GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

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SENATE BILL 623*
Insurance Committee Substitute Adopted 5/10/93

Short Title: HMO Improvements. (Public)

Sponsors:

Referred to:

March 29, 1993

A BILL TO BE ENTITLED

AN ACT TO MAKE IMPROVEMENTS IN THE LAWS GOVERNING HEALTH MAINTENANCE ORGANIZATIONS AND TO PROVIDE FOR THE LICENSING AND REGULATION OF PREFERRED PROVIDER ORGANIZATIONS, EXCLUSIVE PROVIDER PANELS, AND OTHER MANAGED CARE OPERATIONS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-67-5 is amended by adding the following new subsections to read:

"(q) 'Service area' means a geographic area in North Carolina approved by and on file with the Commissioner in which:

(1) An HMO may enroll members who either work in the service area, reside in the service area, or work and reside in the service area.

(2) An HMO may contract with providers for the provision of primary and specialty health care services to its enrolled membership; provided that an HMO may contract outside its service area for organ and tissue transplants, services not reasonably or sufficiently available in its service area, emergency services, and extraordinary case management.

(3) An HMO may market its services to enrollees and dependents; provided that an HMO may market its services to eligible prospective enrollees outside of its service area by conducting such activities as:

a. Meetings with prospective enrollees at their places of work.

b. Meetings with employers before marketing to eligible prospective enrollees of employers.

c. Meetings with prospective employers as a part of service area expansion feasibility studies.

(r) 'Capitation' means the practice of paying a contracted provider or a group of contracted providers for health care services for a defined population on a per capita basis.

(s) 'Covered service' means those health care benefits which an enrollee is entitled to and an HMO provides or arranges for the provision of as specified under the enrollee's Evidence of Coverage, Master Group Contract, or Certificate of Coverage.

(t) 'Emergency' means an unforeseen illness or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or unforeseen medical emergencies of a life-threatening nature, or which would result in the serious impairment of bodily functions if treatment were not rendered immediately.

(u) 'Medical director' means a duly licensed physician who has been hired by, or contracted by, the HMO plan to monitor the provision of covered services to enrollees.

(v) 'Medically necessary' or 'medical necessity' means, for the purposes of payment, covered services and supplies that are:

(1) Provided for the diagnosis or care and treatment of a medical condition;

(2) Necessary for and appropriate to the symptoms, diagnosis, or treatment of a medical condition;

(3) Within generally accepted standards of medical care;

(4) Not primarily for the convenience of his/her family or the provider; and

(5) Performed in the most cost-effective setting and manner appropriate to treat the patient's medical condition.

(w) 'Quality management' or 'quality assurance' means a program of reviews, studies, evaluations, and other activities employed by an HMO for the purpose of monitoring and enhancing the quality of health care and services provided to enrollees.

(x) 'Single service health maintenance organization' means an organization 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 enrollee's responsibility for copayments or deductibles.

(y) 'Utilization management' or 'utilization review' means those methodologies used by HMOs to improve the quality and maximize the efficiency of the health care delivery system.

(z) 'Open enrollment' means a period of time no shorter than 10 business days occurring at least annually, during which time any eligible employee or any dependent may join or transfer from one type of health benefit plan to another, without providing proof of insurability or preexisting exclusions.

(aa) 'Annual enrollment' means an enrollment period of time no shorter than 10 business days that is held on an annual basis in which the HMO accepts eligible

employees and dependents for membership and may use evidence of insurability to impose preexisting exclusions."

Sec. 2. G.S. 58-67-10(b) reads as rewritten:

"(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof. This Article shall not apply to any single service HMO to the extent that the single service HMO solely contracts with, and offers its services through, one or more duly licensed North Carolina HMOs or duly licensed exclusive provider panels.

(4) Except as provided in paragraphs (1), (2), and (3) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article."

Sec. 3. G.S. 58-67-10(c) reads as rewritten:

"(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) A copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be

made between third party administrators, marketing consultants, or persons listed in subdivision (3) of this subsection and the HMO;

(5) A statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this Article;

(9) A financial feasibility plan, which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or a recognized actuarial consultant, a projection of balance sheets, cash flow statements, showing any capital expenditures, purchase and sale of investments and deposits with the State, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year; and a statement as to the sources of working capital as well as any other sources of funding;

(10) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

(11) A statement reasonably describing the geographic area or areas to be served;

(12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 58-67-110;

(12a) A description of the HMO's quality assurance program, utilization review program, and credentialing program;

(13) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances; and

(14) Such other information as the Commissioner may require to make the determinations required in G.S. 58-67-20."

Sec. 4. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-21. Licenses.**

An HMO license shall continue for the ensuing 12 months after July 1 of each year, unless suspended or revoked as provided in G.S. 58-67-140. Application for renewal of an HMO license must be submitted on or before the first day of March on a form approved by the Commissioner. Upon satisfying himself that an HMO has met all requirements of law, the Commissioner shall forward the renewal license to the HMO. An HMO that does not qualify for a renewal license before July 1 shall cease to do business in this State as of July 1, unless its license is suspended or revoked by the Commissioner before that date."

Sec. 5. G.S. 58-67-50(b) reads as rewritten:

"(b) (1) No schedule of premiums for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until a copy of such schedule, or amendment thereto, has been filed with and approved by the Commissioner.

(2) Such premiums may be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of his health. However, the premiums shall not be excessive, inadequate, or unfairly discriminatory; and must exhibit a reasonable relationship to the benefits provided by the evidence of coverage. Such premiums or any revisions thereto with respect to nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 months; or as an alternative to giving such guarantee with respect only to nongroup enrollee coverage, such premium or premium revisions may be made applicable to all similar category of enrollee coverage at one time if the health maintenance organization chooses to apply for such premium revision with respect to such categories of coverages no more frequently than once in any 12-month period. Such premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the corporation has given written notice of the premium revision 45 days prior to the effective date of such revision. The enrollee thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may promulgate reasonable rules, after notice and hearing, to require the submission of supporting data and such information as is deemed necessary to determine whether such rate revisions meet these standards.

(3) A master group contract may provide for readjustment of the rate of premium based on the experience thereunder at the end of the first year, or at any time during any subsequent year based upon at least 12 months of experience: Provided, that any such readjustment after the first year shall not be made any more frequently than once every six

months. Any rate adjustment must be preceded by a 45-day notice to the master group contract holder before the effective date of the rate increase or policy benefit revision. A notice of nonrenewal shall be given 45 days before termination."

Sec. 6. G.S. 58-67-50(c) reads as rewritten:

"(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of ~~paragraph (1)~~ subsection (a) of this section are met and any schedule of premiums if the requirements of ~~paragraph (2)~~ subsection (b) of this section are met. It shall be unlawful to issue the form or use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing of forms and within 60 days after the filing for premiums, they shall be deemed to be approved."

Sec. 7. G.S. 58-67-50(a) reads as rewritten:

"(a) (1) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or the hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commissioner.

(3) An evidence of coverage shall contain:

a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in G.S. 58-67-65(a); and

b. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of:

1. The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

2. Any limitations on the services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

3. Where and in what manner information is available as to how services may be obtained;

4. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;
5. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints;
6. A description of the reasons, if any, for which an enrollee's enrollment may be terminated for cause, which reasons may include behavior that seriously impairs the health maintenance organization's ability to provide services or an inability to establish and maintain a satisfactory physician-patient relationship after reasonable efforts to do so have been made.
7. A grace period of not less than 15 days for the payment of each premium falling due after the first premium, during which time the evidence of coverage shall remain in effect if payment is made during the 15-day period if the group is not delinquent more than twice in any 12-month period.
8. A payment of claims provision allowing at least 180 days within which the enrollee can submit the claims form after delivery of the service, except in the absence of legal capacity.
9. No action shall be brought to recover on the evidence of coverage before the later of the expiration of any mandatory grievance procedure, or other administrative appeals remedy or 60 days after a claim form has been submitted in accordance with the requirements of the evidence of coverage.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of subsection (b) unless it is subject to the jurisdiction of the Commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subsection (c) shall be applicable.

(5) The Commissioner may withdraw approval of an approved form by sending 30-days' advance written notice to the HMO that the form is

no longer in compliance with the statutes and rules of this State. The notice shall include the reasons for the Commissioner's withdrawal of approval. The HMO may request a hearing on the withdrawal of approval of the form. The request for a hearing suspends the Commissioner's withdrawal of approval until an order is issued on the matter."

Sec. 8. Reserved.

Sec. 9. (a) Article 67 of Chapter 58 of the General Statutes is amended by inserting the following new section to read:

"**§ 58-67-56. Punishment for making false statement.**

If any person, in any financial or other statement required by this Article or other applicable provisions of this Chapter, willfully misstates information, that person making oath to or subscribing the statement is guilty of perjury under G.S. 14-209, and the entity on whose behalf the person made the oath or subscribed the statement is subject to a fine imposed by the court of not less than two thousand dollars ($2,000) nor more than ten thousand dollars ($10,000)."

(b) Article 67 of Chapter 58 of the General Statutes is amended by inserting the following new sections to read:

"**§ 58-67-66. Investigation of charges.**

Upon his own motion or upon complaint being filed by a citizen of this State that an HMO authorized to do business in this State has violated any of the provisions of this Article or other applicable provisions of this Chapter, the Commissioner shall investigate the matter, and if necessary, examine under oath, by himself or his accredited representatives, the president or such other officers or agents of such HMO as may be deemed proper; also all books, records, and papers of the same. If the Commissioner finds upon substantial evidence that any complaint against an HMO is justified, the HMO, in addition to such penalties imposed for any of the violations applicable to the HMO, is liable for the expenses of the investigation; and the Commissioner may present the HMO with a statement of such expenses. If the HMO refuses or neglects to pay, the Commissioner may bring a civil action for the collection of these expenses.

