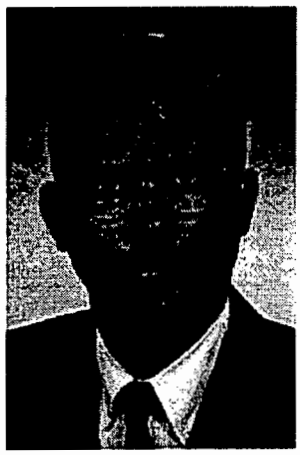
1998

HOUSE INSURANCE – HEALTH

MINUTES



Rep. Daniel McComas
Chair
Subcommittee on Health

Rep. William Wainwright
RMM

Rep. Bobby Barbee, Sr.

Rep. Joanne Bowie

Rep.Nelson Cole

Rep. Walter Dickson

Rep. Theresa Esposito

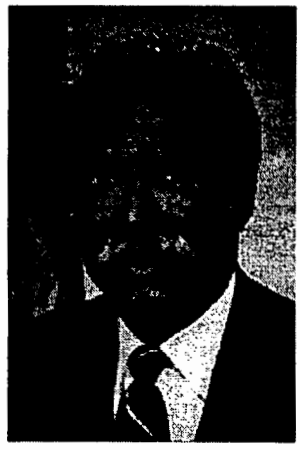
Rep. Edwin Hardy

Rep. Robert Hensley, Jr.

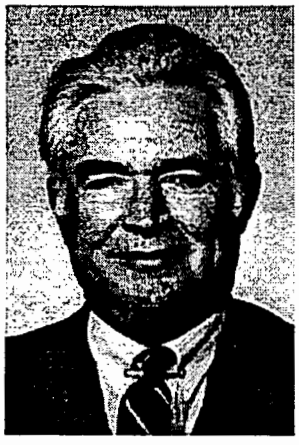
Rep. George Holmes

Rep. William Ives

Rep. Paul Luebke



Rep. Henry Michaux



Rep. George Miller

Rep. David Miner

Rep. Jean Preston

Rep. Carolyn Russell

Rep. Thomas Wright

Rep. Leo Daughtry
Majority Leader
Ex Officio

Rep. Julia Howard
Majority Whip
Ex Officio

Rep. Steve Wood
Speaker Pro Tem
Ex Officio

Subcommittee on Health 1997

HOUSE SUBCOMMITTEE ON HEALTH
1997 SESSION

MEMBER/Clerk	PHONE	OFFICE	SEAT
Rep. Daniel McComas, Chairman Dee Bagley, Committee Clerk	3-5758	2123	63
Rep. William Wainwright, RMM Denise Smith	3-5898	614	20
Rep. Bobby Barbee Rosa Murray	3-5908	1025	74
Rep. Joanne Bowie Sharon Gaudette	3-5853	1206	26
Rep. Nelson Cole Suzanne Smith	3-5779	1218	45
Rep. Walter Dickson Joyce Langdon	3-5662	530	25
Rep. Theresa Esposito Melissa Jackson	5-2530	634	5
Rep. Edwin Hardy Betty Wicham	5-3019	417A	100
Rep. Robert Hensley Margie K. Penven	3-5936	509	67
Rep. George Holmes Glenda Jacobs	3-5900	631	6
Rep. William Ives JayneWalton	3-5784	633	90
Rep. Paul Luebke Norma Bowen	3-5772	1325	44
Rep. Henry Michaux Anne Peele	3-5609	1409	57

HOUSE COMMITTEE ON HEALTH
1997 SESSION

Continued...

MEMBER/Clerk	PHONE	OFFICE	SEAT
Rep. George Miller Marian Bailey	3-5878	611	43
Rep. David Miner Susan Phillips	3-5749	2219	16
Rep. Jean Preston Sandra Ellis	5-3026	403	38
Rep. Carolyn Russell Susan Brothers	5-0875	2207	27
Rep. Thomas Wright Clarestene Stewart	3-5754	528	93
Rep. Leo Daughtry, Majority Leader (Ex Officio) Bernice Bullard	5-0850	2301	30
Rep. Julia Howard, Majority Whip (Ex Officio) Gail Stewart	3-5904	1021	8
Rep. Steve Wood, Speaker Pro Tem (Ex Officio) Sylvia Perkins	3-5807	2208	12
Rep. Jerry Dockham (Insurance Committee Chair) Joanna Mills	3-5822	1106	18
Linda Attarian, Staff Attorney	5-2578	545	
Linwood Jones, Staff Attorney	5-2578	545	
Ed Rossi, Staff Attorney	5-2578	545	

ATTENDANCE

SUBCOMMITTEE ON HEALTH

DATES	7/9	7/29	8/5											
McCOMAS, CHAIR	✓	✓	✓											
WAINWRIGHT, RMM	✓													
BARBEE	✓	✓	✓											
BOWIE	✓		✓											
COLE	✓	✓	✓											
DICKSON	✓	✓	✓											
ESPOSITO	✓	✓												
HARDY	✓	✓	✓											
HENSLEY	✓	✓	✓											
HOLMES	✓													
IVES	✓	✓	✓											
LUEBKE	✓	✓	✓											
MICHAUX			✓											
MILLER	✓	✓												
MINER	✓		✓											
PRESTON	✓	✓	✓											
RUSSELL	✓	✓												
WRIGHT	✓	✓												
DAUGHTRY (Ex Officio)														
HOWARD (Ex Officio)														
WOOD (Ex Officio)														
DOCKHAM (Insurance Com. Chair)	✓	✓	✓											

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1997-98 Regular Session — HOUSE: INSURANCE--HEALTH — Valid Through 22-OCT-1998

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 5	ALDRIDGE	HEALTH COVERAGE/DIABETES	*R -CH. SL 97-0225	04-03-97	04-30-97
H 74=	CANSLER	CREDIT FOR LONG-TERM CARE INSURANCE	*SA-REPTD FAV COM SUBSTITUTE	02-10-97	04-23-97
H 165=	REDWINE	LODGING ESTABLISHMENTS/SANITATION	*S -RE-REF COM ON CH&HUMRS	03-25-97	04-01-97
H 276	SHERRILL	REDUCE TAX ON NONPRESCRIPTION DRUGS	H -REPTD TO INS	03-25-97	03-31-97
H 291	STARNES	AUTOPSY/FAMILY NOTICE	H -REPTD TO INS	03-25-97	03-31-97
H 435	DOCKHAM	STATE HEALTH PLAN TECH. AMDS.	*R -CH. SL 97-0512	03-25-97	06-25-97
H 436	DOCKHAM	STATE HEALTH PLANS SUBSTANTIVE	H -RE-REF COM ON INS	03-25-97	06-25-97
H1223	**LUEBKE**	**FAMILY HEALTH-CARE PROGRAM**	**H -RE-REF COM ON INS-HLTH**	**06-26-97**	
H1455=	**CANSLER**	**PSO MEDICARE LICENSING**	***H -CAL PURSUANT RULE 36(A)**	**07-09-98**	**07-13-98**
S 247	RAND	REMOVE SUNSET/HLTH CONTRACT CONFID.	*R -CH. SL 97-0123	04-10-97	05-12-97
S 247	RAND	REMOVE SUNSET/HLTH CONTRACT CONFID.	*R -CH. SL 97-0123	05-13-97	05-14-97
S 254=	ODOM	GENETIC INFO/NO DISCRIMINATION	*R -CH. SL 97-0350	05-19-97	06-25-97
S 273	FORRESTER	MASTECTOMY/HOSPITAL STAY	*R -CH. SL 97-0440	03-25-97	08-06-97
S 400=	WINNER	MENTAL HEALTH PARITY	*H -ASSIGNED TO INS-HLTH	05-19-97	
S 455=	HOYLE	IMPROVE HMO SERVICES	*R -CH. SL 97-0474	05-19-97	06-25-97
S 785	MARTIN W	DIRECT PAYMENT SUNSETS OFF	R -CH. SL 97-0197	05-19-97	05-29-97
S 866=	RAND	PRESCRIPTION DRUGS/COMPETITION	*H -RE-REF COM ON INS-HLTH	05-27-97	
S1016=	MARTIN W	DIR. PAY/SUBS. ABUSE PROF.	H -ASSIGNED TO INS-HLTH	05-19-97	

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

MEMORANDUM

TO: Representative Luebke

FROM: Representative Daniel F. McComas, Chairman
INSURANCE/Subcommittee on Health

DATE: October 2, 1998

SUBJECT: HB 1223, Family Health-Care Program.

House Rule 36 speaks to reporting bills out of standing committees or permanent subcommittees by the last adjournment of the 1997-98 legislative session. -- "All House bills and resolutions **shall be reported from** the standing committee or permanent subcommittee to which referred with such recommendations as the standing committee or permanent subcommittee may desire to make **except in the case where the principal introducer requests in writing to the Chair of the standing committee or permanent subcommittee that the bill not be considered.**" If it is your intent that the bill listed above not be considered by subcommittee this legislative session, please **sign** and **date** the form and **return** it to the Subcommittee Clerk, Dee Bagley for the Committee on INSURANCE/Subcommittee on Health in Room 2123 by October 9, 1998.

oooooooooooooo

Mr. Chairman:

I request that the above-mentioned House Bill # 1223, for which I am the principal introducer, not be considered by your committee for the 1997-98 legislative session.

P Luebke (Sign)
Representative

10-6-98 (Date)

PLEASE DO NOT DETACH THE FORM FROM THE MEMORANDUM

AGENDA

HOUSE INSURANCE COMMITTEE

Subcommittee On Health

July 9, 1998
Room 643 LOB
12:00 Noon

I. **OPENING REMARKS**

Representative Daniel F. McComas, Chairman
Subcommittee on Health

II. **BILLS TO BE CONSIDERED**

SB 400, Mental Health Parity

III. **ADJOURNMENT**

HOUSE INSURANCE
SUBCOMMITTEE ON HEALTH
MINUTES

July 9, 1998

The House Insurance/Subcommittee on Health met on July 9, 1998, at 12:00 noon in Room 643 of the Legislative Office Building.

Representative Daniel F. McComas, Chairman, presided, and the following members were present:

> Representatives: Wainwright, Barbee, Bowie, Cole, Dickson, Esposito, Hardy, Hensley, Holmes, Ives, Luebke, Miller, Miner, Preston, Russel and Wright. Representative Dockham, Chairman, House Insurance Committee was also present.

Visitors present were as follows: (see Attachment 1).

Staff Counsel Linda Attarian, Linwood Jones and Ed Rossi were present to assist the Subcommittee.

