RRC STAFF OPINION

PERIODIC REVIEW AND EXPIRATION OF EXISTING RULES REPORT

PLEASE NOTE: THIS COMMUNICATION IS EITHER 1) ONLY THE RECOMMENDATION OF AN RRC STAFF ATTORNEY AS TO ACTION THAT THE ATTORNEY BELIEVES THE COMMISSION SHOULD TAKE ON THE CITED REPORT AT ITS NEXT MEETING, OR 2) AN OPINION OF THAT ATTORNEY AS TO SOME MATTER CONCERNING THAT REPORT. THE AGENCY AND MEMBERS OF THE PUBLIC ARE INVITED TO SUBMIT THEIR OWN COMMENTS AND RECOMMENDATIONS (ACCORDING TO RRC RULES) TO THE COMMISSION.

AGENCY: Commissioner of Insurance

REPORT: 11 NCAC 20

RECOMMENDED ACTION:

X Note staff's comment, and approve the report as submitted by the agency.

COMMENT:

In its submission, the Commissioner sent a report and two documents containing comments and the agency response. In order to assist the Commission in its review, staff has compiled the rules, comments, the agency response, and staff's recommendations into this document.

Staff relied upon G.S. 150B-21.3A in making the recommendations set forth below. The relevant portions used in the review are highlighted on the next page of this document, and the entire statute is at the end of the document.

Staff's interpretation of the law is that a public comment must be an objection to the Rule or the classification. Assuming the comment rises to that level, the Commission must then determine whether the public comment has merit. In order to determine whether the comment has merit, G.S. 15B-21.3A(c)(2) states that the comment has merit if it addresses the specific substance of the rule and relates to any of the Commission's standards of review pursuant to G.S. 150B-21.9. Those standards are that the rule is reasonably necessary to implement a law, clear and unambiguous, within the agency's statutory authority and that the agency followed the Administrative Procedure Act.

Amanda J. Reeder
Commission Counsel

11 NCAC 20 .0101 SCOPE AND DEFINITIONS

(a) Scope.

(1) Sections .0200, .0300, and .0400 of this Chapter apply to HMOs, licensed insurers offering PPO benefit plans, and any other entity that falls under the definition of "network plan carrier".

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

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

(b) Definitions. As used in this Chapter:

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

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

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

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

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

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

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

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

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

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

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

(B) health care services are provided by participating providers who are paid on negotiated or discounted fee-for-service bases; and

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

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

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

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

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

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

(14) "Single service HMO" means an HMO 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 a member's responsibility for non-covered services, coinsurance, copayments, or deductibles.

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

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, 1996;
Amended Eff. July 1, 2006.

Amanda J. Reeder
Commission Counsel

Public Comment:

General Comments: NCMS has identified discrepancies with at least two of the defined terms in 11 N.C.A.C. 20 .0101 ("Rule .0101"). Given that these terms are used throughout the Department's managed care rules, NCMS would like to offer the following comments.

The rule defines "preferred provider" as having "the same meaning as in G.S. 58-50-56 and 58-65-1." While the referenced statutes both define the term, they do so differently. This leaves a question as to which definition should apply when the term appears throughout the remainder of the Department's managed care rules.

The rule's definition of "PPO benefit plan" is also problematic because it conflicts with the definition of a nearly-identical term in statute. According to the rule, "under G.S. 58-50-56" a PPO benefit plan is one in which, *inter alia*, "health care services are provided by participating providers *who are paid on negotiated or discounted fee-for-service bases*[.]" In other words, the rule limits PPO benefit plans to only include participating providers paid fee-for-service. Not only is this an inaccurate reflection of PPO plans currently offered throughout the state, but this qualification or condition inappropriately narrows the broader statutory definition of "preferred provider benefit plan," which includes "health care providers *who are under contract with the insurer in accordance with this section*[.]" Other provisions within the same statute specifically *permit* (participating/preferred) health care providers and insurers to agree to payment terms other than fee-for-service without barring those providers from participating in a PPO plan. The statutory definition is more inclusive than the rule definition, and should be more accurately reflected in Rule .0101.