"**§ 58-67-67. Books and papers required to be exhibited.**

It is the duty of any person having in his or her possession or control any books, accounts, or papers of any HMO licensed under this Article, to exhibit the same to the Commissioner or to any deputy, actuary, accountant, or persons acting with or for the Commissioner. Any person who shall refuse, on demand, to exhibit the books, accounts, or papers, as above provided, or who shall knowingly or willfully make any false statement in regard to the same, shall be subject to suspension or revocation of his or her license under the provisions of this Article and other applicable provisions of this Chapter; and shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined or imprisoned, or both, in the discretion of the court.

"**§ 58-67-68. Commissioner may require special reports.**

The Commissioner may address to any authorized HMO any written inquiry in relation to its transactions or condition or any matter connected therewith. Every HMO

so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be verified, if required by the Commissioner, by such individual, or by such officer or officers of the HMO as he shall designate.

"**§ 58-67-69. Examinations, investigations, and hearings.**

All examinations, investigations, and hearings provided for by this Article may be conducted by the Commissioner personally or by one or more of his deputies, investigators, actuaries, examiners, or employees designated by him for the purpose. If the Commissioner or any investigator appointed to conduct such investigations is of the opinion that there is evidence to charge any person or persons with a criminal violation of the laws applicable to HMOs, he may arrest with warrant or cause such person or persons to be arrested, conducted in accordance with Chapter 150B of the General Statutes."

Sec. 10. G.S. 58-67-85 reads as rewritten:

"**§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.**

"(a) An HMO ~~may~~ shall issue a master group contract for each group with the approval of the Commissioner ~~of Insurance~~ provided the contract and the individual certificates issued to members of the group ~~shall~~ comply in substance to other provisions of this ~~Article.~~ Article and this Chapter that are applicable to HMOs. Any such contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the ~~Commissioner of Insurance.~~ Commissioner. If the master group contract is ~~issued, altered,~~ altered or modified, such alteration or modification must be filed and approved before the issuance of the altered or modified form; and the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

(b) ~~For employer groups of 50 or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within 31 days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusteed groups the phrase 'groups of 50' must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.~~ For all employer groups no evidence of individual insurability may be used to exclude the following persons from participation in an HMO:

(1) Employees and dependents at the time such persons first become eligible for coverage within 31 days thereafter; or

(2) Employees or dependents or eligible employees who (i) did not make application for coverage when initially eligible because the individual was covered under another employer health benefit plan, has lost coverage under such plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce, and a request for enrollment is made within 31 days of the qualifying

event; (ii) elect coverage during an annual open enrollment; or (iii) are the subject of a court order requiring coverage be provided for a spouse or minor child under a covered employee's health benefit plan if a request for enrollment is made within 31 days after issuance of the court order.

(c) Employer master group contracts may contain a provision limiting coverage for preexisting conditions. Preexisting conditions must be covered no later than 12 months after the effective date of coverage. Preexisting conditions are defined as 'those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the 12-month period immediately preceding the effective date of the person's coverage.' Preexisting conditions exclusions may not be implemented by any successor plan as to any covered persons who have already met all or part of the waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan.

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term 'employee' is defined as a nonseasonal person working 30 hours or more per ~~week, and who is otherwise eligible for coverage.~~ week. For all employer groups where more than one health benefit plan is available to employees, employees may be added to the plan according to the employer's eligibility requirements for the other plan or plans. Preexisting conditions limitations may be applied to employees and dependents to the same extent applicable in the other plan or plans if not otherwise prohibited under this Article."

Sec. 11. G.S. 58-67-85(e) reads as rewritten:

"(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

(1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and

(2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan.

(3) When an HMO is the sole provider of health care coverage for a group, at the request of the group, the HMO may offer one open enrollment period at the assumption of the group and only offer subsequent annual enrollments. All eligible employees must be

notified at the time of the open enrollment that no additional open enrollments are anticipated by the HMO.

(4) In a dual choice arrangement where eligible employees of a group are offered the choice of joining an HMO or another plan, the HMO shall hold open enrollments to the same extent as all other plans."

Sec. 12. G.S. 58-67-85 is amended by adding the following new subsections to read:

"(f) An HMO shall not require that an eligible employee or a dependent of an eligible employee be subject to medical underwriting, evidence of insurability, or preexisting condition exclusions as a condition of membership or participation in an HMO if the eligible employee or dependent of an eligible employee satisfies the requirements of G.S. 58-67-85(b)(2)(i). An HMO shall not require that a newly hired eligible employee or his or her dependents be subject to the use of medical underwriting or evidence of insurability to impose preexisting condition exclusions as a condition of membership or participation in an HMO if the newly hired employee submits an application to join the HMO within 31 days of becoming eligible, and the group does not have any preexisting condition exclusions for its other plan(s). In the event that the group does not offer other plans, the HMO may, if required by the group, apply preexisting conditions exclusions permitted by law. In the event that the other Plan(s) does (do) include preexisting conditions exclusions, the HMO may impose comparable preexisting conditions exclusions as those of the Plan so long as the imposition of the preexisting conditions exclusions is not in violation of the provisions of this Chapter. An HMO shall not refuse to allow an eligible employee or his/her dependents to join an HMO due to the status of his/her health; provided that the use of medical underwriting or evidence of insurability may be used solely to impose preexisting conditions exclusions to the extent allowed by this Article. If an HMO uses medical underwriting criteria or forms, the criteria and forms shall be filed with the Commissioner prior to their use.

(g) All master group contracts offered or issued by an HMO must be printed in a typeface at least as large as 10-point modern type, one point leaded, and written in a logical and clear order and form; and contain the following:

(1) A statement on the cover, first or insert page that the document is a legal contract subject to the jurisdiction of and is in compliance with the statutes and rules of this State.

(2) An index of the major provisions of the document.

(3) A provision that the contract represents the entire agreement between the signatory parties.

(4) A provision outlining the time limits on certain defenses, if any.

(5) A provision concerning the eligibility of members.

(6) A provision explaining the benefits offered.

(7) A provision explaining the limitations and exclusions of coverage.

(8) A provision explaining the mechanism for the payment of claims incurred and submitted by or on behalf of the member under the benefit plan.

(9) A provision explaining the grievance and complaint procedure.

(10) A provision explaining the rights of continuation and conversion in Article 53 of this Chapter and under any federal law."

Sec. 12.1. Article 67 of Chapter 58 is amended by inserting a new section to read:

"**§ 58-67-86. Right to obtain individual coverage upon termination of group coverage.**

If an HMO is affiliated with one or more authorized health insurance companies, the HMO must provide the opportunity for conversion to a policy issued by one of its affiliates that is an authorized health insurance company for group enrollees who terminate their coverage and move outside of the approved service area of the HMO. If an HMO is not affiliated with one or more authorized health insurance companies, the HMO shall make a good faith effort to contract on reasonable terms with an authorized health insurance company to make conversion coverage available to group enrollees who terminate their coverage and move outside of the approved service area of the HMO. Such conversion policies shall be issued, at a minimum, in compliance with the provisions of Article 53 of this Chapter."

Sec. 12.2. (a) G.S. 58-67-100 is repealed.

(b) Article 67 of Chapter 58 is amended by adding the following new sections to read:

"**§ 58-67-101. Examinations to be made; authority, scope, scheduling, and conduct of examinations.**

(a) This section and G.S. 58-67-102 and G.S. 58-67-103 shall be known and may be cited as the HMO Examination Law. The purpose of the HMO Examination Law is to provide an effective and efficient system for examining the activities, operations, financial condition, and affairs of all persons transacting HMO business in this State and all persons otherwise subject to the Commissioner's jurisdiction; and to enable the Commissioner to use a flexible system of examinations that directs resources that are appropriate and necessary for the administration of the HMO statutes and rules of this State.

(b) As used in this section, G.S. 58-67-101 and G.S. 58-67-102, unless the context clearly indicates otherwise:

(1) 'Commissioner' includes an authorized representative or designee of the Commissioner.

(2) 'Examination' means an examination conducted under the HMO Examination Law.

(3) 'Examiner' means any person authorized by the Commissioner to conduct an examination.

(4) 'Regulator' means the official or agency of another jurisdiction that is responsible for the regulation of a foreign alien HMO.

(5) 'Person' includes a trust or any affiliate of a person.

(c) Before licensing any person to do HMO business in this State, the Commissioner shall be satisfied, by such examination and evidence as the

Commissioner decides to make and require, that the person is otherwise duly qualified under the laws of this State to transact business in this State.

(d) The Commissioner may conduct an examination of any HMO or its affiliates whenever the Commissioner deems it to be prudent for the protection of enrollees, but at a minimum shall conduct an examination of every domestic HMO not less frequently than once every three years. In scheduling and determining the nature, scope, and frequency of examinations, the Commissioner shall consider such matters as the results of financial analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria as set forth in the National Association of Insurance Commissioners (NAIC) Examiners' Handbook.

(e) To complete an examination of any HMO or its affiliates, the Commissioner may authorize an examination or investigation of any person, or the business of any person, insofar as the examination or investigation is necessary or material to the HMO under examination.

