## Burgos, Alexander N

**Subject:** FW: RRC Request to withdraw rules

**From:** Reeder, Amanda J
**Sent:** Tuesday, April 19, 2016 10:43 AM
**To:** Peace-Bunch, Loretta Y <loretta.peace-bunch@ncdoi.gov>
**Cc:** Popkin, Ben <Ben.Popkin@ncdoi.gov>; Burgos, Alexander N <alexander.burgos@oah.nc.gov>; Reeder, Amanda J <amanda.reeder@oah.nc.gov>
**Subject:** RE: RRC Request to withdraw rules

Loretta:

Thank you for your email. I will let the Commission know that you all are withdrawing the rules pursuant to G.S. 150B-21.12.

I will be in touch to help set the readoption deadline for these 10 rules pursuant to G.S. 150B-21.3A.

Amanda

*Amanda J. Reeder*
*Counsel to the Rules Review Commission*
*NC Office of Administrative Hearings*
*919/ 431-3079*



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**From:** Peace-Bunch, Loretta Y
**Sent:** Tuesday, April 19, 2016 9:01 AM
**To:** Reeder, Amanda J <amanda.reeder@oah.nc.gov>
**Cc:** Popkin, Ben <Ben.Popkin@ncdoi.gov>
**Subject:** RRC Request to withdraw rules

Amanda,

This is to notify you that the Department of Insurance is going to withdraw the following rules at this time and will resubmit them at a later date:

11 NCAC 18 .0103, 11 NCAC 20 .0202, 11 NCAC 20 .0203, 11 NCAC 20 .0204,
11 NCAC 20 .0301, 11 NCAC 20 .0302, 11 NCAC 20 .0404, 11 NCAC 20 .0410,
11 NCAC 20 .0601, 11 NCAC 21 .0106

Loretta Peace-Bunch

NC Department of Insurance
919-807-6004
Loretta.peace-bunch@ncdoi.gov

STATE OF NORTH CAROLINA
**OFFICE OF ADMINISTRATIVE HEARINGS**

Mailing address:
6714 Mail Service Center
Raleigh, NC 27699-6700

Street address:
1711 New Hope Church Rd
Raleigh, NC 27609-6285

March 17, 2016

Loretta Peace-Bunch
Department of Insurance
**Sent via email to Loretta.Peace-Bunch@ncdoi.gov**

Re: Objection to Rules 11 NCAC 18 .0103; 11 NCAC 20 .0202, .0203, .0204, .0301, .0302, .0404, .0410, .0601; 11 NCAC 21 .0106.

Dear Ms. Peace-Bunch:

At its meeting today, the Rules Review Commission objected to the above-captioned rules in accordance with G.S. 150B-21.10.

The Commission objected to the rules, finding the agency failed to comply with the Administrative Procedure Act. Specifically, the Commission found that by failing to send notice to its interested persons mailing list, the Department failed to comply with G.S. 150B-21.2(d).

As these rules were readoptions scheduled by the Commission pursuant to G.S. 150B-21.3A(d)(2), the Commission will set a new readoption date for these rules at later meeting.

Please respond to this letter in accordance with the provisions of G.S. 150B-21.12. If you have any questions regarding the Commission's actions, please let me know.

Sincerely,

Amanda J. Reeder
Commission Counsel

Cc: Ben Popkin, Department of Insurance

## RRC STAFF OPINION

*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 rule at its next meeting, or 2) an opinion of that attorney as to some matter concerning that rule. The agency and members of the public are invited to submit their own comments and recommendations (according to RRC rules) to the Commission.*

AGENCY: Department of Insurance

RULE CITATION: All Rules Submitted

RECOMMENDED ACTION:

Approve, but note staff's comment

X Object, based on:

Lack of statutory authority

Unclear or ambiguous

Unnecessary

X Failure to comply with the APA

Extend the period of review

COMMENT:

*On March 10, 2016, staff received an email stating that the Department of Insurance did not send notice of rulemaking for these rules to its interested party mailing list. The individual that sent the email stated that his organization wanted to participate in the rulemaking process, but was never provided with notice that the Department had published the rules for public comment, despite the fact that he was on the Department's interested persons mailing list.*

*G.S. 150B-21.2 governs the permanent rulemaking process. G.S. 150B-21.2(d) requires:*

> Mailing List. - An agency must maintain a mailing list of persons who have requested notice of rule making. When an agency publishes in the North Carolina Register a notice of text of a proposed rule, it must mail a copy of the notice or text to each person on the mailing list who has requested notice on the subject matter described in the notice or the rule affected. An agency may charge an annual fee to each person on the agency's mailing list to cover copying and mailing costs.

