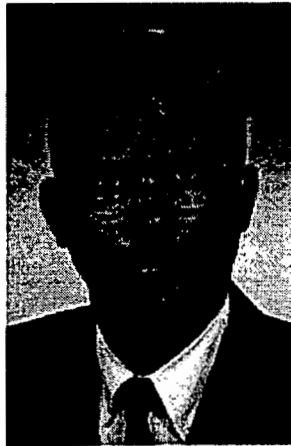


1998

**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



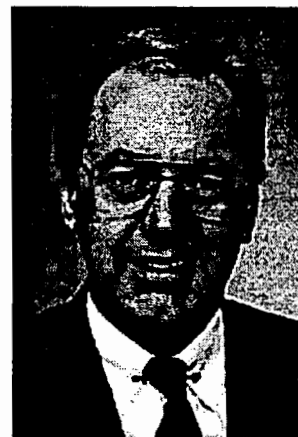
Rep. Thomas Wright



Rep. Leo Daughtry
Majority Leader
Ex Officio



Rep. Julia Howard
Majority Whip
Ex Officio



Rep. Steve Wood
Speaker Pro Tem
Ex Officio

**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 Jayne Walton	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...

<u>MEMBER/Clerk</u>	<u>PHONE</u>	<u>OFFICE</u>	<u>SEAT</u>
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	

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

HOUSE: INSURANCE--HEALTH

Valid Through 22-OCT-1998

1997-98 Regular Session

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.

BOLD 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

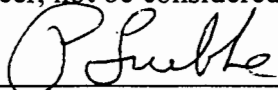
SUBJECT: HB 1223, Family Health-Care Program.

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.

oooooooooooo

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.

 (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

VISITOR REGISTRATION SHEET

House Subcommittee on Health

July 9, 1998

Name of Committee

Date _____

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

[illegible]

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H

1

HOUSE BILL 1455*

Short Title: PSO Medicare Licensing.

(Public)

Sponsors: Representatives Cansler and Bowie.

Referred to: Insurance, if favorable, Finance.

May 25, 1998

1 A BILL TO BE ENTITLED
2 AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION
3 LICENSING.

4 The General Assembly of North Carolina enacts:

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

7 "ARTICLE 17.

8 "Provider Sponsored Organization Licensing.

9 "§ 131E-275. General provisions.

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

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

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

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

14 "§ 131E-276. Definitions.

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

- 17 (1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries
18 of the Medicare+Choice program who are enrolled with the
19 provider sponsored organization (PSO) under the terms of a
20 contract between the PSO and the Medicare program.
- 21 (2) 'Commissioner' means the Commissioner of Insurance of North
22 Carolina.
- 23 (3) 'Current assets' means cash, marketable securities, accounts
24 receivable, and other current items that will be converted into cash
25 within 12 months.
- 26 (4) 'Current liabilities' means accounts payable and other accrued
27 liabilities, including payroll, claims, and taxes that will need to be
28 paid within 12 months.
- 29 (5) 'Current ratio' means the ratio of current assets divided by current
30 liabilities calculated at the end of any accounting period.
- 31 (6) 'Department' means the Department of Health and Human
32 Services acting through the North Carolina Medical Care
33 Commission.
- 34 (7) 'Emergency services' shall have the same meaning as for that term
35 defined in G.S. 58-50-61(a)(5).
- 36 (8) 'Health Care Delivery Assets' means any tangible asset that is part
37 of a PSO operation, including hospitals, medical facilities, and
38 their ancillary equipment, and any property that may reasonably be
39 required for the PSO's principal office or for any purposes that
40 may be necessary in the transaction of the business of the PSO.
- 41 (9) 'Health plan contract' or 'Medicare contract' means a PSO's direct
42 contract with the United States Department of Health and Human
43 Services under section 1857 of the federal Social Security Act.