Chairman McComas called the meeting to order, introduced the Pages and Sergeant-at-Arms serving the Subcommittee and welcomed guests. The following bills were considered:

> HB 1455, An Act To Create Medicare Provider Sponsored Organization Licensing. (See Attachment 2): A proposed Committee Substitute for HB 1455 was presented to the Subcommittee for consideration (see Attachment 3). Representative Dockham moved to adopt the proposed Committee Substitute for discussion. The motion passed. Representative Lanier Cansler, Bill Sponsor, was recognized to explain the bill. Representative Bowie sent forth an amendment (see Attachment 4) and moved that it be adopted. The motion passed. Representative Bowie then moved that the amendment be incorporated into the proposed committee substitute and the proposed committee substitute be given a favorable report. After some discussion and questions, Representative Bowie's motion passed. HB 1455 was reported to the House Floor as follows: (see Attachments 5 and 6).
>
> Pensions and Retirement and Insurance Committee Substitute for SB 400, An Act To Require Parity In Health Insurance For Mental Illness. (See Attachment 7): Senator Leslie Winner, Bill Sponsor, was recognized to explain the bill. A proposed House Committee Substitute was presented to the Subcommittee (see Attachment 8). Representative Bowie moved to adopt the proposed House Committee Substitute for discussion. The motion passed. Senator Winner

explained the differences in the proposed House Committee Substitute and the Senate Committee Substitute. After her explanation, Senator Winner entertained questions from the Subcommittee members.

After extensive discussion and questions, Mr. Ron Bachman, a Principal at Price, Waterhouse, Coopers, was recognized to speak. Mr. Bachman stated that he is in charge of the Health Care Consulting Practice out of their Atlanta, Georgia office. He is an Actuary with certifications of FSA (Fellow Society of Actuaries) and MAA (Member of the American Academy of Actuaries), and he acts as a broad based consultant with clients on both sides of the issue. He stressed that he was before the Subcommittee not as an advocate or lobbyist for the legislation but to give factual information and answer any questions they may have. He then proceeded with his comments and entertained questions from the Subcommittee. No action was taken on the bill during this meeting.

The meeting adjourned at 1:00 p.m.

Representative Daniel F. McComas
Subcommittee Chairman

Jane M. "Dee" Bagley
Subcommittee Clerk

ATTACHMENT 1

VISITOR REGISTRATION SHEET

House Subcommittee on Health — **July 9, 1998**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Victor Smith	NAMI Wilmington, N.C. 910-256-8063
Andy Smith	WCSR
Steve Woodson	NC Farm Bureau Federation
Tommy Worth	Carolinas HealthCare System
Joe Donovan	NAMI - North Carolina
Stephanie Almore	NAMI - NC
Kendrick Van Pelt	NAMI - NC
Timothy Lussman	NAMI - NC
Michael Cotton	DHHS/DMH
Wendy Macherd	BCBSNC
Ken Wright	BCBSNC
Barrett Brewer	Capital Strategies

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

HOUSE BILL 1455*

Short Title: PSO Medicare Licensing. (Public)

Sponsors: Representatives Cansler and Bowie.

Referred to: Insurance, if favorable, Finance.

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 17.

"Provider Sponsored Organization Licensing.

"**§ 131E-275. General provisions.**

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer health insurance or health benefits coverage in each State in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Department of Health and Human Services, acting through the Medical Care Commission. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of Health Care Services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that the organizers and operators of provider sponsored

organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 or the insurance laws of this State, unless otherwise specified in this Article.

(b) As set forth in this Article, the Department of Health and Human Services, acting through the Medical Care Commission, shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Department or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries.

"**§ 131E-276. Definitions.**

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

(1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina.

(3) 'Current assets' means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.

(4) 'Current liabilities' means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.

(5) 'Current ratio' means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.

(6) 'Department' means the Department of Health and Human Services acting through the North Carolina Medical Care Commission.

(7) 'Emergency services' shall have the same meaning as for that term defined in G.S. 58-50-61(a)(5).

(8) 'Health Care Delivery Assets' means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.

(9) 'Health plan contract' or 'Medicare contract' means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.

(10) 'Out-of-network services' means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

(11) 'Parent of a sponsoring provider' means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.

(12) 'Provider' or 'health care provider' means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.

(13) 'Provider sponsored organization' or 'PSO' means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic: (i) that is established or organized by a health care provider or group of affiliated health care providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; (iii) that provides a substantial proportion of the services under each Medicare contract directly through the provider or group of affiliated providers; and (iv) in which the provider or affiliated providers directly or indirectly share substantial financial risk and have at least a majority financial interest. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body.

(14) 'Secretary' means the Secretary of the Department of Health and Human Services.

(15) 'Sponsoring providers' of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.

(16) 'Substantial proportion of the services', as that term is used in G.S. 131E-276(n) and G.S. 131E-309(a), means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual cost of health care services.

(17) A health care provider is affiliated with another provider if through contract, ownership, or otherwise, when: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.

"**§ 131E-277. Direct or indirect sharing of substantial financial risk.**

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

(1) Provide services under its Medicare contract at a capitated rate;

(2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;

(3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment goals either by:

a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or

b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; or

(4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring providers in different specialties offering a complementary mix of

services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or

(5) Agree to any other arrangement that the Department determines to provide for the sharing of substantial financial risk by the sponsoring providers.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

"§ 131E-278. Applicability of other laws.

(a) Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes.

"§ 131E-279. Approval.

(a) Unless otherwise required by federal law, the Department shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare + Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2), or any successor thereof, and which otherwise meet the requirements of the PSO's Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Department's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G), or any successor thereof, or the PSO's Medicare contract.

(c) The Department shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Department not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Department receives an application for licensing, the Department shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Department will explain with particularity the additional information required by the Department in the response to make the application substantially complete. The Department shall be bound by the response unless the Secretary determines that it must be modified in order to meet the purposes of this Article. The Secretary shall not delegate the authority to modify the

response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Department has not acted on an application within 90 days after it is deemed substantially complete, the Department shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Department. Any reapplication which corrects the deficiencies which were specified by the Department in the response shall be approved by the Department.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)B, or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Department receives the applicant's written response to the agency response or an earlier date considered by the Department shall be considered to be that date. The foregoing shall not limit the Department's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) The standards in G.S. 131E-279 through G.S. 131E-288 and in G.S. 131E-290 through G.S. 131E-308 shall apply to PSOs, unless federal law specifies standards more favorable to PSOs or unless otherwise preempted by federal law.

(f) A license shall be denied only after the Department complies with the requirements of G.S. 131E-312.

"§ 131E-280. Applicants for license.

(a) Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;

(3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(n);

(4) 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 and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees,

the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(5) A copy of any contract form made or to be made between any class of providers and the PSO 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 PSO;

(6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel;

(7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;

(8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, or 131E-299 are guaranteed by one or more guarantors, financial statements showing each guarantor's assets, liabilities, and sources of financial support. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(10) A financial plan, satisfactory to the Department, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;

(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. 131E-298; and

(13) Any other information the Department may require to make the determinations required in G.S. 131E-282.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considered unnecessary.

"**§ 131E-281. Additional Information.**

(a) In addition to the information filed under G.S. 131E-280(a), each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;

(2) The program used to evaluate whether the sponsoring providers providers provide a substantial portion of services under each Medicare contract of the PSO;

(3) The program to be used for verifying provider credentials;

(4) The utilization review program for the review and control of health care services provided or paid for by the applicant;

(5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and

(6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The department may promulgate rules and regulations exempting from the filing requirements of subdivision (a) those items it deems unnecessary.

"**§ 131E-282. Issuance of license.**

(a) Before issuing any such license, the Department may make such an examination or investigation as it deems expedient. The Department shall issue a license after receipt of a substantially complete application, upon the payment of the application fee prescribed in G.S. 131E-307 and upon satisfaction of the following requirements:

(1) The applicant is duly organized as a provider sponsored organization as defined by the Article.

(2) That the PSO has initially a minimum net worth of one million five hundred thousand dollars ($1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Department may lower the initial minimum net worth required to one million dollars ($1,000,000) or to any lower amount as

determined by the Department if the PSO operates primarily in rural areas.

(3) The PSO shall have at least seven hundred fifty thousand dollars ($750,000) in cash or equivalents on its balance sheet, except that the Department may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.

(4) The applicant submits a financial plan satisfactory to the Department which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected break-even.

(5) The Department determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Department shall consider the following:

a. The timeliness of payment;

b. The extent to which the current ratio is maintained at one to one, or whether there is a change in the current ratio over a period of time; and

c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Department shall admit the following:

(1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.

(2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.

(3) If at least one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents or if the Department has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars ($1,500,000), then the Department shall admit one hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.

(4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.

(5) Deferred acquisition costs shall not be admitted.

"**§ 131E-283. Financial plan.**

(a) The financial plan shall include the following:

(1) A detailed marketing plan;
(2) Statements of revenue and expense on an accrual basis;
(3) Cash flow statements;
(4) Balance sheets; and
(5) The assumptions in support of the financial plan.

(b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to break even. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (d) of this section, and other means as provided in subsection (e) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.

(c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:

(1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:
a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;
b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and
c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.

(2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Department if the PSO intends to reduce the period of funding of projected losses. The Department shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

(3) If the above guaranty requirements are not met, the Department may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Department retains discretion which shall be reasonably exercised to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(d) The Department may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.

(e) An irrevocable, clean, unconditional letter of credit may be used in place of cash or cash equivalents if satisfactory to the Department.

(f) If approved by the Department, based on appropriate standards promulgated by the Department, PSOs may use the following to fund projected losses for periods

after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

(g) The exceptions in subsections (c), (d), and (e) of this section may be used in an appropriate combination or sequence.

"**§ 131E-284. Modifications.**

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Department under G.S. 131E-280. Such notice shall be filed with the Department prior to the change. If the Department does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Department describes in properly adopted rules. Every PSO shall report to the Department for the Department's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Department may require. This information shall be filed with the Department within 15 days after implementation of the reported changes. Every PSO shall file with the Department all subsequent changes in the information or forms that are required by this Article to be filed with the Department.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary.

"**§ 131E-285. Deposits.**

(a) The Department shall require a deposit of one hundred thousand dollars ($100,000) for all provider sponsored organizations. Said deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be administered in accordance with procedures established by the Department.

"**§ 131E-286. Ongoing financial standards - net worth.**

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greater of the following amounts:

(1) One million dollars ($1,000,000);

(2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Department on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Department;

(4) An amount equal to the sum of:

a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Department; and

b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

(1) For intangible assets, if at least the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Department may lower the minimum ongoing net worth threshold for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of break-even, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Department, meeting all of the requirements established for the initial financial plan.

"**§ 131E-287. Reporting.**

The PSO shall file with the Department financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until break-even; and

(2) On an annual basis after break-even, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Department, after break-even, if the PSO does not have a net operating surplus.