*Staff asked the Department via email on March 10, 2016 to send proof that the notice was sent to the mailing list. The Department responded on that day that it had not sent the notice for this rulemaking.*

Amanda J. Reeder
Commission Counsel
Issued March 10, 2016

*Therefore, staff recommends that the Commission object to all ten rules for failure to comply with the APA, as the agency did not send notice to its interested parties as required by G.S. 150B-21.2(d).*

*Staff further notes that these Rules were readoptions of existing rules, required by G.S. 150B-21.3A(d)(2). At its February 2015 meeting, the RRC established the readoption date for these ten rules as January 31, 2016. As the agency failed to adopt the Rules in accordance with G.S. 150B, Article 2A [specifically G.S. 150B-21.2(d)], staff believes the agency did meet the deadline. Staff recommends rescheduling the date for these readoptions to allow the agency to readopt these Rules as required by G.S. 150B.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 18 .0103

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

***NOTE WELL:* This request when viewed on computer extends 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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*In (a), line 4, replace "must" with "shall"*

*Also on line 4, please confirm this is the current address and name for the organization. Also, are these forms not available on your website? If so, don't you want to include that information in the Rule?*

*Please consider making the language on line 5, beginning with "To apply" a new Paragraph (b).*

*On line 6, change "must" to "shall" Also, I think it would be better to rewrite the sentence to state who is required to submit the information.*

*In (a)(1), (2), and (3), you refer to forms. The contents of rules must in rule or law. Are the contents of these forms in rule or law? If so, is there a cross-reference you can insert? If not, you need to state the contents of the forms in Rule.*

*In (a)(3), line 12, the comma should be inside the quotation marks after "Questionnaire"*

*In (a)(4), line 14, define or delete "complete"*

*Also on line 14, I suggest inserting a comma after "addresses"*

*Why is (a)(5) combined? This seems that the information would be clearer to read if set forth as (a)(5), (a)(6), (a)(7), etc.*

*In (b), line 21, is the term "forms" the same as "applications"? If so, why isn't the same term used for both?*

*Also on line 21, are you saying the only way to get these forms is to write to the Compliance Officer at the PO Box provided on line 5? These forms aren't available online?*

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

*On line 21, change "must" to "shall"*

*On line 22, who will report these changes to the Commissioner? And what is the deadline? The one set forth in Paragraph (f)? Doesn't this language repeat at least part of Paragraph (f)?*

*In (c), line 24, define "current" and "factual"*

*In (d), how does the MEWA satisfy the Commissioner that the conditions are met?*

*On lines 26 and 27, are you saying that the Commissioner will not process incomplete applications, or that the Commissioner may choose to do so? If the Commissioner may choose to do so, when will he refuse to do so?*

*In (e), line 28, I take it the reference to "statutory accounting principles" is a reference to G.S. 58-49-60? If not, what does the phrase mean?*

*Also on line 28, do you mean "the rules of this Section"?*

*Why don't you combine parts of Paragraph (b) with Paragraph (f)?*

*In the History Note, line 36, underline "Readopted Eff. April 1, 2016"*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 18 .0103 is readopted as published in 30:10 NCR 1109-1110 as follows:

**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;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0202

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*Do you need to retain the language on lines 4 and 5? It seems that it's clear that the forms must comply with the provisions in the Rule, especially now that the rule has been effective nearly 20 years.*

*In Item (3), line 11, don't you mean "a statement" or just "the term of the contract"?*

*In Item (6), line 19, define "sufficient"*

*In Item (7), line 24, define "timely"*

*In Item (11), Page 2, line 8, define "adequate"*

*On lines 8 and 9, what are "industry and carrier standards"?*

*In Item (14), line 15, this is merely a stylistic suggestion to remove the parenthesis in the Rule. Please consider stating "provider. For example, …"*

