



**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: 9/6/2018
- 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 24, 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:

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 – 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 NCDOI rules.

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

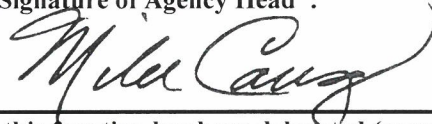
E-Mail: Loretta.Peace-Bunch@ncdoi.gov

Agency contact, if any: John Hoomani

Phone: 919-807-6093

E-Mail: John.Hoomani@ncdoi.gov

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:

Title:

E-Mail:

RULES REVIEW COMMISSION USE ONLY

Action taken:

Submitted for RRC Review:

Date returned to agency:

AMEND PREFERRED PROVIDER DEFINITION

SECTION 4.6.(a) G.S. 58-50-56(a)(2) reads as rewritten:

"(2) "Preferred provider" means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services on a fee-for-service basis. ~~services.~~ A "preferred provider" is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives."

SECTION 4.6.(b) G.S. 58-50-56(e) is repealed.

SECTION 4.6.(c) G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

The term "hospital service plan" as used in this Article includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations or any other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association or the American Medical Association.

The term "medical service plan" as used in this Article includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical or any other professional services authorized or permitted to be furnished by a duly licensed physician or other provider listed in G.S. 58-50-30. The term "medical services plan" also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes.

The term "dental service plan" as used in this Article includes contracting for the payment of fees toward, or furnishing of dental or any other professional services authorized or permitted to be furnished by a duly licensed dentist.

The term "hospital service corporation" as used in this Article is intended to mean any nonprofit corporation operating a hospital or medical or dental service plan, as defined in this section. Any corporation organized and subject to the provisions of this Article, the certificate of incorporation of which authorizes the operation of either a hospital or medical or dental service plan, or any or all of them, may, with the approval of the Commissioner, issue subscribers' contracts or certificates approved by the Commissioner of Insurance, for the payment of either hospital or medical or dental fees, or the furnishing of such services, or any or all of them, and may enter into contracts with hospitals for physicians or dentists, or any or all of them, for the furnishing of fees or services respectively under a hospital or medical or dental service plan, or any or all of them.

The term "preferred provider" as used in this Article with respect to contracts, organizations, policies or otherwise means a health care service provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article or other applicable law, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article. ~~Except to the extent prohibited either by G.S. 58-65-140 or by rules adopted by the Commissioner not inconsistent with this Article, the contractual terms and conditions for special reimbursement shall be those which the corporation and preferred provider find to be mutually agreeable.~~

The term "full service corporation" as used in this Article means any corporation organized under the provisions of this Article that offers a medical service plan or a hospital service plan.

The term "single service corporation" as used in this Article means any corporation organized under the provisions of this Article that offers only a dental service plan."

SECTION 4.6.(d) The Department may adopt temporary rules to implement the provisions of subsection (a) of this section.

AMEND CONTINUING EDUCATION FOR BAIL BONDSMEN AND RUNNERS

SECTION 4.7. G.S. 58-71-71(b) reads as rewritten:

"(b) Each year by June 30 every licensee shall complete at least three hours of continuing education as provided by an approved provider in subjects related to the duties and responsibilities of a runner or bail ~~bondsman before renewal of the license.~~ bondsman. This continuing education shall not include a written or oral examination. A person who receives his or her first license on or after January 1 of any year does not have to comply with this subsection until ~~the period between his first and second license renewals.~~ June 30 of the following year."

NORTH CAROLINA MANUFACTURED HOUSING BOARD TECHNICAL CHANGE

SECTION 4.8. G.S. 143-143.10(a) reads as rewritten:

"(a) There is created the North Carolina Manufactured Housing Board within the Department. The Board shall be composed of 11 members as follows:

- (1) The Commissioner of Insurance or the Commissioner's designee.
- (2) A manufactured home manufacturer.
- (3) A manufactured home dealer.
- (4) A representative of the banking and finance industry.
- (5) A representative of the insurance industry.
- (6) A manufactured home supplier.
- (7) A set-up contractor.
- (8) Two representatives of the general public.
- (9) A person who is employed with a HUD-approved housing counseling agency in the State.
- (10) An accountant.

The Commissioner or the Commissioner's designee shall chair the Board. The Governor shall appoint to the Board the manufactured home manufacturer and the manufactured home dealer. The General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121 shall appoint to the Board the representative of the banking and finance industry, the employee of a HUD-approved housing counseling agency, and the representative of the insurance industry. The General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121 shall appoint to the Board the manufactured home supplier, the accountant, and the set-up contractor. The Commissioner shall appoint two representatives of the general public. Except for the representatives from the general public and the persons appointed by the General Assembly, each member of the Board shall be appointed by the appropriate appointing authority from a list of nominees submitted to the appropriate appointing authority by the Board of Directors of the North Carolina ~~Manufactured Housing Institute.~~ Manufactured and Modular Homebuilders Association. At least three nominations shall be submitted for each position on the Board. The members of the Board shall be residents of the State.