"**§ 131E-288. Liquidity.**

(a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Department shall consider the following:

(1) The timeliness of payment;

(2) The extent to which the current ratio is maintained at one to one or whether there is a change in the current ratio over a period of time; and

(3) The availability of outside financial resources.

(b) The following corresponding remedies apply:

(1) If the PSO fails to pay obligations as they become due, the Department shall require the PSO to initiate corrective action to pay all overdue obligations.

(2) The Department may require the PSO to initiate corrective action if any of the following are evident: (i) the current ratio declines significantly; or (ii) a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one to one.

(3) If there is a change in the availability of the outside resources, the Department shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the Department that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend.

"**§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.**

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

(1) Seven hundred fifty thousand dollars ($750,000) cash or cash equivalents; or

(2) Forty percent (40%) of the minimum net worth required.

(b) The Department may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO.

"**§ 131E-290. Prohibited practice.**

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

"§ 131E-291. Collaboration with local health departments.

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health.

"§ 131E-292. Coverage.

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service.

"§ 131E-293. Rates.

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract.

"§ 131E-294. Consumer protection and quality standards.

(a) Unless otherwise preempted by federal law or mandated by the Medicare program, the Department shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

(1) Quality management programs;
(2) Utilization review procedures;
(3) Unfair or deceptive trade practices;
(4) Antidiscrimination;
(5) Provider accessibility and availability; and
(6) Network provider credentialing.

"§ 131E-295. Powers of insurers and medical service corporations.

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 66 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against

the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service corporation may make benefit payments to provider sponsored organizations for health care services rendered by providers pursuant to the health care plan.

"**§ 131E-296. Examinations.**

The Department may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Department considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

"**§ 131E-297. Hazardous financial condition.**

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Department may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) To reduce the total amount of present and potential liability for benefits by reinsurance;

(2) To reduce the volume of new business being accepted;

(3) To reduce the expenses by specified methods;

(4) To suspend or limit the writing of new business for a period of time;

(5) To require an increase to the provider sponsored organization's net worth by contribution;

(6) To add or delete sponsoring providers;

(7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or

(8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Department determines that the liquidity standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Department may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section.

"**§ 131E-298. Protection against insolvency.**

(a) The Department shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Department may take appropriate action to assure that the continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Department. In determining the adequacy of such a plan, the Department shall consider:

(1) A reinsurance agreement preapproved by the Department covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage;

(2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;

(3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;

(4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;

(5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and

(6) Any other arrangements offering protection against insolvency that the Department may require.

"§ 131E-299. Hold harmless agreements or special deposit.

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of such contracts shall, under any circumstances, change the effect of such a provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:

a. Place an uncovered expenditures insolvency deposit with the Department, or with any organization or trustee acceptable to the Department through which a custodial or controlled

account is maintained, cash or securities that are acceptable to the Department. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Department, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Department shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars ($50,000,000), unless the Department finds that the approval of this guaranty may be financially hazardous to beneficiaries.

(2) The deposit required under sub-subdivision a. of subdivision (1) of this section is an admitted asset of the PSO in the determination of net worth. All income from such deposits or trust accounts shall be assets of the PSO and may be withdrawn from such deposit or account quarterly with the approval of the Department;

(3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Department;

(4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Department may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed _____ percent (%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Department containing the information necessary to determine compliance with sub-division a. of subdivision (1) of this section no later than 30

business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Department may waive or reduce these requirements to such an amount as it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article.

"§ 131E-300. Continuation of benefits.

The Department shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Department may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;

(3) Insolvency reserves as the Department may require;

(4) Letters of credit acceptable to the Department;

(5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;

(6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and

(7) Any other arrangements to assure that benefits are continued as specified.

"§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Department, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Department shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Department determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Department shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's

coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the U.S. Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to obtain other coverage. Each PSO to which beneficiaries are so allocated by the Department shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) Such liabilities shall be computed in accordance with rules adopted by the Department upon reasonable consideration of the ascertained experience and character of the PSO.

"§ 131E-304. Suspension or revocation of license.

(a) The Department may suspend, revoke, or refuse to renew a PSO license if the Department finds that the PSO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Department;

desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Department elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the Department may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"**§ 131E-309. Statutory construction and relationship to other laws.**

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

"**§ 131E-310. Filings and reports as public documents.**

Except for information that constitutes a bona fide trade secret, proprietary information or competitively sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents.

"**§ 131E-311. Confidentiality of medical information.**

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization 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 beneficiary 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

provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim.

"**§ 131E-312. Conflicts; severability.**

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Department shall continue to process applications for provider sponsored organization licenses as described in this Article. If any section, term, or provision of this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"**§ 131E-313. Regulations.**

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Department may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Department shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Department shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof."

Section 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.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the

Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Department of Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

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

Section 3. There is appropriated from the General Fund to the Department of Health and Human Services the sum of ------- for the 1998-99 fiscal year to implement this act.

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1455*
Proposed Committee Substitute H1455-PCS1590-RN

Short Title: PSO Medicare Licensing. (Public)

Sponsors:

Referred to:

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 17.

"Provider Sponsored Organization Licensing.

"**§ 131E-275. General provisions.**

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer Medicare health insurance or health benefits coverage in each state in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Department of Health and Human Services. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of health care services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that

the organizers and operators of provider sponsored organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or the insurance laws of this State, unless otherwise specified in this Article.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

(b) As set forth in this Article, the Department of Health and Human Services shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Department or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries. Nothing in this Article shall be construed to authorize a provider sponsored organization to establish, maintain, or operate a health care plan other than exclusively for Medicare+Choice beneficiaries.

"**§131E-276. Definitions.**

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

(1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina.

(3) 'Current assets' means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.

(4) 'Current liabilities' means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.

(5) 'Current ratio' means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.

(6) 'Department' means the Department of Health and Human Services.

(7) 'Emergency services' shall have the same meaning as for that term defined in G.S. 58-50-61(a)(5).

(8) 'Health care delivery assets' means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.

(9) 'Health plan contract' or 'Medicare contract' means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.

(10) 'Out-of-network services' means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

(11) 'Parent of a sponsoring provider' means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.

(12) 'Provider' or 'health care provider' means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.

(13) 'Provider sponsored organization' or 'PSO' means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic: (i) that is established, organized, and operated by sponsoring providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; and (iii) that provides a substantial proportion of the services under each Medicare contract directly through the sponsoring provider. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body. This subdivision applies only if a

hospital licensed under Chapter 131E or Chapter 122C of the General Statutes is the sponsoring provider or a member of the group of affiliated health care providers that comprises the sponsoring provider.

(14) 'Secretary' means the Secretary of the Department of Health and Human Services.

(15) 'Sponsoring providers' of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.

(16) 'Substantial proportion of the services' means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual health care expenditures.

(17) A health care provider is affiliated with another provider if through contract, ownership, or otherwise, when: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.

"§ 131E-277. Direct or indirect sharing of substantial financial risk.

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

(1) Provide services under its Medicare contract at a capitated rate;

(2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;

(3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment and utilization management goals either by:

a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or

b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent

substantial financial rewards or penalties based on group performance in meeting the targets; or

(4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring providers in different specialties offering a complementary mix of services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or

(5) Agree to any other arrangement that the Department determines to provide for the sharing of substantial financial risk by the sponsoring providers.

"§ 131E-278. Applicability of other laws.

Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes.

"§ 131E-279. Approval.

(a) Unless otherwise required by federal law, the Department shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare+Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Department's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the PSO's Medicare contract.

(c) The Department shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Department not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Department receives an application for licensing, the Department shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Department will explain with particularity the additional information required by the Department in the response to make the application substantially complete. The Department shall be bound by the response unless the Secretary determines that it must be modified in order to meet the

purposes of this Article. The Secretary shall not delegate the authority to modify the response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Department has not acted on an application within 90 days after it is deemed substantially complete, the Department shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Department. Any reapplication which corrects the deficiencies which were specified by the Department in the response shall be approved by the Department.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Department receives the applicant's written response to the agency response or an earlier date considered by the Department shall be considered to be that date. The foregoing shall not limit the Department's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) A license shall be denied only after the Department complies with the requirements of G.S. 131E-305.

"**§ 131E-280. Applicants for license.**

Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;

(3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(17);

(4) 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 and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(5) A copy of any contract form made or to be made between any class of providers and the PSO 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 PSO;

(6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel;

(7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;

(8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, and 131E-299 are guaranteed by one or more guarantors:

a. Documentation that each guarantor meets the following requirements:

1. The guarantor is a legal entity authorized to conduct business in North Carolina.

2. The guarantor is not under federal bankruptcy or State receivership or rehabilitation proceedings.

3. The guarantor has a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the PSO's guarantee.

b. Financial statements showing each guarantor's assets, liabilities, and source of financial support.

c. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Department

directs that additional or more recent financial information is required for the proper administration of this Article.

d. The guarantee document, including a statement of the financial obligation covered by the guarantee, an agreement to unconditionally fulfill the financial obligations covered by the guarantee, an agreement not to subordinate the guarantee to any other claim on the resources of the guarantor and a declaration that the guarantor must act on a timely basis to satisfy the financial obligations covered by the guarantee;

(10) A financial plan, satisfactory to the Department, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;

(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. 131E-298; and

(13) Any other information the Department may require to make the determinations required in G.S. 131E-282.

"§ 131E-281. Additional information.

(a) In addition to the information filed under G.S. 131E-280, each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;

(2) The program used to evaluate whether the sponsoring providers provide a substantial portion of services under each Medicare contract of the PSO;

(3) The program to be used for verifying provider credentials;

(4) The utilization review program for the review and control of health care services provided or paid for by the applicant;

(5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and

(6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The Department may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items it deems unnecessary.

"§ 131E-282. Issuance of license.

(a) Before issuing a PSO license, the Department may make an examination or investigation as it deems expedient. The Department shall issue a license after receipt of a substantially complete application and upon satisfaction of the following requirements:

(1) The applicant is duly organized as a provider sponsored organization as defined by this Article.

(2) The PSO has initially a minimum net worth of one million five hundred thousand dollars ($1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Department may lower the initial minimum net worth required to one million dollars ($1,000,000) or to any lower amount as determined by the Department if the PSO operates primarily in rural areas.

(3) The PSO shall have at least seven hundred fifty thousand dollars ($750,000) in cash or equivalents on its balance sheet, except that the Department may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.

(4) The applicant submits a financial plan satisfactory to the Department which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected breakeven.