*In Sub-Item (15)(b), why not break this down further?*

*(b) Information on:*
*(i) Benefit exclusions;*
*(ii) administrative and utilization management requirements;*
*(iii) quality assessment programs; and*
*(iv) provider sanction policies.*
*Notification of changes …*

*Also, on line 24, how long is the time allowed to providers? Or is that to be negotiated in the contract?*

*In Item (16), on line 27, is there a reason you are using "proviso" rather than "clause" or "stipulation"?*

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

*In the History Note, Page 3, G.S. 58-50-50, 58-50-55, and 58-65-140 were repealed by SL 1997-519. Please remove them.*

*Also in the History Note, there is no need to have a break between citations on line 2. Please continue it as one string.*

*Also, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0202 is readopted as published in 30:10 NCR 1109-1110 as follows:

**11 NCAC 20 .0202 CONTRACT PROVISIONS**

All contract forms that are created or amended on or after the effective date of this Section, and all contract forms that are executed later than six months after the effective date of this Section, shall contain provisions addressing the following:

(1) Whether the contract and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties.

(2) Definitions of technical insurance or managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in the evidence of coverage issued in conjunction with the network plan.

(3) An indication of the term of the contract.

(4) Any requirements for written notice of termination and each party's grounds for termination.

(5) The provider's continuing obligations after termination of the provider contract or in the case of the carrier or intermediary's insolvency. The obligations shall address:

(a) Transition of administrative duties and records.

(b) Continuation of care, when inpatient care is on-going. If the carrier provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.

(6) The provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials.

(7) The provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the carrier and notify the carrier of subsequent changes in status of professional liability insurance on a timely basis.

(8) With respect to member billing:

(a) If the carrier provides or arranges for the delivery of health care services on a prepaid basis under G.S. 58, Article 67, the provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the carrier may not cover or continue to cover specific services and the member chooses to receive the service.

(b) Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

(9) Any provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility.

(10) The carrier's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the carrier, before rendering health care services. Mutually agreeable provision may be made for cases where incorrect or retroactive information was submitted by employer groups.

(11) Provider requirements regarding patients' records. The provider shall:

(a) Maintain confidentiality of enrollee medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.

(b) Maintain adequate medical and other health records according to industry and carrier standards.

(c) Make copies of such records available to the carrier and Department in conjunction with its regulation of the carrier.

(12) The provider's obligation to cooperate with members in member grievance procedures.

(13) A provision that the provider shall not discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.

(14) Provider payment that describes the methodology to be used as a basis for payment to the provider (for example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus).

(15) The carrier's obligations to provide data and information to the provider, such as:

(a) Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.

(b) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. Notification of changes in these requirements shall also be provided by the carrier, allowing providers time to comply with such changes.

(16) The provider's obligations to comply with the carrier's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

(17) The provider's authorization and the carrier's obligation to include the name of the provider or the provider group in the provider directory distributed to its members.

(18) Any process to be followed to resolve contractual differences between the carrier and the provider.

(19) Provisions on assignment of the contract shall contain:

(a) The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the carrier.

(b) The carrier shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

*History Note:* *Authority G.S. 58-2-40(1); 58-2-131; 58-39-45; 58-39-75; 58-50-50; 58-50-55; 58-65-25; 58-65-105; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-115; 58-67-140; 58-67-150; Eff. October 1, 1996; Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0203

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*On line 5, do you mean "Section" or "Rule"? I think you mean "Rule" because the term is not used again in Section .0200. However, it used in Rule .0601 of the Chapter.*

*This is simply a suggestion, but you may wish to break the definition on line 5 further down as follows:*

*"For … this Section, a "material change" includes a change in:*
*(1) the means of calculating ..;*
*(2) the distribution… parties; or*
*(3) the delegation…*

*In the History Note, G.S. 58-50-50, 58-50-55, and 58-65-140 were repealed by SL 1997-519. Please remove them.*

*Also in the History Note, there is no need to have a break between citations on line 10. Please continue it as one string.*

*Also, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0203 is readopted as published in 30:10 NCR 1109-1110 as follows:

**11 NCAC 20 .0203 CHANGES REQUIRING APPROVAL**

All material changes to an approved contract form shall be filed with the Division for approval before use. For the purpose of this Section, a "material change" includes a change in the means of calculating payment to the provider (for example, change from fee for service to capitation), a change in the distribution of risk between parties, or a change in the delegation of clinical or administrative responsibilities.

