REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0202

DEADLINE FOR RECEIPT: Monday, July 9, 2018

***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 the Submission for Permanent Rule form:

In Box 2, please include the Rule name.

In Box 3, please check that this is a readoption.

In the Rule:

In the Introductory Statement, line 1, please change the Register citation to 32:18.

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. Or do you mean the "amended" effective date? If so, state that.

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 Sub-Item (11)(b), 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)(a), line 20, what are "efficiency criteria"?

Amanda J. Reeder
Commission Counsel
Date submitted to agency: June 22, 2018

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"?

In the History Note, Page 3, G.S. 58-50-50, 58-50-55, and 58-65-140 were repealed by SL 1997-519.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

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: June 22, 2018

11 NCAC 20 .0202 is readopted as published in 32:19 NCR 1742-1743 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.~~ October 1, 1996;*
Readopted Eff. August 1, 2018

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0204

DEADLINE FOR RECEIPT: Monday, July 9, 2018

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 Submission for Permanent Rule form:

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In Box 3, please check that this is a readoption.

In the Rule:

In the Introductory Statement, line 1, please change the Register citation to 32:18.

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), lines 10 and 11, the cross-reference is technically correct, but you could also state "Rule .0202 of this Section."

Amanda J. Reeder
Commission Counsel
Date submitted to agency: June 22, 2018

In Subpart (b)(6)(A), line 22, who determines what is "necessary"? Is this entirely up to the parties to the contract?

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

In Subparagraph (b)(7), line 29, what are "applicable statutory and regulatory requirements"? Does your regulated public know?

Also on line 29, why do you have both "applicable" and "that apply" in the same sentence? This is duplicative. Can't you delete "applicable"?

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.

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: June 22, 2018

11 NCAC 20 .0204 is readopted as published in 32:19 NCR 1742-1743 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;*

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