(f) Instead of examining any foreign or alien HMO licensed in this State, the Commissioner may accept an examination report on that HMO prepared by the HMO's regulator until January 1, 1994. Thereafter, reports may only be accepted if (i) the regulator was at the time of the examination accredited under NAIC Financial Regulation Standards and Accreditation Program, or (ii) the examination is performed under the supervision of an NAIC accredited regulator or with the participation of one or more examiners who are employed by the regulator and who, after a review of the examination, work papers, and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by the regulator.

(g) If it appears that the HMO is of good financial and business standing, and it is certified in writing and attested by the seal, if any, of the HMO's regulator that it has been examined by the regulator in the manner prescribed by its laws, and was by the examination found to be in sound condition, that there is no reason to doubt its solvency, and that it is still permitted under the laws of such jurisdiction to do business therein, then, in the Commissioner's discretion, further examination may be dispensed with, and the obtained information and the furnished certificate may be accepted as sufficient evidence of the solvency of the HMO.

(h) Upon determining that an examination should be conducted, the Commissioner shall issue a notice of examination appointing one or more examiners to perform the examination and instructing them about the scope of the examination. In conducting the examination, an examiner shall observe the guidelines and procedures in the NAIC Examiners' Handbook. The Commissioner may also use such other guidelines or procedures as the Commissioner deems to be appropriate.

(i) Every person from whom information is sought, and its officers, directors, and agents, must provide to the Commissioner timely, convenient, and free access, and at all reasonable hours at its offices, to all data relating to the property, assets, business, and affairs of the HMO being examined. The officers, directors, employees, and agents of the person must facilitate and aid in the examination. The refusal of any HMO, by its

officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner or to knowingly or willfully make any false statement in regard to the examination or written request, is grounds for revocation, suspension, refusal, or nonrenewal of any license or authority held by the HMO to engage in an HMO or other business subject to the Commissioner's jurisdiction.

(j) The Commissioner may issue subpoenas, administer oaths, and examine under oath any person about any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition the Superior Court of Wake County, and upon a proper showing the court may enter any order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(k) When making an examination, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which shall be borne by the HMO that is the subject of the examination.

(l) Pending, during, and after the examination of any HMO the Commissioner shall not make public the financial statement, findings, or examination report, or any report affecting the status or standing of the HMO examined, until the HMO has either accepted and approved the final examination report or has been given a reasonable opportunity to be heard on the report and to answer or rebut any statements or findings in the report. The hearing, if requested, shall be informal and private.

(m) Nothing in the HMO Examination Law limits the Commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action under the laws and rules of this State and to use any final or preliminary examination report, any examiner or HMO work papers, other documents, or any other information discovered or developed during any examination in furtherance of any legal or regulatory action that the Commissioner may consider to be appropriate. Findings of fact and conclusions made pursuant to any examination are **prima facie** evidence in any legal or regulatory action.

"**§ 58-67-102. Examination reports.**

(a) All examination reports shall comprise only facts appearing upon the books, records, or other documents of the HMO, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and conclusions and recommendations that the examiners find reasonably warranted from the facts.

(b) No later than 60 days following completion of an examination, the examiners shall file with the Department a verified written examination report under oath. Upon receipt of the verified report, the Department shall send the report to the HMO examined, together with a notice that affords the HMO examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days of the date of the examination report, the HMO shall file affidavits executed by each of its directors stating under oath that they have received and read a copy of the report.

(c) At the end of the 30 days provided for the receipt of written submissions or rebuttals, the Commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant parts of the examiners' work papers and enter an order:

(1) Adopting the examination report as filed or with modifications or corrections. If the examination report reveals that the HMO is operating in violation of any law, rule, or prior order of the Commissioner, the Commissioner may order the HMO to take any action the Commissioner deems necessary and appropriate to cure the violation; or

(2) Rejecting the examination report with directions to the examiners to reopen the examination to obtain additional data, documentation of the information, and refiling under subdivision (1) of this subsection; or

(3) Calling for an investigatory hearing with no less than 20-days' notice to the HMO for purposes of obtaining additional documentation, data, and testimony.

(d) All orders entered under subdivision (c)(1) of this section shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and shall be served upon the HMO by certified mail. Any hearing conducted under subdivision (c)(3) of this section shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent on the face of the filed examination report or raised by or as a result of the Commissioner's review of relevant work papers or by the written submission or rebuttal of the HMO. Within 20 days after the conclusion of any such hearing, the Commissioner shall enter an order under subdivision (c)(1) of this section. The Commissioner may not appoint a member of the Department's examination staff as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the HMO limited to the examiners' work papers that tend to substantiate any assertions set forth in any written submission or rebuttal. The Commissioner may issue subpoenas for the attendance of any witnesses or the production of any documents the Commissioner considers to be relevant to the investigation, whether they are under the control of the Department, the HMO, or other persons. The documents produced shall be included in the record, and testimony taken by the Commissioner shall be under oath and preserved for the record. Nothing in this section requires the Department to disclose any information or records that would show the existence or content of any investigation or activity of any federal or state criminal justice agency. In the hearing, the Commissioner shall question the persons subpoenaed. Thereafter, the HMO and the Department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the Commissioner. The HMO and the Department may make closing statements and may be represented by counsel of their choice.

(e) Upon completion of the examination report under subdivision (c)(1) of this section, the Commissioner shall hold the content of the examination report as private and confidential information for the 30-day period provided for written submissions or rebuttals. If after 30 days after the examination report has been submitted to it, the HMO examined has neither notified the Commissioner of its acceptance and approval of the report nor requested to be heard on the report, the report shall then be filed as a public document and shall be open to public inspection, as long as no court of competent jurisdiction has stayed its publication. Nothing in the HMO Examination Law prohibits the Commissioner from disclosing the content of the examination report, preliminary examination report or results, or any related matter, to an HMO regulator or to law enforcement officials of this or any other state or country or of the United States government at any time, as long as the person or agency receiving the report or related matters agrees in writing and is authorized by law to hold it confidential and in a manner consistent with this section. If the Commissioner determines that further regulatory action is appropriate as a result of any examination, the Commissioner may initiate such proceedings or actions as provided by law.

(f) All work papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person during an examination shall be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person, except to the extent provided in G.S. 58-67-101(1) or subsection (e) of this section. Access may also be granted to the NAIC. Such parties must agree in writing before receiving the information to give it the same confidential treatment this section requires, unless the prior written consent of the HMO to which it pertains has been obtained. The provisions of this section do not prohibit the Commissioner from taking any action provided for, or from exercising any power conferred by, any provision of this Chapter to suspend or revoke the license of any HMO.

"**§ 58-67-103. Conflict of interest; cost of examinations; immunity from liability.**

(a) No person may be appointed as an examiner by the Commissioner if that person, either directly or indirectly, has a conflict of interest or is affiliated with the management or owns a pecuniary interest in any person subject to examination. This section does not preclude an examiner from being:

(1) A policyholder or claimant under an HMO contract;

(2) A grantor of a mortgage or similar instrument on the examiner's residence to an HMO if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies; or

(4) A settler or beneficiary of a blind trust into which any otherwise nonpermissible holdings have been placed.

(b) Notwithstanding the requirements of G.S. 58-67-101, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their

professions, even though they may from time to time be similarly employed or retained by persons subject to examination under the HMO Examination Law.

(c) Any HMO examined shall pay the proper charges incurred in the examination, including the expenses and compensation of the Commissioner. The charges and expenses shall be reasonable as determined by the Commissioner and in accordance with guidelines established by the NAIC set forth in the NAIC Examiners' Handbook. The refusal of any HMO to submit to examination, or the failure of any HMO to pay the expenses of examination upon presentation by the Commissioner of a bill for those expenses, is grounds for the revocation, suspension, or refusal of a license. The Commissioner may make public any such revocation, suspension, or refusal of license and may give reasons for that action. The Commissioner shall promptly begin a civil action to recover the expenses of examination against any HMO that refuses or fails to pay.

(d) The provisions of G.S. 58-2-160 apply to examinations conducted under the HMO Examination Law."

Sec. 13. G.S. 58-67-140 is amended by adding the following new subsection:

"(e) The provisions of Article 30 of this Chapter are incorporated by reference into this Article."

Sec. 14. G.S. 58-67-180 reads as rewritten:

"**§ 58-67-180. Confidentiality of medical ~~information.~~ information; peer review committees.**

(a) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any HMO shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Article; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the HMO wherein such data or information is pertinent. An HMO shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the HMO is entitled to claim.

(b) As used in this section, 'peer review committee' means a committee of duly licensed health care providers of an HMO licensed under this Article that is formed for the purpose of evaluating the quality of, cost of, or necessity for hospitalization or health care, including provider credentialing.

(c) A member of a duly appointed peer review committee who acts without malice or fraud is not subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(d) The proceedings of a peer review committee, the records and materials it produces, and the materials it considers are confidential and not considered public records within the meaning of G.S. 132-1 or G.S. 58-2-100, and are not subject to discovery or introduction into evidence in any civil action against a hospital or provider of professional health services or an HMO licensed under this Chapter that results from matters that are the subject of evaluation and review by the peer review committee. No

person who was in attendance at any meeting of a peer review committee is required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the peer review committee or as to any findings, recommendations, evaluations, opinions, or other actions of the peer review committee or its members. Information, documents, or records otherwise available are not immune from discovery or use in a civil action solely because they were presented during proceedings of a peer review committee. A member of a peer review committee may testify in a civil action but shall not be asked about his testimony before the peer review committee or any opinions that the member formed as a result of the peer review committee hearings. The proceedings of a peer review committee, the records and materials it produces, and the materials it considers are available for examination by the Commissioner."