*History Note:* *Authority G.S. 58-2-40(1); 58-50-50; 58-50-55; 58-65-25; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-115; 58-67-120; 58-67-150;*
*Eff. October 1, 1996;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0204

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*In (a), line 5, I take it the reference to "Division" is from Rule .0201(c) of this Section?*

> **11 NCAC 20 .0201 WRITTEN CONTRACTS**
> (a) All contracts between network plan carriers and health care providers and between network plan carriers and intermediary organizations offering networks of health care providers to be used by network plan carriers for the provision of care on a preferred or in-network basis shall be in writing and shall comply with 11 NCAC 20 .0202 as a condition of such health care providers' and networks' being listed in the carrier's provider directory.
> (b) The form of every contract under Paragraph (a) of this Rule shall be filed with the Division for approval according to these Rules before it is used.
> (c) As used in this Section and in Section .0600 of this Chapter, "Division" means the Life and Health Division of the Department of Insurance.

*Does your regulated public know the contact information for the Division?*

*On line 7, replace "which" with "that"*

*In (b)(1), Rule .0202 requires all contracts to include all provisions in the Rule. Why are only some provisions going to be applicable here, especially when both Rules cite substantially the same statutory authority in the History Note?*

*Also, in (b)(1), line 11, the cross-reference is technically correct, but you could also state "Rule .0202 of this Section."*

*In Subpart (a)(6)(C), line 28, "State of North Carolina" is repetitive. Why not state "State" or "North Carolina"?*

*In the History Note, G.S. 58-50-50, 58-50-55, and 58-65-140 were repealed by SL 1997-519. Please remove them.*

*Also, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0204 is readopted as published in 30:10 NCR 1109-1110 as follows:

**11 NCAC 20 .0204 CARRIER AND INTERMEDIARY CONTRACTS**

(a) If a carrier contracts with an intermediary for the provision of a network to deliver health care services, the carrier shall file with the Division for prior approval its form contract with the intermediary. The filing shall be accompanied by a certification from the carrier that the intermediary will, by the terms of the contract, be required to comply with all statutory and regulatory requirements which apply to the functions delegated. The certification shall also state that the carrier shall monitor such compliance.

(b) A carrier's contract form with the intermediary shall state that:

(1) All provider contracts used by the intermediary shall comply with, and include applicable provisions of, 11 NCAC 20 .0202.

(2) The network carrier retains its legal responsibility to monitor and oversee the offering of services to its members and financial responsibility to its members.

(3) The intermediary may not subcontract for its services without the carrier's written permission.

(4) The carrier may approve or disapprove participation of individual providers contracting with the intermediary for inclusion in or removal from the carrier's own network plan.

(5) The carrier shall retain copies or the intermediary shall make available for review by the Department all provider contracts and subcontracts held by the intermediary.

(6) If the intermediary organization assumes risk from the carrier or pays its providers on a risk basis or is responsible for claims payment to its providers:

(A) The carrier shall receive documentation of utilization and claims payment and maintain accounting systems and records necessary to support the arrangement.

(B) The carrier shall arrange for financial protection of itself and its members through such approaches as member hold harmless language, retention of signatory control of the funds to be disbursed, or financial reporting requirements.

(C) To the extent provided by law, the Department shall have access to the books, records, and financial information to examine activities performed by the intermediary on behalf of the carrier. Such books and records shall be maintained in the State of North Carolina.

(7) The intermediary shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by the carrier and assumed by the intermediary.

(c) If a carrier contracts with an intermediary to provide health care services and pays that intermediary directly for the services provided, the carrier shall either monitor the financial condition of the intermediary to ensure that providers are paid for services, or maintain member hold harmless agreements with providers.

