

G.S. 150B-21.3A Report for 11 NCAC 21, THIRD PARTY ADMINISTRATORS								
Agency - INSURANCE/ THIRD PARTY ADMINISTRATORS								
Comment Period - 5/16/14 - 7/16/14								
Date Submitted to APO - Filled in by RRC staff								
Rule Section	Rule Citation	Rule Name	Date and Last Agency Action on the Rule	Agency Determination [150B-21.3A(c)(1)a]	Implements or Conforms to Federal Regulation [150B-21.3A(d1)]	Federal Regulation Citation	Public Comment Received [150B-21.3A(c)(1)]	Agency Determination Following Public Comment [150B-21.3A(c)(1)]
SECTION .0100 - GENERAL PROVISIONS	11 NCAC 21 .0101	DEFINITIONS: LICENSE APPLICATIONS	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0102	FINANCIAL STATEMENTS	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0103	DETERMINATION OF FINANCIAL RESPONSIBILITY	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0104	SERVICE CONTRACTS	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0105	CLAIM ADJUSTING BY TPAS	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0106	PAYMENT OF CLAIMS	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	Yes	Necessary with substantive public interest
	11 NCAC 21 .0107	GENERAL ADMINISTRATION	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0108	CLAIMS ADMINISTRATION	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0109	MARKETING AND SALES	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest
	11 NCAC 21 .0110	SERVICES TO INSURED	Eff. June 1, 1996	Necessary without substantive public interest	No	N/A	No	Necessary without substantive public interest

July 16, 2014

Ms. Karen Waddell
NC Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Sent via e-mail to ncdoirulescomments@ncdoi.gov

Ms. Waddell:

The North Carolina Medical Society wishes to submit the following comments on the initial rule determinations made by the North Carolina Department of Insurance (“NCDOI” or “Department”) pursuant to N.C.G.S. § 150B-21.3A. Each rule below was originally designated by the Department as “necessary without substantive public interest.”

Chapter 18 – Multiple Employer Welfare Arrangements

11 N.C.A.C. 18 .0103 – Filing Requirements

General Comments: This rule establishes the Department’s procedure for handling licensing applications from Multiple Employer Welfare Arrangements (MEWAs). It also identifies documentation that must be submitted in addition to the materials specifically required by the MEWA license/application statute.¹ NCMS wishes to briefly discuss how 11 N.C.A.C. 18 .0103 (“Rule .0103”) and the licensure process impacts members of the regulated community.

The annual licensure process is laborious and highly repetitive for MEWAs. When taking the filing requirements of § 58-49-50 in combination with the additional items required by Rule .0103(a), the administrative requirements are extraordinary.

Moreover, some of the additional information required is of questionable value to the Department and incredibly difficult for MEWAs to supply. For example, paragraph (a)(4) requires submission of “[a] complete list of names, addresses and telephone numbers of participating employers and the number of employees covered by the MEWA[.]” Paragraph (f) further requires a MEWA to report “[a]ny change in the information required...within two business days after such change.” In tandem, these provisions place substantial burdens on MEWA operations. Must a MEWA submit a refreshed list to the Department every time it signs another employer group to the plan, or every time a covered employer hires or dismisses an employee? As written, the rule requires this. Such a requirement is especially challenging for a newly-forming MEWA since it must consistently pursue and build membership. When established MEWAs submit this information, the list grows stale and inaccurate within days due to the highly fluid nature of member eligibility. The result is an administrative requirement impossible to satisfy.

¹ N.C.G.S. § 58-49-50.

Chapter 150B Analysis: Rule .0103's supplemental requirements are vague. Moreover, the Rule's additional, burdensome disclosure requirements go beyond what is reasonably necessary to implement the MEWA licensing statute.

Conclusion: A properly functioning MEWA licensure process is imperative for the Department, the operation of each plan, those insured by the plan, and for the broader public. In its current form Rule .0103 has not assisted in achieving that result. This is a suitable opportunity, however, to revisit Rule .0103 in an attempt to make it workable, and NCMS hopes to assist the Department in that process.

For all of these reasons, **NCMS objects to Rule .0103 and requests that it be re-designated as "necessary with substantial public interest."**

Chapter 20 – Managed Care Health Benefit Plans

11 N.C.A.C. 20 .0101 – Scope and Definitions

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."² 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"³ 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*["]⁴ 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*["]⁵ Other provisions within the same statute specifically *permit* (participating/preferred) health care providers and insurers to agree to payment terms other than fee-for-service⁶ 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.

² Rule .0101(b)(9).

³ Rule .0101(b)(8).

⁴ *Id.* (Emphasis added.)

⁵ N.C.G.S. § 58-50-56(a)(3) (emphasis added).

⁶ See, e.g., § 58-50-56(a)(2) (defining "preferred provider" as "a health care provider who has agreed to accept special reimbursement or other terms..."), and (e) (stating that "[e]xcept where specifically prohibited...the contractual terms and conditions for special reimbursements shall be those the parties find mutually agreeable.")

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."**

Chapter 21 – Third Party Administrators

11 N.C.A.C. 21 .0106 – Payment of Claims

General Comments: 11 N.C.A.C. 21 .0106 ("Rule .0106") specifies that if a third party administrator ("TPA") or insurer does not pay a claim within 30 days, the TPA or insurer must mail a claim status report to the claimant. Rule .0106 does not differentiate based on the type of insurance policy involved, suggesting that it applies to claims filed against all types of policies.

This rule was adopted prior to the General Assembly's passage of N.C.G.S. § 58-3-225, "Prompt Claim Payments under Health Benefit Plans." This "prompt pay statute" created specific rules for health insurers about how and when to handle claims filed by health care providers and facilities. While silent about TPAs, we understand the statute to override Rule .0106 insofar as the rule relates to insurers. Conceivably, the strictures of the prompt pay statute must still be satisfied by any TPA that handles claims on behalf of a health insurer, but Rule .0106 does not make this clear.