(5) The Department determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Department shall consider the following:

a. The timeliness of payment;

b. The extent to which the current ratio is maintained at one to one, or whether there is a change in the current ratio over a period of time; and

c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Department shall admit the following:

(1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.

(2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.

(3) If at least one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars ($1,000,000) of

the initial minimum net worth requirement is met by cash or cash equivalents or if the Department has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars ($1,500,000), then the Department shall admit one hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.

(4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.

(5) Deferred acquisition costs shall not be admitted.

"**§ 131E-283. Financial plan.**

(a) The financial plan shall include the following:

(1) A detailed marketing plan;

(2) Statements of revenue and expense on an accrual basis;

(3) Cash flow statements;

(4) Balance sheets; and

(5) The assumptions and justifications in support of the financial plan.

(b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to breakeven. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (e) of this section, and other means as provided in subsection (f) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.

(c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:

(1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:

a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;

b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and

c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.

(2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Department if the PSO intends to reduce the period of funding of projected losses. The Department shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

(3) If the above guaranty requirements are not met, the Department may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Department retains discretion which shall be reasonably exercised to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(d) The Department may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.

(e) An irrevocable, clean, unconditional letter of credit may be used as an acceptable resource to fund projected losses in place of cash or cash equivalents if satisfactory to the Department.

(f) If approved by the Department, based on appropriate standards promulgated by the Department, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

(g) The exceptions in subsections (c), (d), and (e) of this section may be used in an appropriate combination or sequence.

"**§ 131E-284. Modifications.**

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Department under G.S. 131E-280. Such notice shall be filed with the Department prior to the change. If the Department does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Department describes in properly adopted rules. Every PSO shall report to the Department for the Department's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Department may require. This information shall be filed with the Department within 15 days after implementation of the reported changes. Every PSO shall file with the Department all subsequent changes in the information or forms that are required by this Article to be filed with the Department.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary.

"**§ 131E-285. Deposits.**

(a) At the time of application, the Department shall require a deposit of one hundred thousand dollars ($100,000) in cash or securities or a combination thereof for all provider sponsored organizations. The deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be restricted to use in the event of insolvency to help assume continuation of services or pay costs associated with receivership or liquidation.

"§ 131E-286. Ongoing financial standards - net worth.

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greatest of the following amounts:

(1) One million dollars ($1,000,000);

(2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Department on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Department;

(4) An amount equal to the sum of:

a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Department; and

b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

(1) For intangible assets, if at least the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to

ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Department may lower the minimum ongoing net worth threshold, and the amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of break-even, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Department, meeting all of the requirements established for the initial financial plan.

"**§ 131E-287. Reporting.**

(a) The PSO shall file with the Department financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until break-even; and

(2) On an annual basis after break-even, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Department, after break-even, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file in the office of the Secretary the following information for the previous calendar year:

(1) The number of and reasons for grievances received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Department, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with G.S. 131E-314.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

(3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare

beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network. The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:

a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the PSO's provider network; and an evaluation of actual plan performance against performance targets.

b. The PSO's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the PSO's program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.

2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare+Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the PSO's methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the PSO's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare+Choice plan performance, and network provider performance.

f. A summary of the PSO's utilization review program activities for the previous calendar year under its Medicare+Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 131E-314.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Department.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. -- To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the

following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bonafide prospective enrollees upon request:

(1) The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.

(d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Department available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.

(e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file in the office of the Secretary a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Secretary shall prescribe. In case the PSO fails to file the annual statement as herein required, the Secretary is authorized to suspend the license issued to the PSO until the statement shall be properly filed.

"§ 131E-288. Liquidity.

(a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Department shall consider the following:

(1) The timeliness of payment;

(2) The extent to which the current ratio is maintained at one to one or whether there is a change in the current ratio over a period of time; and

(3) The availability of outside financial resources.

(b) The following corresponding remedies apply:

(1) If the PSO fails to pay obligations as they become due, the Department shall require the PSO to initiate corrective action to pay all overdue obligations.

(2) The Department may require the PSO to initiate corrective action if either of the following is evident: (i) the current ratio declines significantly; or (ii) there is a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one to one.

(3) If there is a change in the availability of the outside resources, the Department shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the Department that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend.

"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

(1) Seven hundred fifty thousand dollars ($750,000) cash or cash equivalents; or

(2) Forty percent (40%) of the minimum net worth required.

(b) The Department may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO.

"§ 131E-290. Prohibited practice.

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

(c) Unless otherwise preempted by federal law or mandated by the Medicare program, a PSO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license or certification. This subsection does not preclude a PSO from including providers

only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

"§ 131E-291. Collaboration with local health departments.

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health.

"§ 131E-292. Coverage.

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service.

"§ 131E-293. Rates.

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract.

"§ 131E-294. Consumer protection and quality standards.

(a) Unless otherwise preempted by federal law or mandated by the Medicare program, the Department shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

(1) Quality management programs (11 NCAC 20.0500, et seq.);
(2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
(3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the General Statutes);
(4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120; 58-63-15(7), and 58-67-75);
(5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
(6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
(7) Data reporting requirements under G.S. 58-67-50(e).

"§ 131E-295. Powers of insurers and medical service corporations.

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 67 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its

obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service corporation may make benefit payments to provider sponsored organizations for health care services rendered by providers pursuant to the health care plan.

"§ 131E-296. Examinations.

The Department may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Department considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

"§ 131E-297. Hazardous financial condition.

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Department may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) To reduce the total amount of present and potential liability for benefits by reinsurance;

(2) To reduce the volume of new business being accepted;

(3) To reduce the expenses by specified methods;

(4) To suspend or limit the writing of new business for a period of time;

(5) To require an increase to the provider sponsored organization's net worth by contribution;

(6) To add or delete sponsoring providers;

(7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or

(8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Department determines that the standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Department may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section.

"§ 131E-298. Protection against insolvency.

(a) The Department shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Department may take appropriate action to assure

that the continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Department. In determining the adequacy of such a plan, the Department shall consider:

(1) A reinsurance agreement preapproved by the Department covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage;

(2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;

(3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;

(4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;

(5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and

(6) Any other arrangements offering protection against insolvency that the Department may require.

"§ 131E-299. Hold harmless agreements or special deposit.

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of these contracts shall, under any circumstances, change the effect of this provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:

a. Place an uncovered expenditures insolvency deposit with the Department, or with any organization or trustee acceptable to the Department through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Department. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for

uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Department, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Department shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars ($50,000,000), unless the Department finds that the approval of this guaranty may be financially hazardous to beneficiaries.

(2) The deposit required under sub-subdivision a. of subdivision (1) of this subsection is an admitted asset of the PSO in the determination of net worth. All income from these deposits or trust accounts shall be assets of the PSO and may be withdrawn from the deposit or account quarterly with the approval of the Department;

(3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Department;

(4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Department may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed ten percent (10%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Department containing the information necessary to determine compliance with sub-subdivision a. of subdivision (1) of subsection (b) of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Department may waive

or reduce these requirements to an amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article.

"§ 131E-300. Continuation of benefits.

The Department shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Department may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;

(3) Insolvency reserves as the Department may require;

(4) Letters of credit acceptable to the Department;

(5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;

(6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and

(7) Any other arrangements to assure that benefits are continued as specified.

"§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Department, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Department shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Department determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Department shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the U.S. Department

of Health and Human Services fails to make such allocations in a timely manner, the Department shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to obtain other coverage. Each PSO to which beneficiaries are so allocated by the Department shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) These liabilities shall be computed in accordance with rules adopted by the Department upon reasonable consideration of the ascertained experience and character of the PSO.

"§ 131E-304. Suspension or revocation of license.

(a) The Department may suspend, revoke, or refuse to renew a PSO license if the Department finds that the PSO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Department;

(2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with Medicare or Medicaid program requirements as applicable;

(3) No longer maintains the financial reserve specified in G.S. 131E-286 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to beneficiaries or prospective beneficiaries;
(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PSO or with any order issued by the Department after notice and opportunity for a hearing;
(5) Has knowingly made to the Department any false statement or report;
(6) Has sponsoring providers that fail to provide a substantial proportion of the services under any health plan during any 12-month period;
(7) Has itself or through any person on its behalf advertised or merchandised its items or services in an untrue, misrepresentative, misleading, or unfair manner;
(8) If continuing to operate would be hazardous to beneficiaries; or
(9) Has otherwise substantially failed to comply with this Article.

(b) A license shall be suspended or revoked only after compliance with G.S. 131E-305.

(c) When a PSO license is suspended, the PSO shall not, during the suspension, enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

(d) When a PSO license is revoked, the PSO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PSO. The PSO shall engage in no advertising or solicitation. The Department may, by written order, permit any further operation of the PSO that the Department may find to be in the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest practical opportunity to obtain continuing health care coverage.

"§ 131E-305. Administrative procedures.

(a) When the Department has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, it shall notify the provider sponsored organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After this hearing, or upon the failure of the provider sponsored organization to appear at this hearing, the Department shall take the action it considers advisable or make written findings that shall be mailed to the provider sponsored organization. The action of the Department shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Department in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b) of this section.

"**§ 131E-306. Department of Insurance.**

At the request of the Department, the Department of Insurance may evaluate a PSO's compliance with any or all of the solvency requirements set forth in this Article. Upon this request, the Department of Insurance shall undertake the evaluation in accordance with this Article and regulations adopted pursuant to it and shall report its evaluation to the Department in a timely manner. The Department of Insurance may collect from the applicant or PSO subject to the evaluation a fee not to exceed the fee that the Department of Insurance would be entitled to impose on a health maintenance organization for undergoing a similar evaluation. Nothing in this section limits the Department's final authority to license PSOs in accordance with this Article.

"**§ 131E-307. Penalties and enforcement.**

(a) The provisions of G.S. 58-2-70, modified to replace the word 'Commissioner' by the word 'Department', applies to this Article. The Department may, in addition to or in lieu of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as so modified, provided that the provider sponsored organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

(c) If the Department shall for any reason have cause to believe that any violation of this Article has occurred or is threatened, the Department may give notice to the provider sponsored organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Department may deem appropriate under the circumstances.

(d) The Department may issue an order directing a provider sponsored organization or a representative of a provider sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Department elects not to issue a cease and desist order, or in the event of noncompliance with a

cease and desist order issued pursuant to subsection (d) of this section, the Department may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"§ 131E-308. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

(d) Except as otherwise limited by this Article, a PSO may organize in the same manner and may exercise the same prerogatives, powers and privileges as other entities that are organized and existing under the same laws as the PSO.

"§ 131E-309. Filings and reports as public documents.

Except for information that constitutes a bona fide trade secret, proprietary information or competitively-sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents.

"§ 131E-310. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization 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 beneficiary 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 provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim.