Sec. 15. Article 67 of Chapter 58 of the General Statutes is amended by adding the following new section:

"**§ 58-67-190. Provider contracting.**

(a) An HMO may contract for primary care and specialty care within its service area. For services other than services provided by a primary care physician, an HMO may also contract for services in accordance with the approved standard or model forms which will be provided to its providers outside the service area. If an enrollee is sent to the contracted out-of-area provider, the HMO shall document in writing that the provision of services by that provider is necessary or appropriate to the provision of quality health care services and not unduly burdensome to the enrollee. The documentation will be prepared pursuant to medical case management procedures adopted by the HMO.

(b) Each HMO shall execute a written contract with all physicians, hospitals, and other health care providers listed by the HMO as network or participating providers; except those providers employed by or under contract with intermediary provider organizations contracting with the HMO. The contract shall include the provisions listed in subsection (c) of this section. Each contract shall be fully and completely executed, and each physician, hospital, or other health care provider shall be credentialed before the provider is listed as a network or participating provider in the HMO's provider director, marketing materials, member materials, or in response to a request for proposal or other inquiry from an employer or employer organization; provided, however, a physician or other health care practitioner, may be listed in such directories, materials, or responses prior to being credentialed, if the listing clearly designates such provider as pending approval of credentials.

(c) All contracts subject to this section shall, at a minimum, contain provisions:

(1) Requiring the provider to maintain the confidentiality of enrollees' medical information.

(2) Requiring the provider not to discriminate on the basis of race, color, national origin, sex, age, religion, marital status, or health status.

(3) Requiring the HMO to make available to the provider a process to appeal contract disputes.

(4) Requiring the HMO to make available to the provider a description of the HMO's terms, definitions, and methods of operation applicable to the provision of covered services to enrollees.

(5) Allowing the HMO to terminate the contract when the HMO reasonably determines that continuation of the contract may adversely affect enrollee care.

(6) Whereby the provider warrants that the provider is:

a. Currently licensed to practice in the fields and jurisdictions listed by the provider in the HMO's provider applications.

b. Covered by adequate levels of general and professional liability insurance or an adequate level of self-funded coverage satisfactory to the Commissioner.

c. Privileged as a member in good standing of the medical staff of a participating hospital, if applicable.

(7) Whereby the provider agrees to notify the HMO immediately of any changes in the status of the provider's license, certification(s), liability coverage, or hospital privilege status.

(8) Requiring the provider to participate in and cooperate fully with the HMO's utilization management, quality management, and credentialing programs.

(9) Requiring the provider to maintain adequate medical records, to make such records available to the HMO for the purpose of conducting its utilization management, quality management, and credentialing programs, and to make such records available as required by law to the Commissioner in conjunction with an examination of the affairs of the HMO or an investigation of enrollee grievances or complaints.

(10) Whereby the provider agrees that all professional decisions, judgments, treatments, and diagnoses, and other professional services delivered to enrollees by the provider are the provider's sole responsibility.

(11) Stating that the contract is not assignable by the participating provider without the written consent of the HMO.

(12) Stating that the contract and attached amendments or exhibits represent the full and complete agreement between the HMO and the contract provider, or the subcontracting intermediary contractor and the contracting provider.

(13) Applicable to primary care provider contracts requiring the primary care physician to provide or make available 24-hour per day, seven-day per week coverage of Emergency Care Services consistent with the HMO's accessibility plan and marketing materials.

(d) This section applies to all provider contracts entered into on and after January 1, 1994; provided that existing contracts may remain in force until providers are recredentialed or recontracted, but no later than January 1, 1996."

Sec. 16. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-193. Contracting with intermediary provider organizations.**

When an HMO contracts with an independent practice association, a single service HMO, preferred provider organization, medical group that subcontracts with other providers, or hospital-physician organization, the contract shall include:

(1) A requirement that each contract between the intermediary organization and participating providers contain all applicable provisions required by G.S. 58-67-190(c).

(2) Acknowledgment that the contract shall not relieve the HMO of its responsibility to oversee the provision of health care services to its enrollees and that when the HMO delegates responsibility for credentialing, utilization management, quality management, or claims payment to the intermediary organization, the HMO shall review annually the intermediary's plans, policies, and procedures pertaining to each of the delegated services or programs.

(3) A requirement that the intermediary organization maintain copies of all of its health care subcontracts at its principal place of business in a manner that facilitates regulatory review; or shall provide access to all such subcontracts and obtain copies to facilitate regulatory review upon 20 business days prior written notice.

(4) A requirement that the intermediary organization shall:

a. Provide to the HMO, upon its request, utilization and claims paid documentation and information about the timeliness and appropriateness of payment and services received by HMO enrollees.

b. Provide access to the Commissioner to all books, records, documentation, and contracts relating to covered services provided to the HMO's enrollees as required by law.

c. Maintain at its principal place of business, for a period of four years, copies of all contracts into which it enters with physicians, hospitals, health care provider organizations, or other health care providers for covered services to enrollees.

(5) A provision whereby the intermediary provider organization warrants that the physicians or other health care practitioners it will utilize to provide covered services to enrollees are, or before the rendition of services to enrollees will be, properly credentialed by the HMO's credentialing processes, or properly credentialed by the credentialing processes of the intermediary provider organization, consistent with the requirements of G.S. 58-67-194."

Sec. 16.1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-194. Credentialing.**

An HMO, or an entity to whom the credentialing function has been contractually delegated, shall:

(1) Credential, or cause to be credentialed, all physicians and, where appropriate, other health care providers before a contract becomes effective and before such providers are listed as participating providers in HMO marketing and member materials;

(2) Employ or contract with an individual to whom responsibility for the HMO's credentialing program has been delegated. The HMO shall employ or contract with a licensed physician who shall have substantial involvement in the HMO's credentialing program;

(3) Develop or adopt a credentialing plan that specifies criteria for participation in the plan and provides policies and procedures for reviewing provider applications;

(4) Designate a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions;

(5) Require a credentialing application to be completed, on a form approved by the Commissioner, by each applicant. The application shall include specifics relating to call coverage, education and training history, professional affiliations, hospital affiliation, level of general and professional liability coverage, Drug Enforcement Administration (DEA) registration number, medical references, medical and legal liability history, and privileges desired;

(6) Verify the following information provided in the credentialing application, where applicable:

a. Applicant's license to practice medicine or other health care service in North Carolina;

b. Applicant's specialty board certification(s) status;

c. Applicant's general and professional liability coverage;

d. Applicant's malpractice history from all medical licensing boards or a report from a National Practitioner Data Bank query;

e. The status of applicant's hospital privileges.

(7) Maintain full and complete documentation of its credentialing activities including:

a. A signed and dated credentialing application;

b. All required verifications;

c. A signed and dated provider contract;

d. Responses to professional database queries or all medical licensing boards;

e. All correspondence relating to credentialing, if any;

f. Documentation of credentialing committee action;

g. A copy of applicant's notification of acceptance or rejection.

(8) Recredential all participating providers every two years;

(9) The requirements of this section shall be waived by the Commissioner for any HMO that has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner, provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. The HMO shall file with the Department a copy of the initial certification of accreditation and all subsequent recertifications;

(10) This section applies to all provider contracts entered into on or after January 1, 1994, provided existing contracts may remain in force until such time as providers are recredentialed or contracts are renegotiated, but no later than January 1, 1995."

Sec. 16.2. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-195. Requirements for provider availability and accessibility.**

(a) Each HMO shall establish, document, and maintain adequate arrangements to provide health services for its enrollees, without delays detrimental to the enrollees' health consistent with standards of a nationally recognized accrediting body satisfactory to the Commissioner, including:

(1) Reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

(2) Reasonable hours of operation and after-hours services;

(3) Emergency care services available and accessible within the service area 24 hours per day, seven days per week;

(4) Sufficient providers, personnel, administrators, and support staff to assure that all services contracted for will be accessible to enrollees on an appropriate basis.

(b) The HMO shall make available a method by which medically necessary in-plan covered services which are not available from or through providers under contract with the HMO are provided to enrollees upon prior authorization or referral by the HMO.

(c) The HMO shall make provision to pay the usual and reasonable charges for covered emergency services provided outside the HMO's approved service area.

(d) The HMO shall provide information to enrollees on covered benefits and services, limitations and exclusions including the procedures for obtaining out-of-plan coverage."

Sec. 17. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-197. Requirement for enrollee complaint and grievance procedure.**

Each HMO shall have a timely and organized system for resolving members' formal written complaints and grievances, including:

(1) Procedures for registering and responding to formal, written complaints and grievances in a timely fashion, not to exceed 30 days

after the date on which all relevant information is received by the HMO;

(2) Documentation of the substance of complaints, grievances, and actions taken;

(3) Procedures to ensure a resolution of the complaint or grievance;

(4) Aggregation and analysis of complaint and grievance data and use of the data for quality improvement;

(5) An appeal process for grievances that includes at least the following:

a. The member has a right to a review by a grievance panel;

b. The member has a right to a second review with different individuals;

c. At least one of the levels of review permits the member to appear before the panel;

d. There is an expedited procedure for emergency cases.

(6) The requirements of this section shall be waived by the Commissioner for any HMO which has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner, provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. The HMO shall file with the Department a copy of the initial certification of accreditation and all subsequent recertifications."