- 1 (10) 'Out-of-network services' means health care items or services that
2 are covered services under a PSO's Medicare contract and that are
3 provided to beneficiaries by health care providers that are not
4 participating providers in the PSO's network of health care
5 providers.
- 6 (11) 'Parent of a sponsoring provider' means the public or private
7 entity that owns or controls a controlling interest in the sponsoring
8 provider or that has the power to appoint a controlling number of
9 the governing board of a sponsoring provider or that has the power
10 to direct the management policy and decisions of the sponsoring
11 provider.
- 12 (12) 'Provider' or 'health care provider' means: (i) any individual that
13 is engaged in the delivery of health care services and that is
14 required by North Carolina law or regulation to be licensed to
15 engage in the delivery of these health care services and is so
16 licensed; (ii) any entity that is engaged in the delivery of health
17 care services and that is required by North Carolina law or
18 regulation to be licensed to engage in the delivery of these health
19 care services and is so licensed; or (iii) any entity that is owned or
20 controlled entirely by individuals or entities described in subparts
21 (i) or (ii) of this definition.
- 22 (13) 'Provider sponsored organization' or 'PSO' means a public or
23 private entity domiciled in this State, including a business
24 corporation, a nonprofit corporation, a partnership, a limited
25 liability company, a professional limited liability company, a
26 professional corporation, a sole proprietorship, a public hospital, a
27 hospital authority, a hospital district, or a body politic; (i) that is
28 established or organized by a health care provider or group of
29 affiliated health care providers; (ii) in which physicians licensed
30 pursuant to Article 1 of Chapter 90 of the General Statutes or to
31 the laws of any state of the United States comprise no less than
32 fifty percent (50%) of the governing board or body, unless
33 otherwise prohibited by law; (iii) that provides a substantial
34 proportion of the services under each Medicare contract directly
35 through the provider or group of affiliated providers; and (iv) in
36 which the provider or affiliated providers directly or indirectly
37 share substantial financial risk and have at least a majority
38 financial interest. The requirement in subpart (ii) of this definition
39 shall not preclude a PSO that includes a tax-exempt hospital from
40 adopting a bylaw provision that provides a veto for the tax-exempt
41 hospital over actions of the PSO necessary to maintain the
42 hospital's tax-exempt status. A PSO shall not be out of
43 compliance with the requirement in subpart (ii) due to temporary
44 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

1 services, for a fixed, predetermined payment, when the costs of
2 that course of treatment for any individual patient can vary greatly
3 due to the individual patient's treatment or other factors; or
4 (5) Agree to any other arrangement that the Department determines to
5 provide for the sharing of substantial financial risk by the
6 sponsoring providers.

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

10 **"§ 131E-278. Applicability of other laws.**

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

17 **"§ 131E-279. Approval.**

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

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

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

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

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

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

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

21 "§ 131E-280. Applicants for license.

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

- 26 (1) A copy of the basic organizational document, if any, of the
27 applicant and each sponsoring organization that holds greater than
28 a five percent (5%) interest in the PSO, such as the articles of
29 incorporation, articles of organization, partnership agreement, trust
30 agreement, or other applicable documents, and all amendments
31 thereto;
- 32 (2) A copy of the respective bylaws, rules and regulations, or similar
33 documents, if any, regulating the conduct of the internal affairs of
34 the applicant and each sponsoring provider which holds greater
35 than a five percent (5%) interest in the PSO;
- 36 (3) Copies of the document evidencing the arrangements between the
37 applicant and each sponsoring provider that create the
38 relationships and obligations described in G.S. 131E-276(n);
- 39 (4) A list of the names, addresses, and official positions of persons who
40 are to be responsible for the conduct of the affairs of the applicant
41 and of each sponsoring provider that holds greater than a five
42 percent (5%) interest in the PSO, respectively, including all
43 members of the respective boards of directors, boards of trustees,
44 executive committees, or other governing boards or committees.