Chapter 150B Analysis: This rule has not changed since its original adoption in 1996. Since then, multiple legislative changes in the area of prompt payments from insurers have occurred. Those changes to the law lead us to question the ongoing application and efficacy of this rule. At this point, the rule is ambiguous at best.

Conclusion: Because we feel Rule .0106 should be updated to explicitly require TPAs to meet the prompt pay requirements that normally apply to the insurer, **NCMS requests a determination that Rule .0106 is "necessary with substantial public interest."**

The NCMS appreciates the opportunity to share our perspective on these rules, and we look forward to working with NCDOL as this process continues. Should you have any questions about our comments, please contact me at your convenience at (919) 833-3836 or cbrockett@ncmedsoc.org.

Respectfully,



Conor Brockett
Associate General Counsel

North Carolina Department of Insurance (DOI)

Periodic Review of Existing Rules

Response to Public Comment

Date of Final Certification Determination: September 5, 2014

Public Comment Period: May 16, 2014 through July 16, 2014

Rules which received public comment: 11 NCAC 18 .0103, 11 NCAC 20 .0101, 11 NCAC 21 .0106

The following is the DOI response to each rule:

11 NCAC 18 .0103 FILING REQUIREMENTS

(a) All communications and filings must be made with the Compliance Officer, Technical Services Group, North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611. To apply for licensure, in addition to the information required by G.S. 58-49-50, the following items pertaining to the MEWA must be submitted:

- (1) Form MEWA-1 entitled "Application for License for Multiple Employer Welfare Arrangement (MEWA);"
- (2) Form MEWA-2 entitled "Financial Statement", which shall contain the information required by G.S. 58-49-50(8);
- (3) Signed and notarized biographical affidavits by all trustees of the MEWA on Form MEWA-3 entitled "Biographical Questionnaire", which shall contain information to enable the Commissioner to determine if such persons satisfy the criteria specified in G.S. 58-49-40(e);
- (4) A complete list of names, addresses and telephone numbers of participating employers and the number of employees covered by the MEWA; and
- (5) A statement of the reasons for applying for a North Carolina MEWA license; a description of exactly how the MEWA proposes to develop and supervise its operations in North Carolina; the name, title, and qualifications of the person who will be responsible for the MEWA's operation in North Carolina (the managing general agent if the MEWA is domiciled outside of North Carolina); and the location of and a description of the office facilities that will be provided by the MEWA in North Carolina.

(b) All forms may be obtained from the Compliance Officer. Every application must contain a certification that any changes to the information required by G.S. 58-49-50 and this Rule shall be reported to the Commissioner.

(c) During the pendency of an application, the MEWA shall keep all required information, statements, documents, and materials current and factual.

(d) An application for a license is not complete until the MEWA has satisfied the Commissioner that the MEWA is in compliance with all of the requirements of Article 49 of General Statute Chapter 58 and this Section. The Commissioner is not required to process an incomplete application.

(e) All financial information required by G.S. 58-49-50 and this Section shall be prepared in accordance with statutory accounting principles.

(f) Any change in the information required by Article 49 of General Statute Chapter 58 or by this Section shall, unless otherwise specified in that Article or in this Section, be reported to the Commissioner within two business days after such change.

History Note: Authority G.S. 58-2-40(1); 58-49-40; 58-49-50; 58-49-60; Eff. July 1, 1992.

Initial Classification Determination: Necessary without substantive public interest

Public Comment: One comment received from Conor Brockett, Associate General Counsel, North Carolina Medical Society (NCMS). See attached correspondence dated July 16, 2014 for specific comment details.

DOI Response for 11 NCAC 18 .0103: Multiple Employer Welfare Arrangements (MEWAs) are not subject to the protections of the Guaranty Fund. Rules relevant to their solvency are very important. Updated information is important because employer groups can be assessed if there is a shortage. If the rule is changed, paragraph (f) needs to be made to be consistent with those of HMOs as found in 11 NCAC 20.0602. It would be most prudent, however, to have a shorter period at the time of initial licensing or renewal with the longer period after initial licensing and renewal.

DOI Final Classification Determination for 11 NCAC 18 .0103: Necessary with substantive public interest

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.

Initial Classification Determination: Necessary without substantive public interest

Public Comment: One comment received from Conor Brockett, Associate General Counsel, North Carolina Medical Society (NCMS). See attached correspondence dated July 16, 2014 for specific comment details.

DOI Response for 11 NCAC 20 .0101: 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.

DOI Final Classification Determination for 11 NCAC 20 .0101: Necessary without substantive public interest

11 NCAC 21 .0106 PAYMENT OF CLAIMS

If claims filed with a TPA or insurer are not paid within 30 days after receipt of the initial claim by the TPA or the insurer, the TPA or the insurer shall at that time mail a claim status report to the claimant.

History Note: Authority G.S. 58-2-40; 58-3-100; 58-56-31;
Eff. June 1, 1996.

Initial Classification Determination: Necessary without substantive public interest

Public Comment: One comment received from Conor Brockett, Associate General Counsel, North Carolina Medical Society (NCMS). See attached correspondence dated July 16, 2014 for specific comment details.

DOI Response for 11 NCAC 21 .0106: TPA's operate under prompt pay law, but the TPA rules were written before the prompt pay laws were enacted. NCGS 58-3-225 details prompt claim payments under health benefit plans. 11 NCAC 21 .0106 is now redundant and therefore unnecessary. Agency will repeal through Rulemaking Process.

DOI Final Classification Determination for 11 NCAC 21 .0106: Necessary with substantive public interest