

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

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

b. The organizational structure responsible for quality assurance functions.

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

d. Confidentiality policies and procedures.

e. A system of ongoing evaluation.

f. A system of focused evaluation.

g. A system for credentialing providers and performing peer review.
h. Duties of the medical doctor responsible for quality assurance.

(3) A written statement describing the system of ongoing quality assurance, including:
a. Problem identification, assessment, and study.
b. Monitoring, evaluation, reassessment, and any necessary corrective action.
c. Interpretation and analysis of patterns of care furnished to enrollees by providers on individual bases.

(4) A written statement describing the system of focused quality assurance functions based on representative samples of the enrolled population, that identifies methods of topic selection, study, data collection, analysis, interpretation, and the format of reporting this information.

(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 that should have been provided have not been provided.

(c) Each Plan shall:

(1) Record proceedings of formal quality assurance activities and maintain documentation in a confidential manner.

(2) Require the use and maintenance of an adequate patient record system that will facilitate documentation and retrieval of clinical information so the Plan may evaluate continuity and coordination of patient care and assess the quality of covered services.

(3) Establish a mechanism for periodic reporting of quality assurance activities to the governing body, providers, and appropriate Plan staff.

(d) Enrollee clinical records and quality assurance proceeding records and documentation shall be available to the Commissioner for examination to ascertain compliance with this Article but are not public records.

"**§ 58-66-95. Credentialing.**

Each Plan or entity to which a credentialing function has been delegated shall:

(1) Credential, or cause to be credentialed, all medical doctors and, where appropriate, other providers before a contract becomes effective and before such providers are listed as participating providers in Plan marketing and enrollee materials.

(2) Adopt a credentialing system that specifies criteria for participation in the Plan and provides policies and procedures for reviewing provider applications.

(3) Require each applicant to complete a credentialing application. The application shall include specifics relating to call coverage, education and training history, professional affiliations, hospital affiliation, level of general and professional liability coverage, Drug Enforcement

Administration (DEA) registration number, medical references, professional and other legal liability history, and privileges desired.

(4) Verify the following information provided in the application about the applicant's:

a. License, certification, or registration for the practice of health care in North Carolina.

b. Specialty board certification status.

c. General and professional liability coverage.

d. Professional liability history.

e. Hospital privilege status.

(5) Employ or contract with an individual to whom responsibility for the Plan's credentialing program has been delegated. The Plan shall also employ or contract with a licensed medical doctor to be substantially involved in the Plan's credentialing program.

(6) Designate a credentialing committee or other peer review body to make recommendations about credentialing decisions.

(7) Maintain complete documentation of its credentialing activities including:

a. A signed and dated credentialing application.

b. All required verifications.

c. A signed and dated provider contract.

d. Responses to professional database queries, responses to inquiries from all licensing boards.

e. Any correspondence relating to credentialing.

f. Documentation of credentialing committee action.

g. Copies of applicants' notifications of acceptance or rejection.

(8) Recredential all participating providers every two years.

"**§ 58-66-100. Confidentiality of medical information; peer review committees.**

(a) Any data about the diagnosis, treatment, or health of any enrollee or applicant obtained by any Plan from that enrollee or applicant or from any provider are confidential and shall not be disclosed to any person except to the extent necessary to carry out the purposes of this section; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order; or if there is a claim or litigation between the enrollee or applicant and the Plan when the data is pertinent. A Plan may claim any statutory privileges against such disclosure to which any provider who furnished such information to the Plan is entitled.

(b) As used in this section 'peer review committee' or 'committee' means a group of licensed participating providers that is formed for the purpose of evaluating the quality of, cost of, or necessity for hospitalization or health care, including provider credentialing.

(c) A member of a duly appointed peer review committee who acts without malice or fraud is not subject to liability for damages in any civil action on account of any act,

statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(d) The proceedings of a committee, the records and materials it produces, and the materials it considers are confidential and not public records within the meaning of G.S. 132-1 or G.S. 58-2-100; and are not subject to discovery or introduction into evidence in any civil action against a provider or Plan that results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at the meeting of a committee is required to testify in any civil action about any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Information, documents, or records otherwise available are not immune from discovery or use in a civil action solely because they were presented during proceedings of a committee. A member of a committee may testify in a civil action but shall not be asked about the member's testimony before the committee or any opinions that the member formed as a result of the committee hearings. The proceedings of a committee, the records and materials it produces, and the materials it considers are available for examination by the commissioner.

"**§ 58-66-105. Utilization review.**

(a) Each Plan shall have a utilization review program description that describes delegated and nondelegated activities.