"§ 131E-311. Conflicts; severability.

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Department shall continue to process applications for provider sponsored organization licenses as described in this Article. If any section, term, or provision of this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"§ 131E-312. Regulations.

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Department may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Department shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Department shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof.

"§ 131E-313. Utilization review and grievances.

Unless otherwise preempted by federal law or mandated by the Medicare program, the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this Article as if the PSO was an 'insurer' under those sections, except that the Department rather than the Commissioner of Insurance shall regulate a PSO's compliance with those sections."

Section 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.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Department of Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

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

Section 3. G.S. 90-21.22A reads as rewritten:

"**§ 90-21.22A. Medical review committees.**

(a) As used in this section, "medical review committee" means a committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. "Medical review committee" does not mean a medical review committee established under G.S. 131E-95.

~~(b)~~ A member of a duly appointed ~~medical review committee~~ who acts ~~without~~ malice or fraud shall not be 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.

(c) The proceedings of a medical review committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of ~~G.S. 132-1~~ G.S. 132-1, 131E-309, or ~~G.S.~~ 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this ~~Chapter or~~ Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not

immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about his or her testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under ~~G.S. 58-50-61 or G.S. 58-50-62.~~ G.S. 58-50-61, 58-50-62, or 131E-313."

Section 3.1. Nothing in this act shall obligate the General Assembly to appropriate funds to implement this act.

Section 4. This act is effective when it becomes law.

ATTACHMENT 4

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1455

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H1455-ARM-02

Page 1 of __

Date_____,1998

Comm. Sub. [Yes]
Amends Title []

Representative_____

moves to amend the bill on page 25, line 7,
by rewriting that line to read:
"Article. If the Department of Insurance accepts the request, it shall undertake the"; and further
moves to amend the bill on page 25, lines 9-12,
by deleting the sentence that begins on line 9 with the word "The" and ends on line 12.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

1998 PERMANENT SUBCOMMITTEE REPORT
HOUSE OF REPRESENTATIVES

FOR RECOMMENDING BILLS TO STANDING COMMITTEE OR TO THE FLOOR OF THE HOUSE
The following report(s) from permanent sub committee(s) is/are presented:

By Representative(s) **Daniel F. McComas** for the Permanent Subcommittee on **Health** of the Standing Committee on **INSURANCE**.

☑ Committee Substitute for
H.B. 1455 ☐ A BILL TO BE ENTITLED AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

REPORTED TO THE STANDING COMMITTEE ON

RECOMMENDED ACTION:

☐ With a favorable recommendation.

☐ With a favorable recommendation and recommend that the bill be re-referred to the Committee on .

☐ With a favorable recommendation, as amended.

☐ With a favorable recommendation, as amended, and recommend that the bill be re-referred to the Committee on .

☐ With an unfavorable recommendation.

☐ With a favorable recommendation as to proposed committee substitute bill which changes the title, unfavorable as to original bill.

☐ With a favorable recommendation as to proposed House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute bill.

☐ Without prejudice.

☐ Other recommended action: _____.

WITH APPROVAL OF STANDING COMMITTEE CHAIR FOR REPORT TO BE MADE DIRECTLY TO THE FLOOR OF THE HOUSE:

Rep. Dockham for the Standing Committee on INSURANCE.

s/ Jerry C. Dockham

☐ With a favorable report.
☐ With a favorable report, as amended.
☑ With a favorable report as to committee substitute bill ~~(#), which changes the title,~~ unfavorable as to original bill ~~(Committee Substitute Bill #). (and recommendation that the committee substitute bill (#) be referred to the Committee on .)~~
☐ And having received a unanimous vote in committee, be placed on the Consent Calendar. (PUBLIC BILLS ONLY)

3/25/98

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H D

HOUSE BILL 1455*
Proposed Committee Substitute H1455-PCS1592-RN

Short Title: PSO Medicare Licensing. (Public)

Sponsors:

Referred to:

May 25, 1998

A BILL TO BE ENTITLED

AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION LICENSING.

The General Assembly of North Carolina enacts:

Section 1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"ARTICLE 17.

"Provider Sponsored Organization Licensing.

"**§ 131E-275. General provisions.**

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer Medicare health insurance or health benefits coverage in each state in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Department of Health and Human Services. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of health care services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that

the organizers and operators of provider sponsored organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or the insurance laws of this State, unless otherwise specified in this Article.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

(b) As set forth in this Article, the Department of Health and Human Services shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Department or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries. Nothing in this Article shall be construed to authorize a provider sponsored organization to establish, maintain, or operate a health care plan other than exclusively for Medicare+Choice beneficiaries.

"§131E-276. Definitions.

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

(1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.

(2) 'Commissioner' means the Commissioner of Insurance of North Carolina.

(3) 'Current assets' means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.

(4) 'Current liabilities' means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.

(5) 'Current ratio' means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.

(6) 'Department' means the Department of Health and Human Services.

(7) 'Emergency services' shall have the same meaning as for that term defined in G.S. 58-50-61(a)(5).

(8) 'Health care delivery assets' means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.

(9) 'Health plan contract' or 'Medicare contract' means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.

(10) 'Out-of-network services' means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

(11) 'Parent of a sponsoring provider' means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.

(12) 'Provider' or 'health care provider' means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.

(13) 'Provider sponsored organization' or 'PSO' means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic; (i) that is established, organized, and operated by sponsoring providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; and (iii) that provides a substantial proportion of the services under each Medicare contract directly through the sponsoring provider. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body. This subdivision applies only if a

hospital licensed under Chapter 131E or Chapter 122C of the General Statutes is the sponsoring provider or a member of the group of affiliated health care providers that comprises the sponsoring provider.

(14) 'Secretary' means the Secretary of the Department of Health and Human Services.

(15) 'Sponsoring providers' of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.

(16) 'Substantial proportion of the services' means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual health care expenditures.

(17) A health care provider is affiliated with another provider if through contract, ownership, or otherwise, when: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.

"§ 131E-277. Direct or indirect sharing of substantial financial risk.

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

(1) Provide services under its Medicare contract at a capitated rate;

(2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;

(3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment and utilization management goals either by:

a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or

b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent

substantial financial rewards or penalties based on group performance in meeting the targets; or

(4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring providers in different specialties offering a complementary mix of services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or

(5) Agree to any other arrangement that the Department determines to provide for the sharing of substantial financial risk by the sponsoring providers.

"§ 131E-278. Applicability of other laws.

Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes.

"§ 131E-279. Approval.

(a) Unless otherwise required by federal law, the Department shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare+Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Department's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the PSO's Medicare contract.

(c) The Department shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Department not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Department receives an application for licensing, the Department shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Department will explain with particularity the additional information required by the Department in the response to make the application substantially complete. The Department shall be bound by the response unless the Secretary determines that it must be modified in order to meet the

purposes of this Article. The Secretary shall not delegate the authority to modify the response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Department has not acted on an application within 90 days after it is deemed substantially complete, the Department shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Department. Any reapplication which corrects the deficiencies which were specified by the Department in the response shall be approved by the Department.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Department receives the applicant's written response to the agency response or an earlier date considered by the Department shall be considered to be that date. The foregoing shall not limit the Department's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) A license shall be denied only after the Department complies with the requirements of G.S. 131E-305.

"**§ 131E-280. Applicants for license.**

Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department, and shall be set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;

(3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(17);

(4) 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 and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(5) A copy of any contract form made or to be made between any class of providers and the PSO 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 PSO;

(6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel;

(7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;

(8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Department directs that additional or more recent financial information is required for the proper administration of this Article;

(9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, and 131E-299 are guaranteed by one or more guarantors:

a. Documentation that each guarantor meets the following requirements:

1. The guarantor is a legal entity authorized to conduct business in North Carolina.

2. The guarantor is not under federal bankruptcy or State receivership or rehabilitation proceedings.

3. The guarantor has a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the PSO's guarantee.

b. Financial statements showing each guarantor's assets, liabilities, and source of financial support.

c. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Department

directs that additional or more recent financial information is required for the proper administration of this Article.

d. The guarantee document, including a statement of the financial obligation covered by the guarantee, an agreement to unconditionally fulfill the financial obligations covered by the guarantee, an agreement not to subordinate the guarantee to any other claim on the resources of the guarantor and a declaration that the guarantor must act on a timely basis to satisfy the financial obligations covered by the guarantee;

(10) A financial plan, satisfactory to the Department, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;

(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. 131E-298; and

(13) Any other information the Department may require to make the determinations required in G.S. 131E-282.

"§ 131E-281. Additional information.

(a) In addition to the information filed under G.S. 131E-280, each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;

(2) The program used to evaluate whether the sponsoring providers provide a substantial portion of services under each Medicare contract of the PSO;

(3) The program to be used for verifying provider credentials;

(4) The utilization review program for the review and control of health care services provided or paid for by the applicant;

(5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and

(6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The Department may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items it deems unnecessary.

"§ 131E-282. Issuance of license.

(a) Before issuing a PSO license, the Department may make an examination or investigation as it deems expedient. The Department shall issue a license after receipt of a substantially complete application and upon satisfaction of the following requirements:

(1) The applicant is duly organized as a provider sponsored organization as defined by this Article.

(2) The PSO has initially a minimum net worth of one million five hundred thousand dollars ($1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Department may lower the initial minimum net worth required to one million dollars ($1,000,000) or to any lower amount as determined by the Department if the PSO operates primarily in rural areas.

(3) The PSO shall have at least seven hundred fifty thousand dollars ($750,000) in cash or equivalents on its balance sheet, except that the Department may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.

(4) The applicant submits a financial plan satisfactory to the Department which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected breakeven.

(5) The Department determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Department shall consider the following:

a. The timeliness of payment;

b. The extent to which the current ratio is maintained at one to one, or whether there is a change in the current ratio over a period of time; and

c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Department shall admit the following:

(1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.

(2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.

(3) If at least one million dollars ($1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars ($1,000,000) of

the initial minimum net worth requirement is met by cash or cash equivalents or if the Department has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars ($1,500,000), then the Department shall admit one hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.

(4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.

(5) Deferred acquisition costs shall not be admitted.

"§ 131E-283. Financial plan.

(a) The financial plan shall include the following:

(1) A detailed marketing plan;

(2) Statements of revenue and expense on an accrual basis;

(3) Cash flow statements;

(4) Balance sheets; and

(5) The assumptions and justifications in support of the financial plan.

(b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to breakeven. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (e) of this section, and other means as provided in subsection (f) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.

(c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:

(1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:

a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;

b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and

c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.

(2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Department if the PSO intends to reduce the period of funding of projected losses. The Department shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.