*History Note:* *Authority G.S. 58-2-40(1); 58-2-131; 58-34-10; 58-34-15; 58-50-50; 58-50-55; 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-10; 58-67-20; 58-67-30; 58-67-35; 58-67-65; 58-67-100; 58-67-115; 58-67-140; 58-67-150;*

*Eff. October 1, 1996;*

*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0301

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*In the History Note, G.S. 58-50-55 and 58-65-140 were repealed by SL 1997-519. Please remove them.*

*Also, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0301 is readopted as published in 30:10 NCR 1109-1110 as follows:

## SECTION .0300 - PROVIDER ACCESSIBILITY AND AVAILABILITY

### 11 NCAC 20 .0301 PROVIDER AVAILABILITY STANDARDS

Each network plan carrier shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the members. The methodology shall provide for the development of performance targets that shall address the following:

(1) The number and type of primary care physicians, specialty care providers, hospitals, and other provider facilities, as defined by the carrier.

(2) A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier.

(3) A method for arranging or providing health care services outside of the service area when providers are not available in the area.

*History Note:* *Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;*
*Eff. October 1, 1996;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0302

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*On line 4, "carrier" is defined in Rule .0101 of the Chapter as a network plan carrier. Is this the intended use of the term here?*

*On line 5, I believe "hospital based" should be hyphenated.*

*On line 6, what written policies are you referring to? Do they set the performance targets? If so, state that.*

*In Item (1), line 7, please use an article at the beginning of the sentence to be consistent. "The proximity."*

*Also on line 7, please insert a comma after "providers"*

*On line 8, please insert a comma after "specialty care"*

*In Item (2), line 10, please use the numeral 7. [See Rule 26 NCAC 02C .0108(9)(c)]*

*In the History Note, G.S. 58-50-55 and 58-65-140 were repealed by SL 1997-519. Please remove them.*

*Also, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0302 is readopted as published in 30:10 NCR 1109-1110 as follows:

**11 NCAC 20 .0302 PROVIDER ACCESSIBILITY STANDARDS**

Each carrier shall establish performance targets for member accessibility to primary and specialty care physician services and hospital based services. Carriers shall also establish similar performance targets for health care services provided by providers who are not physicians. Written policies and performance targets shall address the following:

(1) Proximity of network providers as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care and hospital services, taking into account local variations in the supply of providers and geographic considerations.

(2) The availability to provide emergency services on a 24-hour, seven day per week basis.

(3) Emergency provisions within and outside of the service area.

(4) The average or expected waiting time for urgent, routine, and specialist appointments.

*History Note:* *Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;*
*Eff. October 1, 1996;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0404

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*On line 4, delete everything after "network," unless you need to retain language for contracts that were entered into before October 1, 2001.*

*In Item (1), line 6, please delete "and" before "that issues…"*

*On line 7, so that I am clear – the form contents are what is set forth in the rest of the Rule?*

*What authority are you relying upon for the sentence on lines 7 – 9? G.S. 58-3-167 gives clear authority for the first sentence, but not the second.*

*On line 9, what is the carrier approving? The provider or the form?*

*On line 10, I take it "when applicable" is clear to the individuals using the form?*

*In Sub-Item (1)(c), please insert a comma after "training"*

*In Sub-Item (1)(k), I suggest removing the parenthesis and inserting a comma after "requested" instead.*

*On line 23, remove "etc."*

*In Sub-Item (1)(l), what is "a statement of completeness and veracity"? Do you mean of the information required by the application?*

*On line 24, what is a "release of information"? A release?*

*What are the documents in Sub-Item (1)(m)? Does your regulated public know?*

*In Sub-Item (2)(a), was the organization renamed "The Joint Commission"?*

*In Sub-Item (2)(d), define "current"*

*What is the purpose of Item (3)?*

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

*In the History Note, what is the purpose of the citation for G.S. 58-67-5?*

*Please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0404 is readopted as published in 30:10 NCR 1109-1110 as follows:

**11 NCAC 20 .0404 APPLICATION**

For all providers who submit applications to be added to a carrier's network on or after October 1, 2001:

(1) The definitions in G.S. 58-3-167 are incorporated into this Rule by reference. Each carrier that is an insurer and that issues a health benefit plan shall obtain and retain on file each provider's signed and dated application on the form approved by the Commissioner under G.S. 58-3-230. All other carriers shall obtain and retain on file the provider's signed and dated application on a form provided by the carrier. All required information shall be current upon final approval by the carrier. The application shall include, when applicable:

(a) The provider's name, address, and telephone number.