Sec. 18. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-200. Quality management; quality assurance program.**

(a) Each HMO or an entity to whom the quality management function has been contractually delegated shall establish procedures to assure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

(b) Each HMO or an entity to whom the quality management function has been contractually delegated shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan that describes the following:

a. The HMO's scope and purpose in quality assurance;

b. The organizational structure responsible for quality assurance activities;

c. Contractual arrangements, where appropriate, for delegation of quality assurance activities;
d. Confidentiality policies and procedures;
e. A system of ongoing evaluation activities;
f. A system of focused evaluation activities;
g. A system for credentialing providers and performing peer review activities;
h. Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(3) A written statement describing the system of ongoing quality assurance activities including:
a. Problem assessment, identification, selection, and study;
b. Corrective action, monitoring, evaluation, and reassessment;
c. Interpretation and analysis of patterns of care rendered to individual patients by individual providers.

(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format;

(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

(c) The HMO shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. The quality assurance program and minutes shall be available to the Commissioner but shall not be public records.

(d) The HMO shall require the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the Commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the Commissioner but will not be public records.

(f) The HMO shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate HMO staff.

(g) The requirements of this section shall be waived by the Commissioner for any HMO which has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner, provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. The HMO shall file with the

Department a copy of the initial certification of accreditation and all subsequent recertifications.

(h) This section shall be applicable to all Quality Management Programs initiated on or after January 1, 1994, provided existing programs may remain in force until January 1, 1995."

Sec. 19. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-210. Utilization management.**

(a) Each HMO shall have a utilization management program description that describes both delegated and nondelegated activities.

(b) The utilization management program description shall include, at a minimum, policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services, and a mechanism for updating the utilization management program description on a periodic basis, which is specified by the HMO.

(c) The requirements of this section shall be waived by the Commissioner for any HMO that has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner, provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. The HMO shall file with the Department a copy of the initial certification or accreditation and all subsequent recertifications.

(d) This section shall be applicable to all Utilization Management Programs initiated on or after January 1, 1994, provided existing programs may remain in force until January 1, 1995."

Sec. 20. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-225. HMO business names, emblems, insignias, etc.**

Every HMO must conduct its business in the State in, and the contracts and evidences of coverage issued by it shall be headed or entitled only by, its proper corporate name. There shall not appear on the face of the master group contract or evidence of coverage or on its filing back anything that would indicate that it is the obligation of any other than the HMO responsible for the coverage, though it will be permissible to stamp or print on the bottom of the filing back, the name or names of the department or general agency issuing the same, and the group of companies with which the HMO is financially affiliated. The use of any emblem, insignia, or anything other than the true, proper, corporate name of the HMO shall be permitted only with the approval of the Commissioner."

Sec. 21. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-230. HMO maintaining office in State required to qualify and secure license.**

Any HMO issuing contracts or maintaining a principal, branch, or other office within this State, whether soliciting prepaid, capitated, health care business in this State

or in other states, shall qualify under the provisions of this Article and secure a license from the Commissioner as provided in this Article. Any officer or agent of any such corporation or association that maintains offices within this State and fails to qualify and secure a license as provided in this Article is guilty of a misdemeanor and upon conviction shall be fined or imprisoned, or both, in the discretion of the court."

Sec. 22. The provisions of G.S. 58-51-45 apply to HMOs.

Sec. 23. G.S. 58-50-50 is amended by designating the present paragraph as subsection (a) and by adding the following:

"(b) As used in subsection (a) of this section, 'special reimbursement' includes any fee-for-service or discounted fee-for-service arrangement.

(c) As used in this Article, 'PPO' means a preferred provider contract, organization, plan, or arrangement.

(d) As used in this Article, 'EPP' means an exclusive provider panel."

Sec. 24. G.S. 58-50-55(a) reads as rewritten:

"(a) Notwithstanding any other provisions of law, except the second and third paragraphs of G.S. 58-50-30, corporations organized pursuant to Articles 1 through 64 of this Chapter are authorized ~~to enter into preferred provider contracts in addition to all other contracts authorized by Articles 1 through 64 of this Chapter, or~~ to enter into cost containment arrangements approved by the Commissioner, with persons, entities or organizations for the purpose of reducing the cost of providing health care services. Such preferred provider contracts may be entered into with licensed institutions and practitioners of all types without regard to specialty of services or limitation to a specific type of practice. All persons, including corporations organized pursuant to Articles 1 through 64 of this Chapter, shall apply to the Commissioner for a license to operate a preferred provider organization in order to enter into fee-for-service or discounted fee-for-service contracts, in addition to all other contracts authorized by Articles 1 through 64 of this Chapter."

Sec. 25. G.S. 58-50-55(c) is repealed.

Sec. 26. G.S. 58-55-50 is amended by adding the following:

"(c1) No person shall act as, offer to act as, or hold himself out as a PPO in this State without a valid PPO license issued by the Commissioner."

Sec. 27. G.S. 58-50-55(d) reads as rewritten:

"(d) A person enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan. The preferred provider plan may, however, limit the coverage for health care services obtained from a provider not participating in the plan, except that payments for services rendered by such non-participating providers may not be reduced by more than ~~twenty percent (20%)~~ forty percent (40%) of payments that would be made to participating providers under coverage for the same services. If the schedule of benefits offered in conjunction with the preferred provider plan imposes deductibles, the amount of any annual deductible per enrollee or per family may not exceed five times the amount of the corresponding annual deductible offered in conjunction with the preferred provider panel, nor may the amount of the deductible offered in conjunction with the preferred provider panel exceed two thousand dollars ($2,000) per individual or six thousand dollars ($6,000) for

a family. The lifetime maximum amount of coverage offered in conjunction with a preferred provider panel may be up to twice the amount of the lifetime coverage offered in conjunction with non-participating providers. ~~This percentage limitation shall not require any waiver of copayments or waiver of deductibles in determining payments for services rendered by non-participating providers.~~ Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating ~~providers.~~ providers; and shall not contain any requirements, except as provided in this section, that limit the choice of access to participating or non-participating providers. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by non-participating providers. Except as provided in this subsection, such payment may differ from that provided to participating providers in the discretion of the corporation. Non-participating providers may participate in other arrangements with the preferred provider, but will be subject to the provider's approved reimbursement mechanisms including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services."

Sec. 28. (a) Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-51. Preferred provider license requirements.**

(a) Each application for the issuance or renewal of a license shall be made on a form prescribed by the Commissioner.

(b) Applications for issuance of licenses shall include:

(1) All organizational documents, if any, of the PPO and any amendments thereto;

(2) The bylaws, rules, regulations, policies, and procedures that govern the internal operations of the PPO;

(3) The names, addresses, official positions, and professional qualifications of the individuals responsible for the operation of the PPO, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers or management;

(4) A general description of the business operations, including information on staffing levels and activities proposed in this State;

(5) A copy of any contract form made or to be made by the applicant on behalf of or by the PPO with any provider or subcontracted provider;

(6) A copy of any contract or agreement made or to be made by the applicant on behalf of or by the PPO with any person providing management services;

(7) A copy of the applicant's credentialing policies and procedures, quality assurance policies and procedures, and utilization management or review policies and procedures, and internal grievance policies and procedures;

(8) Financial statements audited by independent certified public accountants showing the applicant's assets, liabilities, and sources of

financial support. A copy of the applicant's most recent regular certified financial statement satisfies this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this section;

(9) A financial feasibility plan that includes sufficient detail to allow the Commissioner to determine if the proposed operation of the PPO will not have a hazardous effect on the applicant or the citizens of this State that would be participating in the applicant's PPO; and

(10) Such other information that the Commissioner requires to make determinations required in subsection (d) of this section.

(c) A PPO shall file a notice describing in detail any significant modification of the operations set out in the information required in this section. Such notice shall be filed with the Commissioner before the modification. If the Commissioner does not disapprove within 90 days after the filing, the modification shall be deemed to be approved. Modifications to be included in this requirement include, but are not limited to, material changes in the provider network, credentialing process, or contracts with providers. Every PPO shall file with the Commissioner all subsequent changes in the information or forms that are required by this section to be filed with the Commissioner.

(d) Before issuing any license, the Commissioner may make such examinations or investigations he deems to be necessary, including the requirement that a site visit be conducted before the approval of a license to operate a PPO. The site visit will be scheduled within 45 days after the application for a license. The cost of the prelicensing site visit, if any, will be paid by the applicant.

(e) The Commissioner shall issue a license to the applicant to operate a PPO upon receiving sufficient information that the PPO will operate in compliance with the statutes and rules of this State and upon being satisfied that the operation of the PPO will not have a hazardous financial result on the applicant.

(f) The Commissioner may deny, suspend, or revoke a license to operate a PPO if the Commissioner finds that the PPO:

(1) Is being operated by an insolvent insurer;

(2) Is using such methods and practices in the conduct of its business as to render its further transaction of business in this State hazardous or injurious to its participants or to the public;

(3) Is operating in violation of any applicable statutes or rules of this State, or has violated any lawful order of the Commissioner; or

(4) Has refused to produce materials or files for examination pursuant to G.S. 58-2-131."

(b) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-52. Prohibited practices.**

(a) No PPO or representative thereof shall cause or knowingly permit the use of advertising that is untrue or misleading or any solicitation that is untrue or misleading. For the purposes of this Article:

(1) A statement or item of information is untrue if it does not conform to fact in any respect that is or may be significant to a person considering contracting with the PPO;
(2) Article 63 of this Chapter applies to PPOs, except to the extent that the Commissioner determines that the nature of PPOs renders that Article clearly inappropriate; and
(3) No PPO may use in its name, contracts, or literature any of the words 'health maintenance organization', 'HMO', 'HMO-like', 'capitation', 'withholds', or any other of the words descriptive of a health maintenance organization or deceptively similar to the name or business of a health maintenance organization, nor may it hold itself out or represent itself as being an insurance company."

