



TEMPORARY RULE-MAKING

FINDINGS OF NEED

[Authority G.S. 150B-21.1]

OAH USE ONLY

VOLUME:

ISSUE:

1. Rule-Making Agency: Department of Insurance

2. Rule citation & name: 11 NCAC 20 .0101 SCOPE AND DEFINITIONS

3. Action: Adoption Amendment Repeal

4. Was this an Emergency Rule: Yes No Effective date:

5. Provide dates for the following actions as applicable:

- a. Proposed Temporary Rule submitted to OAH: August 6, 2018
- b. Proposed Temporary Rule published on the OAH website: August 9, 2018
- c. Public Hearing date: August 14, 2018
- d. Comment Period: August 9 – August 30, 2018
- e. Notice pursuant to G.S. 150B-21.1(a3)(2): August 6, 2018
- f. Adoption by agency on: 9/19/2018
- g. Proposed effective date of temporary rule [if other than effective date established by G.S. 150B- 21.1(b) and G.S. 150B-21.3]: September 28, 2018
- h. Rule approved by RRC as a permanent rule [See G.S. 150B-21.3(b2)]: n/a

6. Reason for Temporary Action. Attach a copy of any cited law, regulation, or document necessary for the review.

- A serious and unforeseen threat to the public health, safety or welfare.
- The effective date of a recent act of the General Assembly or of the U.S. Congress.
Cite: SL 2018-120, Part 4, Section 4.6(d)
Effective date: June 28, 2018
- A recent change in federal or state budgetary policy.
Effective date of change:
- A recent federal regulation.
Cite:
Effective date:
- A recent court order.
Cite order:
- State Medical Facilities Plan.
- Other:

Explain: This rule is being submitted to reflect changes enacted in SL 2018-120, Part 4, Section 4.6(a). S.L. 2018-120 amends G.S. 58-50-56(a)(2) to allow preferred providers to receive reimbursement on an other than fee-for-services basis. As a result, it is necessary to amend 11 NCAC 20 .0101 to reflect this change.

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7. Why is adherence to notice and hearing requirements contrary to the public interest and the immediate adoption of the rule is required? **G.S. 150B-21.1(a)2** – In SL 2018-120, Part 4, Section 4.6(d) (became effective on June 28, 2018) amends the definition of a preferred provider, which needs to be reflected in NCDOT rules. In SL 2018-120, the Legislature expressly authorized adopting this rule using temporary rulemaking.

8. Rule establishes or increases a fee? (See G.S. 12-3.1)

Yes

Agency submitted request for consultation on:
Consultation not required. Cite authority:

No

9. Rule-making Coordinator: Loretta Peace-Bunch

Phone: 919-807-6004

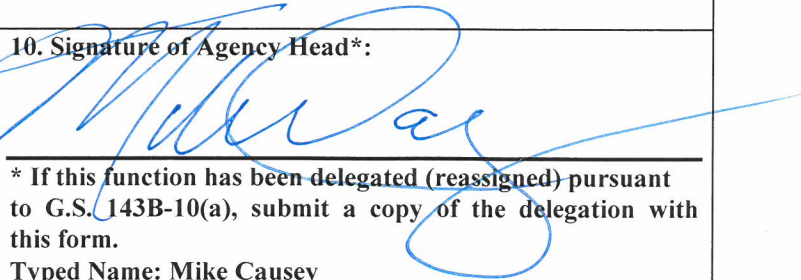
E-Mail: Loretta.Peace-Bunch@ncdoi.gov

Agency contact, if any: John Hoomani

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10. Signature of Agency Head*:



* If this function has been delegated (reassigned) pursuant to G.S. 143B-10(a), submit a copy of the delegation with this form.

Typed Name: Mike Causey

Title: Commissioner of Insurance

E-Mail: mike.causey@ncdoi.gov

RULES REVIEW COMMISSION USE ONLY

Action taken:

Submitted for RRC Review:

Date returned to agency:

1 11 NCAC 20 .0101 is amended under temporary procedures as follows:

2

3 **11 NCAC 20 .0101 SCOPE AND DEFINITIONS**

4 (a) Scope.