The members of the Board shall serve for terms of three years. In the event of any vacancy of a position appointed by the Governor or Commissioner, the appropriate appointing authority shall appoint a replacement in the same manner as provided for the original appointment to serve the remainder of the unexpired term. Vacancies in appointments made by the General Assembly shall be filled in accordance with G.S. 120-122. In the event of any vacancy, the appropriate

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0101

DEADLINE FOR RECEIPT: Friday, September 14, 2018

PLEASE NOTE: This request may extend to several pages. Please be sure you have reached the end of the document.

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends that the following technical changes be made:

Line 5 – add “shall” before “apply”

Line 6 – replace “that falls under the definition of “network plan carrier”.” with “is a network plan carrier as defined in this Rule.”

Line 7 – add “shall” before “apply”

Line 8 – replace “applies” with “shall apply”

Line 8 – replace “under” with “pursuant to”

Line 13 – replace “under” with “pursuant to”

Line 14 – delete “or” before “a health care facility”

Line 17 – delete the comma

Line 19 – replace “covered” with “insured” if that is what is meant.

Line 21 – delete the commas

Line 22 – delete the semicolon

Line 27 – replace “under” with “pursuant to”

Line 30 – add “or” after the semicolon

Line 32 – add “and” after the semicolon if that is what is meant.

Jason Thomas
Commission Counsel
Date submitted to agency: Friday, September 7, 2018

Lines 33-36 – consider revising in one of the follow ways, if one of them fully captures what is meant:

(B) health care services are provided by a preferred provider.

or

(B) health care services are provided by participating providers who are paid on negotiated or discounted fee-for-service bases or by a preferred provider.

Page 2, line 6 – add “the” before “quality”

Page 2, line 9 – replace “and” with “area” if that is what is meant

Page 2, line 9 – add a comma after “area” if “area” replaces “and” as recommended above.

Page 2, line 11 – replace “under” with “pursuant to”

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Jason Thomas
Commission Counsel
Date submitted to agency: Friday, September 7, 2018

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 apply to HMOs, licensed insurers offering PPO
6 benefit plans, and any other entity that falls under the definition of "network plan carrier".
7 (2) Sections .0500 and .0600 of this Chapter apply only to HMOs.
8 (3) Nothing in this Chapter applies to service corporations offering benefit plans under G.S. 58-65-25
9 or G.S. 58-65-30 that do not have any differences in copayments, coinsurance, or deductibles based
10 on the use of network versus non-network providers.

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

- 12 (1) "Carrier" means a network plan carrier.
13 (2) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90
14 of the General Statutes; or a health care facility as defined in G.S. 131E-176(9b); or a pharmacy.
15 (3) "Health maintenance organization" or "HMO" has the same meaning as in G.S. 58-67-5(f).
16 (4) "Intermediary" or "intermediary organization" means any entity that employs or contracts with
17 health care providers for the provision of health care services, and that also contracts with a network
18 plan carrier or its intermediary.
19 (5) "Member" means an individual who is covered by a network plan carrier.
20 (6) "Network plan carrier" means an insurer, health maintenance organization, or any other entity acting
21 as an insurer, as defined in G.S. 58-1-5(3), that provides reimbursement or provides or arranges to
22 provide health care services; and uses increased copayments, deductibles, or other benefit reductions
23 for services rendered by non-network providers to encourage members to use network providers.
24 (7) "Network provider" means any health care provider participating in a network utilized by a network
25 plan carrier.
26 (8) "PPO benefit plan" means a benefit plan that is offered by a hospital or medical service corporation
27 or network plan carrier, under G.S. 58-50-56, in which plan:
28 (A) either or both of the following features are present:
29 (i) utilization review or quality management programs are used to manage the
30 provision of covered services;
31 (ii) enrollees are given incentives via benefit differentials to limit the receipt of
32 covered services to those furnished by participating providers;
33 (B) health care services are provided by participating providers who are paid on negotiated or
34 discounted fee-for-service bases; ~~and bases~~ or have agreed to accept special reimbursement
35 or other terms for health care services under a contract with the hospital or medical service
36 corporation or network plan carrier.

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

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

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

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

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

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

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

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

21
22 *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,*
23 *1996; Amended Eff. July 1, 2006; Pursuant to G.S. 150B-21.3A, rule is necessary without*
24 *substantive public interest Eff. December 16, 2014;*
25 *Temporary Amendment Eff. September 24, 2018.*