(c) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-53. Powers of PPOs.**

PPOs may contract with providers on a fee-for-service or discounted fee-for-service basis for the provision of health care services, and may also contract with:

(1) Any person or any licensed health insurance company for the provision of health care benefits;
(2) A licensed hospital or medical service corporation for the provision of health care benefits;
(3) A self-insured, single employer, or an employee benefit plan preempted from State insurance regulation by the Employee Retirement Income Security Act of 1974, for the provision of health care to its employees and dependents; or
(4) Any person for the performance on its behalf of certain functions such as marketing, management information systems, quality assurance and utilization review, and other similar services. However, if the PPO subcontracts any element of its business to a third party, the PPO will still retain the responsibility for regular monitoring of the delegated responsibilities and the regulatory compliance of its total operations."

(d) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-56. Exclusive provider panels.**

(a) No person may establish or operate an exclusive provider panel in this State or sell or offer to sell or solicit offers to purchase or receive advance or periodic consideration in conjunction with an EPP without first obtaining a license from the Commissioner to operate an EPP, as a line of business of an insurer organized under Articles 1 through 64 of this Chapter.

(b) Insurers organized under Articles 1 through 64 of this Chapter may apply for a license to operate an EPP as a line of business by submitting to the Commissioner:

(1) An application on a form approved by the Commissioner and executed by an officer of the applicant insurer;

(2) A copy of the basic organizational documents of the EPP, if any, and all amendments thereto;
(3) A copy of the bylaws, rules, and regulations or similar documents regulating the internal conduct of the EPP, if any;
(4) A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the proposed EPP;
(5) A copy of any contract or subcontract form made or to be made between any class of providers and the proposed EPP and a copy of any contract made by or on behalf of the proposed EPP and any third party for the purpose of providing marketing or administrative services to the proposed EPP;
(6) A statement generally describing the proposed EPP, its health care delivery system, and personnel;
(7) A copy of the group or individual contract and evidences of coverage that will be issued in conjunction with the proposed EPP;
(8) A financial statement and financial feasibility plan, satisfactory to the Commissioner, showing the financial effect of the proposed EPP line of business on the applicant insurer;
(9) A detailed explanation of the premium rating methodologies to be used in conjunction with the proposed EPP;
(10) A description of the internal grievance procedures to be used in conjunction with the proposed EPP;
(11) A description of the credentialing program, utilization management or review program, and the quality assurance program to be used in conjunction with the proposed EPP; and
(12) Such other information the Commissioner requires to determine the potential compliance of the proposed EPP with applicable rules and statutes of this State.

(c) Before issuing a license to operate an EPP to an insurer, the Commissioner may make such examinations and investigations, at the applicant's expense, as he deems to be reasonable and expedient. The Commissioner shall issue a license to operate an EPP to an insurer upon being satisfied on the following:
(1) The applicant is a bona fide insurer;
(2) The applicant has submitted sufficient documentation in subsection (b) of this section to assure the Commissioner that the proposed EPP will operate in compliance with the statutes and rules of this State;
(3) The operations of the proposed EPP as a line of business of the applicant insurer will not have a hazardous effect on the solvency of the applicant insurer; and
(4) The rates and benefits of the proposed EPP are fair and reasonable.

(d) An insurer operating a duly licensed EPP shall file a notice describing any significant modification of the operation set out in the information required in subsection (b) of this section. Such notices shall be filed with the Commissioner before the modification. If the Commissioner does not disapprove within 90 days after the

filing, the modification shall be deemed to be approved. Changes subject to this section include changes in provider contract forms and any other changes described in adopted administrative rules. Every EPP shall promptly report to the Commissioner when it knows of the potential of changes, deletions, or additions to the contracted provider panel that would be greater than ten percent (10%) of the total providers participating in the EPP or any other significant changes in the provider panel that would impair the EPP's ability to arrange for the delivery of health care services.

(e) The license to operate an EPP as a line of business of an insurer is subject to renewal on the first day of July of each year. Requests for renewal of such licenses will be made to the Commissioner on forms approved by the Commissioner and will be subject to the continued operations of the EPP and its duly licensed insurer in compliance with the statutes and rules of this State.

(f) The Commissioner may suspend or revoke any license to operate an EPP if he finds that any of the following conditions exist:

(1) The EPP is operating in a manner contrary to that described in and reasonably inferred from information submitted in the application process or subsequent amendments thereof or any other information submitted to the Commissioner concerning the operations of an EPP or the insurer licensed to operate the EPP;

(2) Contracts, benefits, or schedules of premiums are issued in conjunction with the operation of an EPP that have not been approved by the Commissioner before their use;

(3) The insurer licensed to operate the EPP or the EPP has represented itself in an untrue, unfair, deceptive, or misleading manner;

(4) The continued operation of the EPP would be hazardous to the citizens of the State or the insurer licensed to operate the EPP; or

(5) The insurer licensed to operate the EPP has otherwise failed to substantially comply with applicable statutes or rules.

(g) When the license to operate an EPP is suspended, the EPP and the insurer licensed to operate the EPP shall not contract to cover any additional groups or individuals except newborn children or other newly acquired dependents of existing covered employees or spouses thereof of participating employer groups in an EPP, and shall not engage in any sales, marketing, or soliciting activities for an EPP.

(h) When the license to operate an EPP is revoked, the insurer licensed to operate the EPP shall immediately proceed to terminate the affairs of its EPP and shall conduct no further EPP business except that approved by the Commissioner as essential to the orderly conclusion of the EPP's affairs.

(i) Any person who operates an EPP in this State without a license issued by the Commissioner is subject to G.S. 58-2-70.

(j) This section does not apply to any EPP to the extent that the Employee Retirement Income Security Act of 1974 preempts State regulation.

(k) The Commissioner may adopt rules governing the operations of EPPs."

(e) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-57. Prohibited practices of exclusive provider panels.**

(a) No EPP may be offered in conjunction with a benefit plan in which:

(1) The policy requires that a covered person pay more than a forty percent (40%) differential between the exclusive provider panel benefit and the non-participating provider benefit;

(2) The non-participating provider deductible is more than five times greater than the exclusive provider panel deductible;

(3) The annual individual out-of-plan deductible exceeds two thousand dollars ($2,000) and the total family out-of-plan deductible exceeds three times that of the individual out-of-plan deductible;

(4) The out-of-plan maximum lifetime benefit is less than one-half of the in-plan maximum lifetime benefit; and

(5) Where the exclusive provider panel includes copayments, the difference between the in-plan and out-of-plan copayment exceeds fifty dollars ($50.00) or one hundred percent (100%)."

(f) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-160. Managed Care Operations Act; finding; purpose; scope.**

(a) This section and G.S. 58-50-165 through G.S. 58-50-205 are known and may be cited as the 'Managed Care Operations Act', referred to in those sections as 'this Act'.

(b) The General Assembly finds that in order to deliver high quality, cost-effective health care benefits, the health insurance industry has by necessity evolved to contain elements of managed care, which include utilization management, quality assurance, provider contracting, and provider credentialing. The purpose of this Act is to provide a uniform set of standards to govern the development, implementation, and operation of all types of managed care plans providing health care benefits to individuals in North Carolina and to ensure that the quality of care and quality of service provided is preserved and enhanced.

(c) This Act applies to all preferred provider organizations licensed under G.S. 58-50-55 and G.S. 58-65-140; all exclusive provider panels organized under G.S. 58-50-56 and G.S. 58-65-142; all utilization review companies; all exclusive provider panels; all insurance companies organized under Articles 1 through 64, and corporations organized under Article 65 of this Chapter that meet the definition of a managed care plan used in this Act. This Act does not apply to any employee benefit plan to the extent that the Employee Retirement Income Security Act of 1974 preempts State regulation."

(g) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-165. Definitions.**

As used in this Article,

(1) 'Capitation' means the practice of prepaying a contracted provider or a group of contracted providers for the health care services of a defined population on a per capita basis.

(2) 'Coinsurance' means the portion of each covered service, calculated as a percentage of the cost of such service, which is to be paid by the enrollee.

(3) 'Copayment' means a fixed-dollar payment made by the enrollee, which is collected by the provider at the time the service is delivered.

(4) 'Covered service' means those health care benefits to which an enrollee is entitled and for which a managed care plan provides or arranges health care services as specified under the enrollee's evidence of coverage, master group contract, or certificate of coverage.

(5) 'Deductible' means the amount of money, specified as a fixed-dollar amount, that an individual or family must pay before covered medical services are reimbursed.

(6) 'Enrollee' means an individual who is covered by a managed care plan.

(7) 'Emergency' means an unforeseen illness, or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or unforeseen medical emergencies of a life-threatening nature, or which would result in the serious impairment of bodily functions if treatment were not rendered immediately.

(8) 'Exclusive provider panel' or 'EPP' means a managed care plan organized under G.S. 58-50-56 or G.S. 58-65-142 that provides nonemergency, prepaid, covered health care services only through a contracted panel of participating providers.

(9) 'In-plan covered services' means covered health care services obtained from providers who are employed by, under contract or subcontract with, or referred by the managed care plan; and means emergency services.

(10) 'Medical director' means a duly licensed physician who has been hired or contracted by the plan to monitor the provision of covered services to enrollees.