(3) If the above guaranty requirements are not met, the Department may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Department retains discretion which shall be reasonably exercised to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(d) The Department may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.

(e) An irrevocable, clean, unconditional letter of credit may be used as an acceptable resource to fund projected losses in place of cash or cash equivalents if satisfactory to the Department.

(f) If approved by the Department, based on appropriate standards promulgated by the Department, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.

(g) The exceptions in subsections (c), (d), and (e) of this section may be used in an appropriate combination or sequence.

"**§ 131E-284. Modifications.**

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Department under G.S. 131E-280. Such notice shall be filed with the Department prior to the change. If the Department does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Department describes in properly adopted rules. Every PSO shall report to the Department for the Department's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Department may require. This information shall be filed with the Department within 15 days after implementation of the reported changes. Every PSO shall file with the Department all subsequent changes in the information or forms that are required by this Article to be filed with the Department.

(b) The Department may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary.

"**§ 131E-285. Deposits.**

(a) At the time of application, the Department shall require a deposit of one hundred thousand dollars ($100,000) in cash or securities or a combination thereof for all provider sponsored organizations. The deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be restricted to use in the event of insolvency to help assume continuation of services or pay costs associated with receivership or liquidation.

"§ 131E-286. Ongoing financial standards - net worth.

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greatest of the following amounts:

(1) One million dollars ($1,000,000);

(2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Department on the first one hundred fifty million dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars ($150,000,000);

(3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Department;

(4) An amount equal to the sum of:

a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Department; and

b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

(1) For intangible assets, if at least the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars ($1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Department shall admit the book value of intangible assets up to

ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Department may lower the minimum ongoing net worth threshold, and the amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of break-even, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Department, meeting all of the requirements established for the initial financial plan.

"§ 131E-287. Reporting.

(a) The PSO shall file with the Department financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until break-even; and

(2) On an annual basis after break-even, if the PSO has a net operating surplus; or

(3) On a quarterly or monthly basis, as specified by the Department, after break-even, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file in the office of the Secretary the following information for the previous calendar year:

(1) The number of and reasons for grievances received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Department, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with G.S. 131E-314.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

(3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare

beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network. The report shall show voluntary and involuntary terminations separately.

(4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:

a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the PSO's provider network; and an evaluation of actual plan performance against performance targets.

b. The PSO's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the PSO's program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.

2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare + Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the PSO's methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the PSO's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare + Choice plan performance, and network provider performance.

f. A summary of the PSO's utilization review program activities for the previous calendar year under its Medicare + Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 131E-314.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Department.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. -- To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the

following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bonafide prospective enrollees upon request:

(1) The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.

(d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Department available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.

(e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file in the office of the Secretary a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Secretary shall prescribe. In case the PSO fails to file the annual statement as herein required, the Secretary is authorized to suspend the license issued to the PSO until the statement shall be properly filed.

"§ 131E-288. Liquidity.

(a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Department shall consider the following:

(1) The timeliness of payment;

(2) The extent to which the current ratio is maintained at one to one or whether there is a change in the current ratio over a period of time; and

(3) The availability of outside financial resources.

(b) The following corresponding remedies apply:

(1) If the PSO fails to pay obligations as they become due, the Department shall require the PSO to initiate corrective action to pay all overdue obligations.

(2) The Department may require the PSO to initiate corrective action if either of the following is evident: (i) the current ratio declines significantly; or (ii) there is a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one to one.

(3) If there is a change in the availability of the outside resources, the Department shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the Department that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend.

"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

(1) Seven hundred fifty thousand dollars ($750,000) cash or cash equivalents; or

(2) Forty percent (40%) of the minimum net worth required.

(b) The Department may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO.

"§ 131E-290. Prohibited practice.

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

(c) Unless otherwise preempted by federal law or mandated by the Medicare program, a PSO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license or certification. This subsection does not preclude a PSO from including providers

only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

"§ 131E-291. Collaboration with local health departments.

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health.

"§ 131E-292. Coverage.

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service.

"§ 131E-293. Rates.

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract.

"§ 131E-294. Consumer protection and quality standards.

(a) Unless otherwise preempted by federal law or mandated by the Medicare program, the Department shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

(1) Quality management programs (11 NCAC 20.0500, et seq.);
(2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
(3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the General Statutes);
(4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120; 58-63-15(7), and 58-67-75);
(5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
(6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
(7) Data reporting requirements under G.S. 58-67-50(e).

"§ 131E-295. Powers of insurers and medical service corporations.

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 67 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its

obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service corporation may make benefit payments to provider sponsored organizations for health care services rendered by providers pursuant to the health care plan.

"§ 131E-296. Examinations.

The Department may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Department considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

"§ 131E-297. Hazardous financial condition.

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Department may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) To reduce the total amount of present and potential liability for benefits by reinsurance;

(2) To reduce the volume of new business being accepted;

(3) To reduce the expenses by specified methods;

(4) To suspend or limit the writing of new business for a period of time;

(5) To require an increase to the provider sponsored organization's net worth by contribution;

(6) To add or delete sponsoring providers;

(7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or

(8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Department determines that the standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Department may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section.

"§ 131E-298. Protection against insolvency.

(a) The Department shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Department may take appropriate action to assure

that the continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Department. In determining the adequacy of such a plan, the Department shall consider:

(1) A reinsurance agreement preapproved by the Department covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage;

(2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;

(3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;

(4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;

(5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and

(6) Any other arrangements offering protection against insolvency that the Department may require.

"§ 131E-299. Hold harmless agreements or special deposit.

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of these contracts shall, under any circumstances, change the effect of this provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:

a. Place an uncovered expenditures insolvency deposit with the Department, or with any organization or trustee acceptable to the Department through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Department. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for

uncovered expenditures for enrollees, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Department, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Department shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars ($50,000,000), unless the Department finds that the approval of this guaranty may be financially hazardous to beneficiaries.

(2) The deposit required under sub-subdivision a. of subdivision (1) of this subsection is an admitted asset of the PSO in the determination of net worth. All income from these deposits or trust accounts shall be assets of the PSO and may be withdrawn from the deposit or account quarterly with the approval of the Department;

(3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Department;

(4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Department may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed ten percent (10%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Department containing the information necessary to determine compliance with sub-subdivision a. of subdivision (1) of subsection (b) of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Department may waive

or reduce these requirements to an amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article.

"§ 131E-300. Continuation of benefits.

The Department shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Department may require:

(1) Insurance to cover the expenses to be paid for benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;

(3) Insolvency reserves as the Department may require;

(4) Letters of credit acceptable to the Department;

(5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;

(6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and

(7) Any other arrangements to assure that benefits are continued as specified.

"§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Department, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Department shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Department determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Department shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Department shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the U.S. Department

of Health and Human Services fails to make such allocations in a timely manner, the Department shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to obtain other coverage. Each PSO to which beneficiaries are so allocated by the Department shall offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract.

"§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance.

"§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) These liabilities shall be computed in accordance with rules adopted by the Department upon reasonable consideration of the ascertained experience and character of the PSO.

"§ 131E-304. Suspension or revocation of license.

(a) The Department may suspend, revoke, or refuse to renew a PSO license if the Department finds that the PSO:

(1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Department;

(2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with Medicare or Medicaid program requirements as applicable;

(3) No longer maintains the financial reserve specified in G.S. 131E-286 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to beneficiaries or prospective beneficiaries;

(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PSO or with any order issued by the Department after notice and opportunity for a hearing;

(5) Has knowingly made to the Department any false statement or report;

(6) Has sponsoring providers that fail to provide a substantial proportion of the services under any health plan during any 12-month period;

(7) Has itself or through any person on its behalf advertised or merchandised its items or services in an untrue, misrepresentative, misleading, or unfair manner;

(8) If continuing to operate would be hazardous to beneficiaries; or

(9) Has otherwise substantially failed to comply with this Article.

(b) A license shall be suspended or revoked only after compliance with G.S. 131E-305.

(c) When a PSO license is suspended, the PSO shall not, during the suspension, enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

(d) When a PSO license is revoked, the PSO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PSO. The PSO shall engage in no advertising or solicitation. The Department may, by written order, permit any further operation of the PSO that the Department may find to be in the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest practical opportunity to obtain continuing health care coverage.

"**§ 131E-305. Administrative procedures.**

(a) When the Department has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, it shall notify the provider sponsored organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After this hearing, or upon the failure of the provider sponsored organization to appear at this hearing, the Department shall take the action it considers advisable or make written findings that shall be mailed to the provider sponsored organization. The action of the Department shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Department in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b) of this section.

"§ 131E-306. Department of Insurance.

At the request of the Department, the Department of Insurance may evaluate a PSO's compliance with any or all of the solvency requirements set forth in this Article. If the Department of Insurance accepts the request, it shall undertake the evaluation in accordance with this Article and regulations adopted pursuant to it and shall report its evaluation to the Department in a timely manner. Nothing in this section limits the Department's final authority to license PSOs in accordance with this Article.

"§ 131E-307. Penalties and enforcement.

(a) The provisions of G.S. 58-2-70, modified to replace the word 'Commissioner' by the word 'Department', applies to this Article. The Department may, in addition to or in lieu of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as so modified, provided that the provider sponsored organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

(c) If the Department shall for any reason have cause to believe that any violation of this Article has occurred or is threatened, the Department may give notice to the provider sponsored organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Department may deem appropriate under the circumstances.

(d) The Department may issue an order directing a provider sponsored organization or a representative of a provider sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Department elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the Department may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"**§ 131E-308. Statutory construction and relationship to other laws.**

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

(d) Except as otherwise limited by this Article, a PSO may organize in the same manner and may exercise the same prerogatives, powers and privileges as other entities that are organized and existing under the same laws as the PSO.

"**§ 131E-309. Filings and reports as public documents.**

Except for information that constitutes a bona fide trade secret, proprietary information or competitively sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents.

"**§ 131E-310. Confidentiality of medical information.**

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization 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 beneficiary 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 provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim.

"**§ 131E-311. Conflicts; severability.**

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Department shall continue to process applications for provider sponsored

organization licenses as described in this Article. If any section, term, or provision of this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"§ 131E-312. Regulations.

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Department may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Department shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Department shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof.

"§ 131E-313. Utilization review and grievances.

Unless otherwise preempted by federal law or mandated by the Medicare program, the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this Article as if the PSO was an 'insurer' under those sections, except that the Department rather than the Commissioner of Insurance shall regulate a PSO's compliance with those sections."

Section 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.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization

certified, qualified, or otherwise approved by the Department of Health and Human Services pursuant to Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

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

Section 3. G.S. 90-21.22A reads as rewritten:

"§ 90-21.22A. Medical review committees.