Finally, we note that the Department's report identifies a total of eight (8) managed care rules as "necessary with substantive public interest." Many of those rules, in turn, employ the specifically- defined terms set forth in Rule .0101. This should weigh in favor of also revisiting this rule to address the issues highlighted above and others that arise.

Chapter 150B Analysis: The definition of the term "preferred provider" is ambiguous because it seeks to incorporate two separate statutory provisions. Furthermore, the rule's definition of "PPO benefit plan" contradicts § 58-50-56, indicating that the Department lacks the authority for the rule.

Conclusion: NCMS objects to 11 N.C.A.C. 20 .0101 and requests that the Department change its designation to "necessary *with* substantial public interest."

Agency Response:

We do not find the comment to have merit. The definition in the rule mirrors the definition in the statutes. It is important to note that Article 65 of our statutes applies only to Medical Service Corporations. The PPO benefit plan is only for fee for service arrangements. The statutes have to be read together as a whole.

Staff Recommendation:

The public comment addresses two terms:

1) "Preferred provider," as defined in Subparagraph (b)(9). While staff understands the concerns of the regulated public regarding the difference in the term as it defined in two statutes, staff does not agree that the term is ambiguous as used in the Rule. Staff further notes the term "preferred provider" is used only once in the Chapter, and that is in Rule .0101(b)(9), where it is defined. Staff does not believe this comment has merit.

2) "PPO Benefit Plan," as defined in Subparagraph (b)(8). The comment states that the term places limitations on the plans above the statutory requirements by stating the plan must include payment on negotiated or discounted fee-for-service arrangements. Staff notes that G.S. 58-50-56(a)(3) defines "preferred provider benefit plan" to include "health care providers who are under a contract with the insurer[.]" Subsection (b) of the law states, "Insurers may enter into preferred provider contracts or enter

into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services." This may include contracts that require negotiated or discounted fee-for-services. Staff does not believe this is beyond the statutory authority of the agency and does not believe this comment has merit.

Part 2. PPOs, Utilization Review and Grievances.

§ 58-50-50: Repealed by Session Laws, 1997-519, s. 3.17.

§ 58-50-55: Repealed by Session Laws 1997-519, s. 3.17.

§ 58-50-56. Insurers, preferred provider organizations, and preferred provider benefit plans.

(a) Definitions. - As used in this section:

(1) "Insurer" means an insurer or service corporation subject to this Chapter.

(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. 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.

(3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who are under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers.

(4) "Preferred provider organization" or "PPO" means an insurer holding contracts with preferred providers to be used by or offered to insurers offering preferred provider benefit plans.

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice. A preferred provider contract or other cost containment arrangement that is not disapproved by the Commissioner within 90 days of its filing by the insurer shall be deemed to be approved.

(c) At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. G.S. 58-50-30 applies to preferred provider benefit plans.

(d) Any provision of a contract between an insurer offering a preferred provider benefit plan and a health care provider that restricts the provider's right to enter into preferred provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(e) Except where specifically prohibited either by this section or by rules adopted by the Commissioner, the contractual terms and conditions for special reimbursements shall be those that the parties find mutually agreeable.

(f) Every insurer offering a preferred provider benefit plan and contracting with a PPO shall require by contract that the PPO shall provide all of the preferred providers with whom it holds contracts information about the insurer and the insurer's preferred provider benefit plans. This information shall include for each insurer and preferred provider benefit plan the benefit designs and incentives that are used to encourage insureds to use preferred providers.

(g) The Commissioner may adopt rules applicable to insurers offering preferred provider benefit plans under this section. These rules shall provide for:

(1) Accessibility of preferred provider services to individuals within the insured group.

(2) The adequacy of the number and locations of health care providers.

(3) The availability of services at reasonable times.

(4) Financial solvency.

(h) Each insurer offering a preferred provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall disclose annually the following information:

(1) The name by which the preferred provider benefit plan is known and its business address.

(2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.

(3) The terms of the agreements entered into by the insurer with preferred providers.

(4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(i) A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan. In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products.

(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician.

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers. (1997-443, s. 11A.122; 1997-519, s. 3.1; 1998-211, s. 2; 1999-210, s. 3; 2001-297, s. 3; 2001-334, s. 2.1.)