(b) The description shall include policies and procedures to evaluate medically necessary services or supplies, criteria used, information sources, and the process used to review and approve the provision of medical services; and a mechanism for updating the description on a periodic basis, as specified by the Plan.

"**§ 58-66-110. Utilization review organizations.**

(a) This section applies to all accident and health insurers, third-party administrators, PPOs, service corporations, HMOs, and all entities that perform utilization review.

(b) No person shall perform utilization review on insureds in this State without filing the following information with the Commissioner:

(1) All organizational documents of the URO, including any articles of incorporation, articles of association, partnership agreement, and any amendments;

(2) The bylaws, rules, regulations, policies, procedures, or similar documents regulating the URO's internal affairs;

(3) The names, addresses, official positions, and professional qualifications of all individuals responsible for the URO's operations, including the medical or clinical director; governing board or committee; principal officers and management; and all shareholders directly or indirectly holding more than ten percent (10%) of the URO's voting securities;

(4) A general description of the business operations, including staffing levels;

(5) A copy of any contract used by the URO;

(6) A copy of clinical criteria to be used for utilization review; provided that the criteria are not public records, except as required by law; and

(7) Such other information the Commissioner requires to determine compliance with this Article.

(c) In addition to examinations under G.S. 58-66-130, the Commissioner may examine a URO to determine that the organization:

(1) Is using nationally recognized medical and clinical criteria or medical and clinical criteria developed with the input of a panel of providers.

(2) Has reasonable staffing and availability of service capacity to be able to deliver the services in this State.

(d) No URO shall allow any breach of confidentiality of any medical records or personal information, including disclosure or publication of individual medical records or any other confidential medical information.

(e) No person shall give and no URO shall receive any reimbursement based on any amounts or expenditures saved or reduced or anticipated to be saved or reduced by utilization review; nor shall any URO represent or contract regarding specific amounts to be saved by or overall cost reductions to result from utilization review.

(f) If a URO issues a denial of certification and the provider or person for whom certification is sought appeals the decision, the URO shall disclose to the appellants all clinical criteria upon which the denial was made.

"**§ 58-66-115. UROs; appeals of noncertifications.**

(a) Each URO shall establish an appeals committee to reconsider any noncertification that is appealed by an enrollee or the enrollee's representative or provider. Except as provided in subsection (f) of this section, notification of the results of the appeal process shall be provided to the appellant no later than 30 days after the date the appeal is made, and shall be in writing if so requested.

(b) The appeals committee shall either:

(1) Have as a member at least one provider who is certified or licensed in the same health care category as the provider that furnishes or proposes to furnish services to the enrollee or who is skilled in that health care category; or

(2) Have access to and discuss the specific appeal with area providers who are licensed, certified, or registered for that health care category.

(c) Except as provided in subsection (f) of this section, a decision shall be communicated to the appellant with supporting medical reasons for the noncertification decision no later than five business days after the decision on the appeal. The decision shall be in writing if so requested.

(d) The URO shall allow the appellant to present additional evidence for consideration by the appeals committee. Before rendering a final decision, the committee shall review the pertinent medical records of the enrollee's provider and the pertinent records of any facility in which health care is provided to the enrollee.

(e) In the appeals process, due consideration shall be given to the availability or nonavailability of optional health care services proposed by the URO and any hardship imposed by the optional health care on the enrollee and the enrollee's immediate family.

(f) When an appellant requests an expedited appeal, the URO must make such appeal proceeding available within 72 hours after the request and make decisions no later than one business day after receipt by the URO of all necessary information. An expedited appeal may be requested only when the regular appeals process will cause a delay in the rendering of health care that would be detrimental to the health of the enrollee.

(g) The appeals process described in this section does not apply to any noncertification rendered solely on the basis that a Plan does not provide benefits for the health care performed or being requested.

"**§ 58-66-120. PPOs; general provisions.**

(a) Licensed insurers, HMOs, or service corporations may enter into cost containment arrangements under this Article to reduce the cost of providing health care services.

(b) An individual enrolled in a PPO may obtain covered services from nonparticipating providers. The PPO may, however, limit benefits for covered services obtained from a nonparticipating provider subject to the following:

(1) No covered individual is required to pay more than a thirty percent (30%) differential between the participating provider benefit and the nonparticipating provider benefit.

(2) The nonparticipating provider deductible shall not exceed five times the amount of the participating provider deductible.

(3) The annual nonparticipating provider deductible for any individual shall not exceed two thousand dollars ($2,000) and the total nonparticipating provider deductible for any family shall not exceed three times the amount of the nonparticipating provider deductible for individuals.