- 1 the principal officers in the case of a corporation, and the partners
2 or members in the case of a partnership or association;
3 (5) A copy of any contract form made or to be made between any
4 class of providers and the PSO and a copy of any contract form
5 made or to be made between third-party administrators, marketing
6 consultants, or persons listed in subdivision (3) of this subsection
7 and the PSO;
8 (6) A statement generally describing the provider sponsored
9 organization, its sponsoring providers, its health care plan or plans,
10 facilities, and personnel;
11 (7) A copy of the hospital license of each sponsoring provider that is a
12 hospital, a copy of the license to practice medicine of each
13 sponsoring provider or owner of a sponsoring provider that is a
14 licensed physician, and a copy of the health care service or facility
15 license held by any other licensed sponsoring provider;
16 (8) Financial statements showing the applicant's assets, liabilities,
17 sources of financial support, and the financial statements of each
18 sponsoring provider that holds greater than a five percent (5%)
19 interest in the PSO showing the sponsoring provider's assets,
20 liabilities, and sources of support. If the applicant's or any such
21 sponsoring provider's financial affairs are audited by independent
22 certified public accountants, a copy of the applicant's or
23 sponsoring provider's most recent regular certified financial
24 statement shall be considered to satisfy this requirement unless the
25 Department directs that additional or more recent financial
26 information is required for the proper administration of this
27 Article;
28 (9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-
29 297, 131E-298, or 131E-299 are guaranteed by one or more
30 guarantors, financial statements showing each guarantor's assets,
31 liabilities, and sources of financial support. If a guarantor's
32 financial affairs are audited by independent certified public
33 accountants, a copy of the guarantor's most recent regular audited
34 financial statement shall be considered to satisfy this requirement
35 unless the Department directs that additional or more recent
36 financial information is required for the proper administration of
37 this Article;
38 (10) A financial plan, satisfactory to the Department, covering the first
39 12 months of operation under the PSO's Medicare contract and
40 which meets the requirements of G.S. 131E-283. If the financial
41 plan projects losses, the financial plan must cover the period
42 through 12 months beyond the projected breakeven;
43 (11) A statement reasonably describing the geographic area or areas to
44 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 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

- 1 determined by the Department if the PSO operates primarily in
2 rural areas.
- 3 (3) The PSO shall have at least seven hundred fifty thousand dollars
4 (\$750,000) in cash or equivalents on its balance sheet, except that
5 the Department may permit a PSO operating primarily in rural
6 areas to have a lesser amount held in cash or equivalents on its
7 balance sheets.
- 8 (4) The applicant submits a financial plan satisfactory to the
9 Department which covers the first 12 months of operation of the
10 PSO's Medicare contract and which meets the requirements of
11 G.S. 131E-283. If the plan projects losses, the financial plan shall
12 cover the period through 12 months beyond projected break-even.
- 13 (5) The Department determines that the applicant has sufficient cash
14 flow to meet its obligations as they become due. In making that
15 determination, the Department shall consider the following:
- 16 a. The timeliness of payment;
17 b. The extent to which the current ratio is maintained at one
18 to one, or whether there is a change in the current ratio
19 over a period of time; and
20 c. The availability of outside financial resources.
- 21 (b) In calculating the net worth of a PSO, the Department shall admit the
22 following:
- 23 (1) One hundred percent (100%) of the book value of health care
24 delivery assets on the balance sheet of the applicant.
- 25 (2) One hundred percent (100%) of the value of cash and cash
26 equivalents on the balance sheet of the applicant.
- 27 (3) If at least one million dollars (\$1,000,000) of the initial minimum
28 net worth requirement is met by cash or cash equivalents, then one
29 hundred percent (100%) of the book value of the PSO's intangible
30 assets up to twenty percent (20%) of the minimum net worth
31 amount required. If less than one million dollars (\$1,000,000) of
32 the initial minimum net worth requirement is met by cash or cash
33 equivalents or if the Department has used its discretion to reduce
34 the initial net worth requirement below one million five hundred
35 thousand dollars (\$1,500,000), then the Department shall admit one
36 hundred percent (100%) of the book value of intangible assets of
37 the PSO up to ten percent (10%) of the minimum net worth
38 amount required.
- 39 (4) Standard accounting principles treatment shall be given to other
40 assets of the PSO not used in the delivery of health care for the
41 purposes of meeting the minimum net worth requirement.
- 42 (5) Deferred acquisition costs shall not be admitted.
- 43 **"§ 131E-283. Financial plan.**
44 (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

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

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

6 **"§ 131E-284. Modifications.**

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

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

25 **"§ 131E-285. Deposits.**

26 (a) The Department shall require a deposit of one hundred thousand dollars
27 (\$100,000) for all provider sponsored organizations. Said deposits shall be included
28 in the calculations of a PSO's or applicant's net worth.