5 (1) Sections .0200, .0300, and .0400 of this Chapter shall apply to HMOs, licensed insurers offering
6 PPO benefit plans, and any other entity that falls under the definition of "network plan carrier" is a
7 network plan carrier as defined in this Rule.

8 (2) Sections .0500 and .0600 of this Chapter shall apply only to HMOs.

9 (3) Nothing in this Chapter applies shall apply to service corporations offering benefit plans under
10 pursuant to G.S. 58-65-25 or G.S. 58-65-30 that do not have any differences in copayments,
11 coinsurance, or deductibles based on the use of network versus non-network providers.

12 (b) Definitions. As used in this Chapter:

13 (1) "Carrier" means a network plan carrier.

14 (2) "Health care provider" means any person who is licensed, registered, or certified under pursuant to
15 Chapter 90 of the General Statutes; or a health care facility as defined in G.S. 131E-176(9b); or a
16 pharmacy.

17 (3) "Health maintenance organization" or "HMO" has the same meaning as in G.S. 58-67-5(f).

18 (4) "Intermediary" or "intermediary organization" means any entity that employs or contracts with
19 health care providers for the provision of health care services, services and that also contracts with
20 a network plan carrier or its intermediary.

21 (5) "Member" means an individual who is covered insured by a network plan carrier.

22 (6) "Network plan carrier" means an insurer, health maintenance organization, or any other entity acting
23 as an insurer, insurer as defined in G.S. 58-1-5(3); G.S. 58-1-5(3) that provides reimbursement or
24 provides or arranges to provide health care services; services and uses increased copayments,
25 deductibles, or other benefit reductions for services rendered by non-network providers to encourage
26 members to use network providers.

27 (7) "Network provider" means any health care provider participating in a network utilized by a network
28 plan carrier.

29 (8) "PPO benefit plan" means a benefit plan that is offered by a hospital or medical service corporation
30 or network plan carrier, under pursuant to G.S. 58-50-56, in which plan:

31 (A) either or both of the following features are present:

32 (i) utilization review or quality management programs are used to manage the
33 provision of covered services; or

34 (ii) enrollees are given incentives via benefit differentials to limit the receipt of
35 covered services to those furnished by participating providers; and

36 (B) health care services are provided by participating providers who are paid on negotiated or
37 discounted fee-for-service bases; and bases or have agreed to accept special reimbursement

1 or other terms for health care services under a contract with the hospital or medical service
2 corporation or network plan carrier.

3 ~~(C) — there is no transfer of insurance risk to health care providers through capitated payment~~
4 ~~arrangements, fee withholds, bonuses, or other risk sharing arrangements.~~

5 (9) "Preferred provider" has the same meaning as in G.S 58-50-56 and 58-65-1.

6 (10) "Provider" means a health care provider.

7 (11) "Quality management" means a program of reviews, studies, evaluations, and other activities used
8 to monitor and enhance the quality of health care and services provided to members.

9 (12) "Service area" means the geographic area in North Carolina as described by the HMO pursuant to
10 G.S. 58-67-10(c)(11) in which an HMO enrolls persons who either work in the service area, reside
11 in the service area, or work and reside in the service and area, as approved by the Commissioner
12 pursuant to G.S. 58-67-20.

13 (13) "Service corporation" means a medical or hospital service corporation operating under pursuant to
14 Article 65 of Chapter 58 of the General Statutes.

15 (14) "Single service HMO" means an HMO that undertakes to provide or arrange for the delivery of a
16 single type or single group of health care services to a defined population on a prepaid or capitated
17 basis, except for a member's responsibility for non-covered services, coinsurance, copayments, or
18 deductibles.

19 (15) "Utilization review" means those methodologies used to improve the quality and maximize the
20 efficiency of the health care delivery system through review of particular instances of care,
21 including, whenever performed, precertification, concurrent review, discharge planning, and
22 retrospective review.

23
24 *History Note: Authority G.S. 58-2-40(1); ~~58-50-50; 58-50-55; 58-65-1; 58-65-140; 58-67-150~~; Eff. October 1,*
25 *1996; Amended Eff. July 1, 2006; Pursuant to G.S. 150B-21.3A, rule is necessary without*
26 *substantive public interest Eff. December 16, 2014;*
27 *Temporary Amendment Eff. September 24, 2018.*