(11) 'Medically necessary' or a 'medical necessity' means, for the purposes of payment, covered services and supplies that are:

a. Provided for the diagnosis or care and treatment of a medical condition;

b. Necessary for and appropriate to the symptoms, diagnosis, or treatment of a medical condition;

c. Within generally accepted standards of medical care;

d. Not primarily for the convenience of the member, his family, or the provider; and

e. Performed in the most cost-effective setting and manner appropriate to treat the patient's medical condition.

(l2) 'Out-of-plan covered services' means nonemergency, self-referred, covered health care services obtained from providers who are not

otherwise employed by or under contract with the plan; or services obtained from an affiliated specialist without plan authorization.

(13) 'Participating provider' means a physician or other health care provider, or a group of physicians or health care providers, or a medical facility, program, or agency that has a contractual arrangement with the plan to provide specified covered health care services to enrollees.

(14) 'Plan' means a managed care plan.

(15) 'Point-of-service plan' means a plan or insurance product that includes in-plan and out-of-plan covered services that provide or reimburse at different benefit levels.

(16) 'Preferred Provider Organization' or 'PPO' means a type of health plan that may be offered by an insurance company, a hospital or medical service corporation, or arranged by a self-funded employer for the sole use of its employees and dependents, which is characterized by all or most of the following features:

a. Services are provided by a network of contract providers who are paid on a negotiated or discounted fee-for-service basis,

b. Enrollees are offered incentives to limit care to the panel of contract providers,

c. Utilization and quality management programs are employed to manage care, and

d. No transfer of insurance risk to providers through capitated payment arrangements, fee withholds, or other risk-sharing arrangements.

(17) 'Primary care physician' means a physician duly licensed to practice medicine in the fields of general and family practice, general internal medicine, or pediatrics.

(18) 'Quality management (quality assurance)' means a program of reviews, studies, evaluations, and other activities employed by the plan for the purpose of monitoring and enhancing quality of health care and services provided to enrollees.

(19) 'Urgent care' means services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that in the absence of immediate care the individual could reasonably be expected to suffer an extended illness, prolonged impairment, or require a more hazardous treatment.

(20) 'Utilization management (utilization review)' means those methodologies used by managed care plans and utilization review organizations to improve the quality and maximize the efficiency of the health care delivery system.

(21) 'Withholds (risk reserves, physician incentive pools)', as a noun, means the contractual practice of withholding a portion of a provider's claim reimbursement, or the setting aside of a preset percentage of premium

income that eventually may be payable to the provider(s) based upon a previously established set of utilization review performance standards or claims dollar volumes."

(h) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-170. Requirements for provider contracting.**

(a) Each plan shall execute a written contract with all physicians, hospitals, and other health care practitioners listed by the plan as network or participating providers (except those providers employed by or under contract with intermediary provider organizations contracting with the plan). Such contract shall include the provisions listed in subsection (b) of this section. Each contract shall be fully and completely executed, and each physician or other health care provider shall be credentialed, before the provider is listed as a network or participating provider in the plan's provider directory, marketing materials, member materials, or in response to a request for proposal or other inquiry from an employer or employer organization.

(b) All contracts shall, at a minimum, contain the following provisions:

(1) A provision requiring the provider to maintain the confidentiality of enrollees' medical information;

(2) A provision requiring the provider not to discriminate on the basis of race, color, national origin, sex, age, religion, marital status, or health status;

(3) A provision requiring the plan to make available to the provider a grievance and appeal process;

(4) A provision requiring the plan to make available to the provider a description of the plan's terms, definitions, and methods of operation applicable to the provision of covered services to enrollees;

(5) A provision allowing the plan to terminate the contract when the plan reasonably determines that continuation of the contract may adversely affect enrollee care;

(6) A provision whereby the provider warrants that the provider is:

a. Currently licensed to practice in the fields and jurisdictions listed by the provider in the managed care plan's provider applications;

b. Covered by adequate levels of general and professional liability insurance or self-funded coverage satisfactory to the Commissioner; and

c. Privileged as a member in good standing of the medical staff of a participating hospital, if applicable.

(7) A provision whereby the provider agrees to notify the managed care plan immediately of any changes in the status of the provider's license, certification(s), liability coverage, or hospital privilege status;

(8) A provision requiring the provider to participate in and cooperate fully with the plan's utilization management, quality management, and credentialing programs;

(9) A provision requiring the provider to maintain adequate medical records, to make such records available to the managed care plan for the purpose of conducting its utilization management, quality management, and credentialing programs, and to make such records available as required by law to the Commissioner in conjunction with an examination of the affairs of the managed care plan or an investigation of enrollee grievances or complaints;

(10) A provision whereby the provider agrees that all professional decisions, judgments, treatments, and diagnoses, and other professional services delivered to enrollees by the provider are his sole responsibility;

(11) A provision stating that the contract is not assignable by the participating provider without the written consent of the managed care plan;

(12) A provision stating that the contract and attached amendments or exhibits represent the full and complete agreement between the managed care plan and the contract provider, or the subcontracting intermediary contractor and the contracting provider;

(13) A provision applicable to primary care provider contracts requiring the primary care physician provide, or make available 24 hour-per-day, seven day-per-week coverage consistent with the managed care plan's accessibility plan and marketing materials."

(i) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-175. Contracts with intermediary organizations.**

When a managed care plan contracts with an independent practice association, a single service HMO, a PPO, a medical group that subcontracts with other providers, or a hospital-physician organization, the contract shall include the following provisions:

(1) A requirement that each contract between the intermediary organization and participating providers contain all applicable provisions required by G.S. 58-50-170;

(2) Acknowledgment that the contract shall not relieve the managed care plan of its responsibility to oversee the provision of health care services to its enrollees and that when the managed care plan delegates responsibility for credentialing, utilization management, quality management, or claims payment to the intermediary organization, the managed care plan shall review annually the intermediary's plans, policies, and procedures pertaining to each of the delegated services or programs;

(3) A requirement that the intermediary organization maintains copies of all of its health care subcontracts at its principal place of business in a manner which facilitates regulatory review, or shall provide access to all such subcontracts and obtain copies to facilitate regulatory review upon 20 business days prior written notice;

(4) A requirement that organization shall:
a. Provide to the managed care plan, upon its request, utilization and claims-paid documentation and information about the timeliness and appropriateness of payment and services received by managed care plan enrollees;
b. Provide access to the Commissioner to all books, records, documentation, and contracts relating to covered services provided to the managed care plan's enrollees as required by law; and
c. Maintain at its principal place of business, for a period of four years, copies of all contracts which it enters into with physicians, hospitals, health care provider organizations, or other health care providers for covered services to enrollees.
(5) A provision whereby the intermediary provider organization warrants that the physicians or other health care providers it will use to provide covered services to enrollees are, or before the rendition of services to enrollees will be, properly credentialed by the managed care plan's credentialing processes, or properly credentialed by the credentialing processes of the intermediary provider organization, consistent with the requirements of G.S. 58-50-195."

(j) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-180. Requirements for provider availability and accessibility.**

(a) Each managed care plan shall establish, document, and maintain adequate arrangements to provide health services for its enrollees, without delays detrimental to the enrollee's health consistent with standards of a nationally-recognized accrediting body satisfactory to the Commissioner, including:
(1) Reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility.
(2) Reasonable hours of operation and after hours services.
(3) Emergency care services available and accessible within the service area 24 hours per day, seven days per week.
(4) Sufficient providers, personnel, administrators, and support staff to ensure that all services contracted for will be accessible to enrollees on an appropriate basis.

(b) The plan shall make available a method by which medically-necessary in-plan covered services which are not available from or through providers under contract with the plan are provided to enrollees upon prior authorization or referral by the plan.

(c) The plan shall make provision to pay the usual and reasonable charges for covered emergency services provided outside the plan's approved service area.

(d) The plan shall provide information to enrollees on covered benefits and services, limitations and exclusions including the procedures for obtaining out-of-plan coverage."

(k) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-185. Requirements for complaint and grievance procedure.**

Each managed care plan shall have a timely and organized system for resolving members' formal, written complaints and grievances, including:

(1) Procedures for registering and responding to formal, written complaints and grievances in a timely fashion, not to exceed 30 days after the date on which all relevant information is received by the plan.

(2) Documentation of the substance of complaints, grievances, and actions taken.

(3) Procedures to ensure a resolution of the complaint or grievance.

(4) Aggregation and analysis of complaint and grievance data and use of the data for quality improvement.

(5) An appeal process for grievances that includes at least the following:

a. The member has a right to review by the grievance panel.

b. The member has a right to a second review with different individuals.

c. At least one of the levels of review permits the member to appear before the panel.

d. There is an expedited procedure for emergency cases.

(6) The requirements of this section may be waived by the Commissioner for any plan which has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner, provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. In making such application for waiver, the plan shall file with the Commissioner a copy of the initial application for accreditation and initial certification and all subsequent reapplications and subsequent recertifications."

(l) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-190. Requirements for quality management.**

(a) Each plan or any entity to which the quality management function has been contractually delegated shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing, professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

(b) Each plan or any entity to which the quality management function has been contractually delegated shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

a. The plan's scope and purpose in quality assurance;

b. The organizational structure responsible for quality assurance activities;

c. Contractual arrangements, where appropriate, for delegation of quality assurance activities;

d. Confidentiality policies and procedures;

e. A system of ongoing evaluation activities;

f. A system of focused evaluation activities;

g. A system for credentialing providers and performing peer review activities; and

h. Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(3) A written statement describing the system of ongoing quality assurance activities including:

a. Problem assessment, identification, selection, and study;

b. Corrective action, monitoring, evaluation, and reassessment; and

c. Interpretation and analysis of patterns of care rendered to individual patients by individual providers.