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

31 **"§ 131E-286. Ongoing financial standards - net worth.**

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

- 35 (1) One million dollars (\$1,000,000);
36 (2) Two percent (2%) of annual premium revenues as reported on the
37 most recent annual financial statement filed with the Department
38 on the first one hundred fifty million dollars (\$150,000,000) of
39 premium and one percent (1%) of annual premium on the
40 premium in excess of one hundred fifty million dollars
41 (\$150,000,000);
42 (3) An amount equal to the sum of three months uncovered health
43 care expenditures as reported on the most recent financial
44 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

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

5 **"§ 131E-288. Liquidity.**

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

- 9 (1) The timeliness of payment;
10 (2) The extent to which the current ratio is maintained at one to one
11 or whether there is a change in the current ratio over a period of
12 time; and
13 (3) The availability of outside financial resources.

14 (b) The following corresponding remedies apply:

- 15 (1) If the PSO fails to pay obligations as they become due, the
16 Department shall require the PSO to initiate corrective action to
17 pay all overdue obligations.
18 (2) The Department may require the PSO to initiate corrective action
19 if any of the following are evident: (i) the current ratio declines
20 significantly; or (ii) a continued downward trend in the current
21 ratio. The corrective action may include a change in the
22 distribution of assets, a reduction of liabilities, or alternative
23 arrangements to secure additional funding requirements to restore
24 the current ratio to one to one.
25 (3) If there is a change in the availability of the outside resources, the
26 Department shall require the PSO to obtain funding from
27 alternative financial resources.

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

33 **"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.**

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

- 37 (1) Seven hundred fifty thousand dollars (\$750,000) cash or cash
38 equivalents; or
39 (2) Forty percent (40%) of the minimum net worth required.

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

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

44 **"§ 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

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

9 "§ 131E-296. Examinations.

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

15 "§ 131E-297. Hazardous financial condition.

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

- 22 (1) To reduce the total amount of present and potential liability for
23 benefits by reinsurance;
- 24 (2) To reduce the volume of new business being accepted;
- 25 (3) To reduce the expenses by specified methods;
- 26 (4) To suspend or limit the writing of new business for a period of
27 time;
- 28 (5) To require an increase to the provider sponsored organization's
29 net worth by contribution;
- 30 (6) To add or delete sponsoring providers;
- 31 (7) To increase the amount of payments from the PSO which
32 sponsoring providers agree to forego; or
- 33 (8) To require additional guaranties from sponsoring providers or from
34 parents of sponsoring providers.

35 (b) If the Department determines that the liquidity standards in G.S. 131E-286,
36 131E-288, and 131E-289 do not provide sufficient early warning that the continued
37 operation of any provider sponsored organization might be hazardous to its
38 beneficiaries, creditors, or the general public, the Department may adopt rules to set
39 uniform standards and criteria for such an early warning and to set standards for
40 evaluating the financial condition of any provider sponsored organization, which
41 standards shall be consistent with the purposes expressed in subsection (a) of this
42 section.

43 "§ 131E-298. Protection against insolvency.

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

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

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

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

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

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

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

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

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

27 "§ 131E-299. Hold harmless agreements or special deposit.