(a) As used in this section, "medical review committee" means a committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. "Medical review committee" does not mean a medical review committee established under G.S. 131E-95.

(b) A member of a duly appointed medical review committee who acts without malice or fraud shall not be 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.

(c) The proceedings of a medical review committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of ~~G.S. 132-1~~ G.S. 132-1, 131E-309, or ~~G.S.~~ 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this ~~Chapter or~~ Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about his or her testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under ~~G.S. 58-50-61 or G.S. 58-50-62.~~ G.S. 58-50-61, 58-50-62, or 131E-313."

Section 3.1. Nothing in this act shall obligate the General Assembly to appropriate funds to implement this act.

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-51-55. The plan may use a case management program in accordance with G.S. 58-51-55.

Section 2. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(d) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group health insurance contracts covering 5 or more employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a policy or contract if the insurer demonstrates to the Commissioner that compliance has increased the cost of the policy by two percent (2%) or more on an annual basis."

Section 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every group insurance certificate or group subscriber contract under a hospital or medical plan subject to this Article shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) The service corporation may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group contracts covering 5 or more employees. The remainder of this section applies only to group contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a subscriber contract or certificate if the service corporation demonstrates to the Commissioner that

compliance has increased the cost of the contract or certificate by two percent (2%) or more on an annual basis."

Section 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every health maintenance organization that issues a health care plan on a group basis for medical and hospitalization care shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) A health maintenance organization may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) This section applies only to group contracts covering five or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a health care plan if the HMO demonstrates to the Commissioner that compliance has increased the cost of the plan by two percent (2%) or more on an annual basis."

Section 5. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998. This act expires October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97
Proposed House Committee Substitute S400-PCS9602-RN006

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. The plan may use a case management program in accordance with G.S. 58-3-220."

Section 2.(a) The following are repealed: G.S. 58-51-55(b1) and (c), 58-65-90(b1) and (c), and 58-67-75(b1) and (c).

(b) G.S. 58-51-55(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this~~ This section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

(c) G.S. 58-65-90(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this~~ This section applies only to group contracts covering 20 or more employees."

(d) G.S. 58-67-75(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this~~ This section applies only to group contracts covering 20 or more employees."

Section 3. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Parity Requirement. -- A health insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Averages. -- If the plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Exceptions. -- This section does not apply to either of the following:

(1) A group health benefit plan covering fewer than five employees.

(2) Any other group health benefit plan if the insurer demonstrates to the Commissioner that compliance with this section has increased the cost of the policy by two percent (2%) or more on an annual basis. If the group health plan or contract granted an exemption under this section nevertheless wants to offer limited mental illness benefits coverage and there are 50 or more employees in the plan, the plan may not provide a lesser lifetime or annual dollar limitation than is provided under the plan for physical illness generally, unless providing parity in annual and lifetime limits increases the plan's cost by one percent (1%) or more.

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

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-190 and includes a blanket health policy or blanket accident and health policy.

(2) 'Insurer' has the same meaning as in G.S. 58-3-190.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals."

Section 4. This act becomes effective January 1, 1999, and applies to contracts issued, delivered, or renewed on or after that date. This act expires October 1, 2002.

AGENDA

HOUSE INSURANCE COMMITTEE

Subcommittee On Health

July 29, 1998
Room 1228 LB
15 Minutes after Session

I. OPENING REMARKS

Representative Daniel F. McComas, Chairman
Subcommittee on Health

II. BILLS TO BE CONSIDERED

SB 400, Mental Health Parity.

III. ADJOURNMENT

HOUSE INSURANCE
SUBCOMMITTEE ON HEALTH
MINUTES

July 29, 1998

The House Insurance/Subcommittee on Health met on July 29, 1998, 15 minutes after Session in Room 1228 of the Legislative Building.

Representative Daniel F. McComas, Chairman, presided, and the following members were present:

> Representatives: Barbee, Cole, Dickson, Esposito, Hardy, Hensley, Ives, Luebke, Miller, Preston, Russel and Wright. Representative Dockham, Chairman of the House Insurance Committee, was also present.

Visitors present were as follows: (see Attachment 1).

Staff Counsel Linda Attarian, Linwood Jones and Ed Rossi were present to assist the Subcommittee.

Chairman McComas called the meeting to order, introduced the Pages and Sergeant-at-Arms serving the Subcommittee and welcomed guests. After some instructions concerning the procedures for the meeting, the following bill was considered:

> Pensions and Retirement and Insurance Committee Substitute for SB 400, An Act To Require Parity In Health Insurance For Mental Illness. (see Attachment 2) The proposed House Committee Substitute for SB 400 was before the Subcommittee for discussion (see Attachment 3): Representative McComas introduced the following members of the audience to speak on the bill:
>
> 1. **Beth Melcher**, Director of NOMI North Carolina, spoke in favor of the bill.
>
> 2. **Mike Herman**, Assistant General Counsel with the Health Insurance Association of America, spoke in opposition to the bill.
>
> 3. **Marlyn Webb** who suffers with Bipolar Disorder spoke in favor of the bill.
>
> 4. **Dr. Windy McLeod**, a Medical Director with Blue Cross/Blue Shield of North Carolina, spoke in opposition to the bill.
>
> 5. **Polly Williams**, standing in for Evelyn Brendel with the AARP State Legislative Committee, read Ms. Brendel's remarks which were in favor of the bill.

6. **Perri Morgan** with the National Federation of Independent Businesses spoke in opposition to the bill.

7. **Theo Pitt**, President of the Mental Health Association in North Carolina, spoke in favor of the bill.

8. **Graham Blanton** with Mid South Life Insurance Company spoke in opposition to the bill.

9. **Dan Hill** with Hill Chesson Associates spoke in opposition to the bill.

After their remarks, each speaker entertained questions from the Subcommittee. Perri Morgan was instructed to provide further information to the Subcommittee regarding how many employees and employers of the National Federation of Independent Businesses would be affected statewide by the bill's more stringent requirements on employers covering more than 50 employees. Graham Blanton was instructed to provide further information to the Subcommittee regarding how much Mid South Life Insurance Company's small group plans for mental health coverage raised their monthly premium in percentage or dollars.

Linwood Jones, Subcommittee Counsel, was instructed to provide the Subcommittee with the type of mental health plan the State of Georgia has for their review.

Ron Bachman, an Actuary with Price, Waterhouse, Coopers, was recognized to entertain any questions from the Subcommittee.

No action was taken on the bill during this meeting.

On a motion by Representative Dickson, the meeting adjourned at 5:15 p.m.

Representative Daniel F. McComas
Subcommittee Chairman

Jane M. "Dee" Bagley
Subcommittee Clerk

VISITOR REGISTRATION SHEET

House Subcommittee on Health — **July 29, 1998**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
B. Michael Herman	Health Insurance Association of America
Robert Paschal	Young, Moore + Henderson, P.A.
Wendy MacLeod	BCBSNC
[illegible]	BCBSNC
Anna Jo Bain	Smith Anderson
Leslie Hicks	NCNA
Dan Hill	Hill Chesson & Assoc.
Fred Joyner	N.C. Assoc. Life Underwriters
"	N.C. Assoc. of Health Underwriters
Perri Morgan	NFIB
John Bowdish	Zeb Alley P.A.
Paul Mahoney	NC Assn of Health Plans
Marilin Webb	Invited by Chairman McComas to speak.
[illegible]	APAC
[illegible]	Mid South [illegible]
[illegible]	Morris Van Alk
Alec Case	NCRMA
Fran Preston	"
Andy Ellen	"
Patrice Alexander	Champion Int'l Corporation
George Reed	NC Council of Churches
Jim Tott	MHA/NC
Liz Jordak	MHA/Mecklenburg County
[illegible]	DMH/DD/SAS
Joyce Peters	[illegible] Assoc/Manns
Cindy Parker	Bone & Assoc.
Kevin Kukura	DuPont
Allen Spader	NC Council of Community Programs

VISITOR REGISTRATION SHEET

House Subcommittee on Health — **July 29, 1998**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Woodson	NC Farm Bureau
[illegible]	[illegible] Poe
Barrett Brewer	Capital Strategies
A. Christine Yates	Capital Strategies
[illegible] Robinson-Oberschall	Depressive Bi-Polar [illegible]
Gail Pruett	NCNA
Joanne Schron	N.C. nurses assoc.
Mac Brownlee	Gov. Advocacy Council for Persons w Disabilities
GEORGE KERNS	Gov Advocacy Council for Persons w. Disabilities
Scott J Geddes	Self
Paula A. Wolf.	Covenant with NC's Children
T. Jerry Wilson	NC Retirement Assn.
Katherine Huff	NC Psychiatric Assoc.
Polly Williams	AARP
Myrna Miller	Nat'l Assoc. of Social Workers - NC Chapter (NASW-NC)
Laura W. Langner	NATIONAL ASSOC OF Social Workers → INTERN

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S D

SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97
Proposed House Committee Substitute S400-PCS9602-RN006

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. The plan may use a case management program in accordance with G.S. 58-3-220."

Section 2.(a) The following are repealed: G.S. 58-51-55(b1) and (c), 58-65-90(b1) and (c), and 58-67-75(b1) and (c).

(b) G.S. 58-51-55(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this~~ This section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

(c) G.S. 58-65-90(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this~~ This section applies only to group contracts covering 20 or more employees."

(d) G.S. 58-67-75(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this~~ This section applies only to group contracts covering 20 or more employees."

Section 3. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Parity Requirement. -- A health insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Averages. -- If the plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Exceptions. -- This section does not apply to either of the following:

(1) A group health benefit plan covering fewer than five employees.

(2) Any other group health benefit plan if the insurer demonstrates to the Commissioner that compliance with this section has increased the cost of the policy by two percent (2%) or more on an annual basis. If the group health plan or contract granted an exemption under this section nevertheless wants to offer limited mental illness benefits coverage and there are 50 or more employees in the plan, the plan may not provide a lesser lifetime or annual dollar limitation than is provided under the plan for physical illness generally, unless providing parity in annual and lifetime limits increases the plan's cost by one percent (1%) or more.

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

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-190 and includes a blanket health policy or blanket accident and health policy.

(2) 'Insurer' has the same meaning as in G.S. 58-3-190.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals."

Section 4. This act becomes effective January 1, 1999, and applies to contracts issued, delivered, or renewed on or after that date. This act expires October 1, 2002.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

S 3

SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97

Short Title: Mental Health Parity. (Public)

Sponsors:

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March 17, 1997

A BILL TO BE ENTITLED

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Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-51-55. The plan may use a case management program in accordance with G.S. 58-51-55.