(b) Practice information, including call coverage.

(c) Education, training and work history.

(d) The current provider license, registration, or certification, and the names of other states where the applicant is or has been licensed, registered, or certified.

(e) Drug Enforcement Agency (DEA) registration number and prescribing restrictions.

(f) Specialty board or other certification.

(g) Professional and hospital affiliation.

(h) The amount of professional liability coverage and any malpractice history.

(i) Any disciplinary actions by medical organizations and regulatory agencies.

(j) Any felony or misdemeanor convictions.

(k) The type of affiliation requested (for example, primary care, consulting specialists, ambulatory care, etc.).

(l) A statement of completeness, veracity, and release of information, signed and dated by the applicant.

(m) Letters of reference or recommendation or letters of oversight from supervisors, or both.

(2) The carrier shall obtain and retain on file the following information regarding facility provider credentials, when applicable:

(a) Joint Commission on Accreditation of Healthcare Organization's certification or certification from other accrediting agencies.

(b) State licensure.

(c) Medicare and Medicaid certification.

(d) Evidence of current malpractice insurance.

(3) No credential item listed in Items (1) or (2) of this Rule shall be construed as a substantive threshold or criterion or as a standard for credentials that must be held by any provider in order to be a network provider.

*History Note:* *Authority G.S. 58-2-40(1); 58-2-131; 58-3-167; 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;*
*Eff. October 1, 1996;*
*Temporary Amendment Eff. October 1, 2001;*
*Amended Eff. May 1, 2008; August 1, 2002;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0410

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*On line 5, how does the approval occur? And is the approval entirely within the discretion of the carrier?*

*On lines 6 and 7, how will the monitoring occur? Is there a requirement for frequency?*

*In Item (2), line 11, is "no less frequently" needed? Generally, terms like "at a minimum" and "at least" are not favored in rules, as rules set the minimum standard. Do you need to retain it here?*

*For Item (3), line 12, do you need to retain "at least"?*

*In the History Note, what is the purpose of the citation for G.S. 58-67-5?*

*Please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0410 is readopted as published in 30:10 NCR 1109-1110 as follows:

**11 NCAC 20 .0410 DELEGATION OF CREDENTIAL VERIFICATION ACTIVITIES**

Whenever any carrier delegates credential verification activities to a contracting entity, whether an intermediary or subcontractor, the carrier shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements in this Section. The carrier shall monitor the contracting entity's credential verification activities. The carrier shall implement oversight mechanisms, including:

(1) Reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures.

(2) Requiring the contract entity to submit an updated list of providers no less frequently than quarterly.

(3) Conducting an evaluation of the contracting entity's credential verification program at least every three years.

*History Note:* *Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;*
*Eff. October 1, 1996;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0601

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*Since the language of Paragraphs (a) and (b) are repetitive, why not create a new Paragraph (a) that states:*

Requests pursuant to Paragraphs (b) and (c) of this Rule shall be submitted in writing to the Division for review and approval. An HMO shall submit an original and eight copies of the application which shall include:

(1) A description of operational changes that will result from the expansion.

(2) Financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605.

(3) A description of provider interest and network development in the service area requested and information as to the HMO's existing provider network.

(4) Copies of any form contracts to be made as a result of the expansion, including providers and subcontractors.

*Then you can just change current Paragraph (a) into (b) and state "All requests to expand an HMO's service plan shall comply with Paragraph (a) of this Rule."*

*Paragraph (b) would become Paragraph (c) along the same lines.*

*In current Paragraph (b), what is your authority to require review and approval, rather than just review? G.S. 58-67-10(d)(1) appears to govern this, and the statute states:*

> (d)(1) A health maintenance organization shall file a notice describing any significant modification of the operation set out in the information required by subsection (c) of this section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Changes subject to the terms of this section include expansion of service area, changes in provider contract forms and group contract forms where the distribution of risk is significantly changed, and any other changes that the Commissioner describes in properly promulgated rules. Every HMO shall report to the Commissioner for his information material changes in the provider network, the addition or deletion of Medicare risk or Medicaid risk arrangements and the addition or deletion of employer groups that exceed ten percent (10%) of the health maintenance organization's book of business or such other information as the Commissioner may require. Such information shall be filed with the Commissioner within 15 days after implementation of the

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Commission Counsel
Date submitted to agency: February 26, 2016

reported changes. Every HMO shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.