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

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

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

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

- 1 account is maintained, cash or securities that are acceptable
2 to the Department. This deposit shall at all times have a
3 fair market value in an amount of one hundred twenty
4 percent (120%) of the PSO's outstanding liability for
5 uncovered expenditures for enrollees, including incurred but
6 not reported claims, and shall be calculated as of the first
7 day of the month and maintained for the remainder of the
8 month. If a PSO is not otherwise required to file a quarterly
9 report, it shall file a report within 45 days of the end of the
10 calendar quarter with information sufficient to demonstrate
11 compliance with this section; or
- 12 b. Maintain adequate insurance or a guaranty arrangement
13 approved in writing by the Department, to pay for any loss
14 to beneficiaries claiming reimbursement due to the
15 insolvency of the PSO. The Department shall approve a
16 guaranty arrangement if the guarantying organization is a
17 sponsoring provider, has been operating for at least 10 years
18 and has a net worth, including organization-related land,
19 buildings, and equipment of at least fifty million dollars
20 (\$50,000,000), unless the Department finds that the approval
21 of this guaranty may be financially hazardous to
22 beneficiaries.
- 23 (2) The deposit required under sub-subdivision a. of subdivision (1) of
24 this section is an admitted asset of the PSO in the determination of
25 net worth. All income from such deposits or trust accounts shall
26 be assets of the PSO and may be withdrawn from such deposit or
27 account quarterly with the approval of the Department;
- 28 (3) A PSO that has made a deposit may withdraw that deposit or any
29 part of the deposit if (i) a substitute deposit of cash or securities of
30 equal amount and value is made, (ii) the fair market value exceeds
31 the amount of the required deposit, or (iii) the required deposit
32 under this subsection is reduced or eliminated. Deposits,
33 substitutions, or withdrawals may be made only with the prior
34 written approval of the Department;
- 35 (4) The deposit required under sub-subdivision a. of subdivision (1) of
36 this section is in trust and may be used only as provided under this
37 section. The Department may use the deposit of an insolvent PSO
38 for administrative costs associated with administering the deposit
39 and payment of claims of enrollees of the PSO.
- 40 (c) Whenever the reimbursements described in this section exceed
41 percent (%) of the PSO's total costs for health care
42 services over the immediately preceding six months, the PSO shall file a written
43 report with the Department containing the information necessary to determine
44 compliance with sub-division a. of subdivision (1) of this section no later than 30

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

6 "§ 131E-300. Continuation of benefits.

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

- 12 (1) Insurance to cover the expenses to be paid for benefits after an
13 insolvency;
- 14 (2) Provisions in provider contracts that obligate the provider to
15 provide services for the duration of the period after the PSO's
16 insolvency for which premium payment has been made and until
17 the beneficiaries' discharge from inpatient facilities;
- 18 (3) Insolvency reserves as the Department may require;
- 19 (4) Letters of credit acceptable to the Department;
- 20 (5) Additional guaranties from a sponsoring provider of the PSO or
21 from the parent of a sponsoring provider;
- 22 (6) Legally binding obligations of sponsoring providers to forego
23 payment from the PSO for services provided to beneficiaries in
24 order to avoid the insolvency of the PSO; and
- 25 (7) Any other arrangements to assure that benefits are continued as
26 specified.

27 "§ 131E-301. Insolvency.

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

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

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

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

12 **"§ 131E-302. Replacement coverage.**

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

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

28 **"§ 131E-303. Incurred but not reported claims.**

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

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

37 **"§ 131E-304. Suspension or revocation of license.**

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

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

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

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

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

13 **"§ 131E-309. Statutory construction and relationship to other laws.**

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

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

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

31 **"§ 131E-310. Filings and reports as public documents.**

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

36 **"§ 131E-311. Confidentiality of medical information.**

37 Any data or information pertaining to the diagnosis, treatment, or health of any
38 beneficiary or applicant obtained from the person or from any provider by any
39 provider sponsored organization or by any provider acting pursuant to its provider
40 contract with a provider sponsored organization shall be held in confidence and shall
41 not be disclosed to any person except to the extent that it may be necessary to carry
42 out the purposes of this Article; or upon the express consent of the beneficiary or
43 applicant; or pursuant to statute or court order for the production of evidence or the
44 discovery thereof; or in the event of claim or litigation between such person and the

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

5 "§ 131E-312. Conflicts; severability.