Section 2. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(d) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group health insurance contracts covering 5 or more employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a policy or contract if the insurer demonstrates to the Commissioner that compliance has increased the cost of the policy by two percent (2%) or more on an annual basis."

Section 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every group insurance certificate or group subscriber contract under a hospital or medical plan subject to this Article shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) The service corporation may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group contracts covering 5 or more employees. The remainder of this section applies only to group contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a subscriber contract or certificate if the service corporation demonstrates to the Commissioner that

compliance has increased the cost of the contract or certificate by two percent (2%) or more on an annual basis."

Section 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

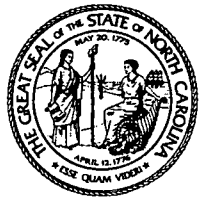
(d) Every health maintenance organization that issues a health care plan on a group basis for medical and hospitalization care shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) A health maintenance organization may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) This section applies only to group contracts covering five or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a health care plan if the HMO demonstrates to the Commissioner that compliance has increased the cost of the plan by two percent (2%) or more on an annual basis."

Section 5. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998. This act expires October 1, 2001.



AGENDA

HOUSE INSURANCE COMMITTEE

Subcommittee On Health

August 5, 1998
Room 544 LOB
15 Minutes After Session

I. OPENING REMARKS

Representative Daniel F. McComas, Chairman
Subcommittee on Health

II. BILLS TO BE CONSIDERED

SB 400, Mental Health Parity.

III. ADJOURNMENT

HOUSE INSURANCE
SUBCOMMITTEE ON HEALTH
MINUTES

August 5, 1998

The House Insurance/Subcommittee on Health met on August 5, 1998, 15 minutes after Session in Room 544 of the Legislative Office Building.

Representative Daniel F. McComas, Chairman, presided, and the following members were present:

> Representatives: Barbee, Bowie, Cole, Dickson, Hardy, Hensley, Ives, Luebke, Michaux, Miner and Preston. Representative Dockham, Chairman of the House Insurance Committee, was also present.

Visitors present were as follows: (see Attachment 1).

Staff Counsel Linda Attarian and Ed Rossi were present to assist the Subcommittee.

Chairman McComas called the meeting to order, introduced the Pages and Sergeant-at-Arms serving the Subcommittee and welcomed guests. The following bill was considered:

> Pensions and Retirement and Insurance Committee Substitute for SB 400, An Act To Require Parity In Health Insurance For Mental Illness. (see Attachment 2) The proposed House Committee Substitute for SB 400 was before the Subcommittee for discussion (see Attachment 3): After expressing his heartfelt discontent with how childish, personal and confrontational the issue had become from both sides; he stated that, in order to get an agreeable bill that would be to the satisfaction of most, if not all, Subcommittee members; he was appointing a Special Subcommittee to study the issue. He reiterated that he was committed to seeing the bill come to a vote and, in order to assure that, the Standing Subcommittee would be scheduling a meeting on August 19, at which time the Special Subcommittee would present legislation to them. He encouraged the Special Subcommittee to meet with professionals in all areas that they do not know much about (i.e. clinical, biological and medical). The members of the Special Subcommittee are as follows:
>
> > Representatives Dockham, Barbee, Miner, Russell, Bowie and Miller. Representative Dockham was appointed as chair.
>
> A question was raised as to where the bill would go after it was voted on by the Standing Subcommittee. Representative Dockham, Chairman of

the Insurance Committee, stated that it was his understanding that it would be reported to the House Floor.

Representative Luebke questioned Representative McComas' directive to the Special Subcommittee to reach a consensus, and expressed his fear that all bills were not capable of that in terms of their content. Representative McComas clarified that he stated to most, if not all members of the Standing Subcommittee. He went on to say that he was confident that the Special Subcommittee, after addressing the clinical and biological sides of the issue, could come up with a reasonable compromise; and the bill could be voted on by the Standing Subcommittee.

No action was taken on the bill during this meeting.

The meeting adjourned at 4:13 p.m.

Representative Daniel F. McComas
Subcommittee Chairman

Jane M. "Dee" Bagley
Subcommittee Clerk

VISITOR REGISTRATION SHEET

HOUSE INSURANCE/Subcommittee on Health — **AUGUST 5, 1998**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Howell	NCBA
Robt PAschal	Young, Moore
NANCYE BRYAN	NC. Alliance for the Mentally Ill
Shirley Strobel	NAMI-NC
Katherine Pittman	NC Psychiatric Assoc.
Polly Williams	AARP
Ballard Everett	NAMI-NC
Gail Pruett	NCNA
Joe Donovan	NAMI-NC
Stephanie Gilmore	NAMI-NC
Norma Whitfield	NAMI-NC
Barrett Brewer	Capital Strategies
Rogers Bowe	Bowe & Assoc-
W M Meade	The Herndon Group, INC.
Mary T. [illegible]	NAMI LPNC Inc.
Ken Vandell	NAMI NC
Theo Pitt, Jr	MHA/NC
Kay [illegible]	MHA/DC
Christina Hedlin	Covenant w/ NC Children
Ann Case	NCRMA
Nancy Bradley	NCCBI
Laura Hernandez	NASW
Myrna Miller	NASW

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-51-55. The plan may use a case management program in accordance with G.S. 58-51-55.

Section 2. G.S. 58-51-55 reads as rewritten:

"**§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-51-50

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No insurance company licensed in this State under ~~the provisions of Articles 1 through 64 of~~ this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any insurance company from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the insurance company or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group health insurance contracts covering 20 or more employees.~~

(d) Every insurer that writes a policy or contract of group or blanket health insurance or group or blanket accident and health insurance shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group health insurance contracts covering 5 or more employees. The remainder of this section applies only to group health insurance contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a policy or contract if the insurer demonstrates to the Commissioner that compliance has increased the cost of the policy by two percent (2%) or more on an annual basis."

Section 3. G.S. 58-65-90 reads as rewritten:

"**§ 58-65-90. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-65-75

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No ~~hospital, medical, dental or health service~~ corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

(1) Refuse to issue or deliver to that individual any individual or group hospital, dental, medical or health service contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any hospital or medical plan from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the hospital or medical plan or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every group insurance certificate or group subscriber contract under a hospital or medical plan subject to this Article shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) The service corporation may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) Subsections (d) and (e) of this section apply only to group contracts covering 5 or more employees. The remainder of this section applies only to group contracts covering 20 or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a subscriber contract or certificate if the service corporation demonstrates to the Commissioner that

compliance has increased the cost of the contract or certificate by two percent (2%) or more on an annual basis."

Section 4. G.S. 58-67-75 reads as rewritten:

"**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

(a) As used in this section, the term:

(1) 'Mental illness' has the same meaning as defined in G.S. 122C-3(21); and

(2) 'Chemical dependency' has the same meaning as defined in G.S. 58-67-70

with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals.

(b) No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(c) Nothing in this section prevents any health maintenance organization from excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency which has existed previous to coverage of the individual by the health maintenance organization or from refusing to issue or deliver to that individual any policy because of the underwriting of any physical condition whether or not related to ~~mental illness or~~ chemical dependency.

~~(d) This section applies only to group contracts covering 20 or more employees.~~

(d) Every health maintenance organization that issues a health care plan on a group basis for medical and hospitalization care shall provide to its insureds benefits for the necessary care and treatment of mental illness that are not less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as are benefits for physical illness generally. For purposes of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors, copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(e) A health maintenance organization may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section concerning parity between the benefits for mental illness and those for physical illness generally.

(f) This section applies only to group contracts covering five or more employees.

(g) Subsections (d) and (e) of this section shall not apply to a health care plan if the HMO demonstrates to the Commissioner that compliance has increased the cost of the plan by two percent (2%) or more on an annual basis."

Section 5. This act is effective when it becomes law and applies to contracts issued, delivered, or renewed on or after January 1, 1998. This act expires October 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 400*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/28/97
Third Edition Engrossed 4/30/97
Proposed House Committee Substitute S400-PCS9602-RN006

Short Title: Mental Health Parity. (Public)

Sponsors:

Referred to:

March 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL ILLNESS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-155 is amended by adding the following new subsection to read:

"(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for the treatment of mental illness that is at least equal to the coverage required by G.S. 58-3-220. The plan may use a case management program in accordance with G.S. 58-3-220."

Section 2.(a) The following are repealed: G.S. 58-51-55(b1) and (c), 58-65-90(b1) and (c), and 58-67-75(b1) and (c).

(b) G.S. 58-51-55(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to group health insurance contracts covering more than 50 employees. The remainder of this~~ This section applies only to group health insurance contracts covering 20 or more employees. For purposes of this section, 'group health insurance contracts' include MEWAs, as defined in G.S. 58-49-30(a)."

(c) G.S. 58-65-90(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to subscriber contracts covering more than 50 employees. The remainder of this~~ This section applies only to group contracts covering 20 or more employees."

(d) G.S. 58-67-75(d) reads as rewritten:

"(d) Applicability. -- ~~Subsection (b1) of this section applies only to group contracts covering more than 50 employees. The remainder of this~~ This section applies only to group contracts covering 20 or more employees."

Section 3. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-220. Mental illness benefits coverage.**

(a) Mental Parity Requirement. -- A health insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally. Benefits for treatment of mental illness shall be subject to the same limits as benefits for physical illness generally. For purposes of this subdivision, 'limits' includes durational limits, deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) Weighted Averages. -- If the plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the plan, the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(c) Case Management. -- An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and medically appropriate care and treatment for each patient, provided that the program complies with rules adopted by the Commissioner of Insurance. These rules shall ensure that case management programs are not designed to avoid the requirements of this section for parity between the benefits for mental illness and those for physical illness generally.

(d) Exceptions. -- This section does not apply to either of the following:

(1) A group health benefit plan covering fewer than five employees.

(2) Any other group health benefit plan if the insurer demonstrates to the Commissioner that compliance with this section has increased the cost of the policy by two percent (2%) or more on an annual basis. If the group health plan or contract granted an exemption under this section nevertheless wants to offer limited mental illness benefits coverage and there are 50 or more employees in the plan, the plan may not provide a lesser lifetime or annual dollar limitation than is provided under the plan for physical illness generally, unless providing parity in annual and lifetime limits increases the plan's cost by one percent (1%) or more.

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

(1) 'Health benefit plan' has the same meaning as in G.S. 58-3-190 and includes a blanket health policy or blanket accident and health policy.

(2) 'Insurer' has the same meaning as in G.S. 58-3-190.

(3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV or the International Classification of Diseases ICD/9/CM, or a later edition of those manuals."

Section 4. This act becomes effective January 1, 1999, and applies to contracts issued, delivered, or renewed on or after that date. This act expires October 1, 2002.