(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation, and report format; and

(5) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

(c) The plan shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. The quality assurance program and minutes shall be available to the Commissioner but are not public records.

(d) The plan shall require the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the plan evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the Commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed to be necessary by the Commissioner, but are not public records.

(f) The plan shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers, and appropriate plan staff.

(g) The requirements of this section may be waived by the Commissioner for any managed care plan that has received accreditation from a nationally recognized accrediting body, satisfactory to the Commissioner; provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. In making an application for a waiver, the plan shall file with the Commissioner a copy of the initial application for accreditation and initial certification, and all subsequent reapplications and subsequent recertifications."

(m) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-195. Credentialing.**

(a) A plan or any entity to which the credentialing function has been delegated shall:

(1) Credential, or cause to be credentialed, all physicians and, where appropriate, other health care practitioners before a contract becomes effective and before such providers are listed as participating providers in plan marketing and member materials;

(2) Employ or contract with an individual to whom responsibility for the plan's credentialing program has been delegated. The plan shall employ or contract with a licensed physician who shall have substantial involvement in the plan's credentialing program;

(3) Develop or adopt a credentialing plan that specifies criteria for participation in the plan and provides policies and procedures for reviewing provider applications;

(4) Designate a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions;

(5) Require a credentialing application to be completed, on a form approved by the Commissioner, by each applicant. The application should include, but is not limited to, specifics relating to call coverage, education/training history, professional affiliations, hospital affiliation, level of general and professional liability coverage, Drug Enforcement Administration (DEA) registration number, medical references, medical/legal liability history, and privileges desired;

(6) Verify the following information provided in the credentialing application, where applicable:

a. Applicant's license to practice medicine or other health care service in North Carolina;

b. Applicant's specialty board certification(s) status;

c. Applicant's general and professional liability coverage;

d. Applicant's malpractice history and a report from a National Practitioner Data Bank query;

e. The status of applicant's hospital privileges;

(7) Maintain full and complete documentation of its credentialing activities including:

a. A signed and dated credentialing application;
b. All required verifications;
c. A signed and dated provider contract;
d. Responses to professional data base queries;
e. All correspondence relating to credentialing, if any;
f. Documentation of credentialing committee action;
g. A copy of applicant's notification of acceptance or rejection; and

(8) Recredential all participating providers every two years.

(b) The requirements of this section may be waived by the Commissioner for any plan which has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner, provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. In making such application for waiver, the plan shall file with the Commissioner a copy of the initial application for accreditation and initial certification and all subsequent reapplications and subsequent recertifications."

(n) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-200. Utilization management.**

(a) The plan shall have a utilization management program description that describes both delegated and nondelegated activities:

(1) The utilization management program description shall include, at a minimum, policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services; and

(2) A mechanism for updating the utilization management program description on a periodic basis, which is specified by the plan.

(b) The requirements of this section may be waived by the Commissioner for any plan that has received accreditation from a nationally recognized accrediting body satisfactory to the Commissioner; provided, however, that the Commissioner may decline to issue a waiver when the Commissioner finds it necessary and appropriate for the protection of enrollees or in the public interest. In making such application for waiver, the plan shall file with the Commissioner a copy of the initial application for accreditation and initial certification and all subsequent reapplications and subsequent recertifications."

Sec. 29. (a) G.S. 58-65-140 is repealed.

(b) Article 65 of Chapter 58 is amended by adding a new section to read:

"**§ 58-65-141. Preferred provider organizations.**

The provisions of G.S. 58-50-50 through G.S. 58-50-55 shall apply to corporations organized pursuant to this Article."

Sec. 30. Article 65 of Chapter 58 of the General Statutes is amended by adding the following:

"**§ 58-65-142. Exclusive provider panels.**

(a) No person may operate an exclusive provider panel ('EPP') in this State, nor sell or offer to sell or solicit offers to purchase or receive in conjunction with an EPP, advance or periodic consideration without obtaining a license from the Commissioner to operate an EPP as a line of business of a corporation organized under this Article.

(b) Corporations organized under this Article may apply for a license to operate an EPP by submitting to the Commissioner:

(1) An application on a form approved by the Commissioner and executed by an officer of the applicant corporation;

(2) A copy of the basic organizational documents of the applicant and all amendments thereto;

(3) A copy of the bylaws, rules, and regulations or similar documents regulating the internal conduct of the applicant;

(4) A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the proposed EPP;

(5) A copy of any contract or subcontract form made or to be made between any class of providers and the proposed EPP and a copy of any contract made by or on behalf of the proposed EPP and any third party for the purpose of providing marketing or administrative services to the proposed EPP;

(6) A statement generally describing the proposed EPP, its health care delivery system, and personnel;

(7) A copy of the group or individual contract and evidences of coverage that will be issued in conjunction with the proposed EPP;

(8) A financial statement and financial feasibility plan, satisfactory to the Commissioner, showing the financial impact of the proposed EPP line of business on the applicant corporation;

(9) A detailed explanation of the premium rating methodologies to be used in conjunction with the proposed EPP;

(10) A description of the internal grievance procedures to be utilized in conjunction with the proposed EPP;

(11) A description of the credentialing program, utilization management or review program, and the quality assurance program to be used in conjunction with the proposed EPP;

(12) Such other information the Commissioner requires to determine the potential compliance of the proposed EPP with the applicable rules and statutes of this State.

(c) Before issuing a license to operate an EPP, the Commissioner may make such examinations and investigations, at the applicant's expense, as he deems expedient. The Commissioner shall issue a license upon being satisfied that:

(1) The applicant is a bona fide corporation organized pursuant to this Article;

(2) The applicant has submitted sufficient documentation in subsection (b) of this section to be assured that the proposed EPP will operate in compliance with the statutes and rules of this State;

(3) The operations of the proposed EPP as a line of business of the applicant corporation will not have a hazardous effect on the solvency of the applicant corporation; and

(4) The rates and benefits of the proposed EPP are fair and reasonable.

(d) A corporation operating a duly licensed EPP shall file a notice describing any significant modification of the operation set out in the information required in subsection (b) of this section. Such notices shall be filed with the Commissioner before 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 this section include changes in provider contract forms and any other changes described in adopted rules. Every EPP shall report to the Commissioner within 48 hours after having knowledge of the potential of changes, deletions, or additions to the contracted provider panel that would be greater than ten percent (10%) of the total providers participating in the EPP or any other significant changes in the provider panel that would impair the EPP's ability to arrange for the delivery of medical services.

(e) Each license is subject to renewal on the first day of July of each year. Requests for renewals shall be made on forms approved by the Commissioner and shall be subject to the continued operations of the EPP and its duly licensed corporation in compliance with the statutes and rules of this State.

(f) The Commissioner may suspend or revoke any license to operate an EPP if he finds that any of the following conditions exist:

(1) The EPP is operating in a manner contrary to that described in and reasonably inferred from information submitted in the application process or subsequent amendments thereof or any other information submitted to the Commissioner concerning the operations of an EPP or the corporation licensed to operate the EPP;

(2) Contracts, benefits, or schedules of premiums are issued in conjunction with the operation of an EPP that have not been approved by the Commissioner before their use;

(3) The corporation licensed to operate an EPP or the EPP has represented itself in an untrue, unfair, deceptive, or misleading manner;

(4) The continued operation of the EPP would be hazardous to the citizens of the State or the corporation licensed to operate the EPP;

(5) The corporation licensed to operate the EPP has otherwise failed to substantially comply with this Article.

(g) When a license is suspended, the EPP and the corporation licensed to operate the EPP shall not contract to cover any additional groups or individuals, except newborn children or other newly acquired dependents of existing covered employees or spouses thereof of participating employee groups in an EPP, and shall not engage in any sales, marketing, or soliciting activities for an EPP.

(h) When a license is revoked, the corporation licensed to operate the EPP shall immediately proceed to terminate the affairs of its EPP and shall conduct no further EPP business, except that approved by the Commissioner as essential to the orderly conclusion of the EPP's affairs.

(i) Any person that operates an EPP in this State without a license issued by the Commissioner is subject to G.S. 58-2-70.

(j) This section does not apply to any health maintenance organization organized under Article 67 of this Chapter or to a single employee welfare benefit plan to the extent the Employee Retirement Income Security Act of 1974 preempts State regulation.

"**§ 58-65-143. Prohibited practices of exclusive provider panels.**

(a) No EPP may be offered by a hospital or medical service corporation or its affiliates in which the benefit plan contains:

(1) A difference in coinsurance rates covered by the exclusive provider panel and the nonparticipating provider that exceeds 40 percentage points.

(2) A deductible for out-of-plan covered services that is more than five times the deductible for in-plan covered services.

(b) The total out-of-plan deductible shall not exceed two thousand dollars ($2,000) per individual and the total family deductible shall not exceed three times that of the individual.

(c) If the in-plan benefit schedule has a lifetime maximum, the out-of-plan lifetime maximum shall not be less than one-half of the in-plan lifetime maximum.

(d) Where the covered services of the exclusive provider panel contain a copayment, the difference between in-plan and out-of-plan copayments shall not exceed fifty dollars ($50.00) or one hundred percent (100%)."

Sec. 31. Sections 1 through 22 of this act become effective January 1, 1994. Sections 23 through 30 become effective October 1, 1993.