(4) If the PPO has a maximum lifetime benefit for services received from participating providers, the corresponding lifetime maximum benefit for services provided by nonparticipating providers shall not be less than one-half of the participating provider maximum lifetime benefit.

(5) If a PPO includes copayments for in-plan and out-of-plan covered services, the copayment for an out-of-plan covered service shall not exceed the copayment for an in-plan covered service by more than fifty dollars ($50.00) or one hundred percent (100%), whichever is greater.

(6) A PPO shall cover all benefits mandated by State or federal laws or regulations under the in-plan part of the PPO.

(7) Any out-of-plan covered service must be covered on an in-plan covered basis.

(8) A PPO may exclude out-of-plan coverage for preventive health care.

(9) PPOs shall allow insureds to choose participating or nonparticipating providers every time health care is authorized, obtained, or rendered.

(c) PPOs may require enrollees to access utilization review. All payments to nonparticipating providers are subject to the PPO's approved reimbursement mechanisms, including direct payment of benefits to the enrollee without right of assignment to the provider.

(d) Upon the initial offering of a PPO to the public, providers have at least 30 days to submit proposals for participation in accordance with the terms of the PPO. After the initial offering of a PPO, any provider seeking to submit a proposal may be permitted to do so. Every PPO shall consider all pending applications for participation and give reasons for any rejections on at least an annual basis. Any provider seeking to participate in the PPO, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the PPO. The second and third paragraphs of G.S. 58-50-30(a) apply to PPOs.

(e) No PPO shall restrict a provider's right to enter into PPO contracts with other parties. Any such restriction in a contract between a PPO and a provider is void, but its existence does not invalidate any other provision of the contract.

(f) A list of the current participating providers in the geographic area in which a substantial portion of covered services are available shall be provided to enrollees and contracting parties.

(g) PPO publications or advertisements shall not refer to the quality or efficiency of nonparticipating providers.

"**§ 58-66-125. PPOs; filing requirements.**

(a) No PPO shall operate in this State without filing the following information with the Commissioner:

(1) All organizational documents of the PPO.

(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 all individuals responsible for the PPO's operation, including any governing board or committee, and the principal officers and management.

(4) A general description of the business operations, including staffing levels and activities proposed in this State.

(5) A copy of any contract form between the PPO and any provider or subcontracting provider.

(6) A copy of any contract form between the PPO and any person providing management services.

(7) A copy of the PPO's internal grievance policies and procedures.

(8) A description of the PPO's quality assurance, utilization review, and credentialing programs.

(10) Such other information that the Commissioner requires to determine compliance with this Article.

(b) A PPO shall file a notice describing in detail any significant modification of the information required in this section. Such notice shall be filed with the

Commissioner before the modification. 'Significant modifications' include material changes in the provider network or in the credentialing process and any changes in any contracts with providers.

(c) Every PPO shall file all subsequent changes in the information that must be filed with the Commissioner under this section.

"**§ 58-66-130. PPOs; practices and powers.**

(a) No PPO shall cause or knowingly permit the use of untrue or misleading advertising or solicitations. 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 may be significant to a person considering contracting with the PPO;

(2) No PPO may use in its name, contracts, or literature any of the terms 'health maintenance organization', 'HMO', 'capitation', 'withholds', or other words descriptive of an HMO or deceptively similar to the name or business of an HMO; nor may it hold itself out as being an insurer or a service corporation.

(b) PPOs may contract with:

(1) Providers on fee-for-service or discounted fee-for-service bases to furnish covered services.

(2) Any licensed insurer or service corporation to provide insurance, indemnity, or reimbursement against the cost of covered services.

(3) Any person to perform on the PPO's behalf functions such as marketing, management information, quality assurance, utilization review, or other similar services.

(c) If a PPO subcontracts any element of its business, it is responsible for regular monitoring and legal compliance of the delegated responsibilities.

"**§ 58-66-135. Examinations; cease and desist orders.**

(a) To ensure compliance with this Article, the Commissioner may make such examinations or investigations of any Plan that he considers necessary. The provisions of G.S. 58-2-131, 58-2-132, and 58-2-133 apply to examinations under this Article.

(b) The Commissioner may issue a cease and desist order upon any Plan if the Commissioner finds the Plan:

(1) Is being operated by an insolvent insurer, HMO, or service corporation;

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

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

(4) Has refused to produce materials or files for examinations or investigations under this section.

(c) The provisions of G.S. 58-2-60, 58-2-180, 58-2-185, 58-2-190, and Article 63 of this Chapter apply to Plans operating in this State."

Sec. 10. G.S. 58-50-50, 58-50-55, 58-50-60 and 58-65-140 are repealed.

Sec. 11. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Sec. 12. This act becomes effective January 1, 1996.