*Is the product line not a part of the provider network? Are you relying upon the "properly promulgated rules" portion of the statute here?*

*On line 17, put "material changes" in quotation marks since you are defining it in the sentence.*

*On line 18, replace the semicolon with a comma.*

*On line 19, what is an "IPA model"? Does your regulated public know?*

*In (c), line 27, what is an "intermediary"? Does your regulated public know?*

*In (d), line 31, please replace "once" with "formerly"*

*In (e), the citation on line 33 is technically correct, but you can replace it with "Rule .0203 of this Chapter."*

*In (f), lines 34-35, replace "which that HMO owns or control or manages" with "that the HMO owns, controls, or manages…"*

*In the History Note, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 20 .0601 is readopted as published in 30:10 NCR 1109-1110 as follows:

## SECTION .0600 - SIGNIFICANT MODIFICATIONS TO HMO OPERATIONS

### 11 NCAC 20 .0601 APPLICATIONS FOR MODIFICATIONS TO SERVICE AREAS OR PRODUCT LINES

(a) All requests to expand an HMO's service area shall be submitted in writing as an application to the Division for review and approval. An HMO shall submit an original and eight copies of the application, which shall include the following information:

(1) A description of operational changes that will result from the expansion.

(2) Financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605.

(3) A description of provider interest and network development in the service area requested and information as to the HMO's existing provider network.

(4) Copies of any form contracts to be made as a result of the expansion, including providers and subcontractors.

(b) Material changes in the product lines offered by an HMO shall be submitted in writing as an application to the Division for review and approval. For the purposes of this Section, material changes include the addition of a point of service product; or the addition of or changes to the HMO's existing health care delivery model, such as the addition of an IPA product or group model product or the addition of a gatekeeper product. HMOs shall submit an original and eight copies of the application, which shall include the following information:

(1) A description of operational changes that will result from the expansion.

(2) Financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605.

(3) A description of provider interest and network development in the service area requested and information as to the HMO's existing provider network.

(4) Copies of form contracts to be made as a result of the expansion, including providers and subcontractors.

(c) Notice of the addition of an intermediary shall be submitted by an HMO in writing to the Division within 30 days after the execution of the contract for the intermediary's services.

(d) Notice of the deletion of an intermediary shall be submitted by the HMO in writing within 30 days after termination of the contract, unless termination is immediate, along with a plan to select another intermediary or for the HMO to perform the once delegated functions in-house.

(e) All changes to provider and intermediary contract forms shall be submitted to the Division for review and approval in accordance with 11 NCAC 20 .0203 prior to the use of the amended form.

(f) Each HMO shall submit written notice to the Division of its intent to engage in any arrangement through which that HMO owns or controls or manages any operations of another HMO in any other state, before entering into the arrangement.

*History Note:* *Authority G.S. 58-2-40; 58-67-10; 58-67-150;*
*Eff. October 1, 1996;*
*Readopted Eff. April 1, 2016.*

# REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 21 .0106

**DEADLINE FOR RECEIPT: Friday, March 11, 2016**

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 this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

*Since "TPA" is defined by G.S. 58-56-4 as a Third Party Administrator, I take it your regulated public understands what this means in this Rule?*

*What is your authority to require the TPA to send this report to claimants? G.S. 58-3-100(c) requires this from an insurer, but not TPAs. I don't read G.S. 58-56-31 to require this of TPAs. Is there another statute, or is the nature of TPAs such that they should be included as insurers?*

*In the History Note, please underline "Readopted Eff. April 1, 2016."*

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

Amanda J. Reeder
Commission Counsel
Date submitted to agency: February 26, 2016

11 NCAC 21 .0106 is readopted as published in 30:10 NCR 1109-1110 as follows:

**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;*
*Readopted Eff. April 1, 2016.*