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

14 "§ 131E-313. Regulations.

15 This Article shall be self-implementing. No later than six months after the date of
16 enactment of this Article, the Department may adopt rules consistent with this Article
17 to authorize and regulate provider sponsored organizations to contract directly with
18 the federal Medicare program to provide health care services to the beneficiaries of
19 such programs. The Department shall issue permanent rules and, may issue
20 temporary rules, to the extent these rules may be necessary. The Department shall
21 limit its regulation of provider sponsored organizations to the licensing and regulating
22 of these organizations as risk bearing entities contracting directly with the Medicare
23 program and to the consumer protection and quality standards as provided in G.S.
24 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-
25 26(b)(3), or any successor thereof."

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

- 27 "(b) (1) It is specifically the intention of this section to permit such persons
28 as were providing health services on a prepaid basis on July 1,
29 1977, or receiving federal funds under Section 254(c) of Title 42,
30 U.S. Code, as a community health center, to continue to operate in
31 the manner which they have heretofore operated.
- 32 (2) Notwithstanding anything contained in this Article to the contrary,
33 any person can provide health services on a fee for service basis to
34 individuals who are not enrollees of the organization, and to
35 enrollees for services not covered by the contract, provided that
36 the volume of services in this manner shall not be such as to affect
37 the ability of the health maintenance organization to provide on an
38 adequate and timely basis those services to its enrolled members
39 which it has contracted to furnish under the enrollment contract.
- 40 (3) This Article shall not apply to any employee benefit plan to the
41 extent that the Federal Employee Retirement Income Security Act
42 of 1974 preempts State regulation thereof.
- 43 (3a) This Article does not apply to any prepaid health service or
44 capitation arrangement implemented or administered by the

1 Department of Health and Human Services or its representatives,
2 pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General
3 Statutes, a provider sponsored organization or other organization
4 certified, qualified, or otherwise approved by the Department of
5 Health and Human Services pursuant to Article 17 of Chapter
6 131E of the General Statutes, or to any provider of health care
7 services participating in such a prepaid health service or capitation
8 arrangement. Article; provided, however, that to the extent this
9 Article applies to any such person acting as a subcontractor to a
10 Health Maintenance Organization licensed in this State, that
11 person shall be considered a single service Health Maintenance
12 Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25,
13 and G.S. 58-67-110.

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

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

21 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

1 A BILL TO BE ENTITLED
2 AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION
3 LICENSING.

4 The General Assembly of North Carolina enacts:

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

7 "ARTICLE 17.

8 "Provider Sponsored Organization Licensing.

9 "§ 131E-275. General provisions.

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

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

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

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

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

19 "§131E-276. Definitions.

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

- 22 (1) 'Beneficiary' or 'beneficiaries' means a beneficiary or beneficiaries
23 of the Medicare+Choice program who are enrolled with the
24 provider sponsored organization (PSO) under the terms of a
25 contract between the PSO and the Medicare program.
- 26 (2) 'Commissioner' means the Commissioner of Insurance of North
27 Carolina.
- 28 (3) 'Current assets' means cash, marketable securities, accounts
29 receivable, and other current items that will be converted into cash
30 within 12 months.
- 31 (4) 'Current liabilities' means accounts payable and other accrued
32 liabilities, including payroll, claims, and taxes that will need to be
33 paid within 12 months.
- 34 (5) 'Current ratio' means the ratio of current assets divided by current
35 liabilities calculated at the end of any accounting period.
- 36 (6) 'Department' means the Department of Health and Human
37 Services.
- 38 (7) 'Emergency services' shall have the same meaning as for that term
39 defined in G.S. 58-50-61(a)(5).
- 40 (8) 'Health care delivery assets' means any tangible asset that is part of
41 a PSO operation, including hospitals, medical facilities, and their
42 ancillary equipment, and any property that may reasonably be
43 required for the PSO's principal office or for any purposes that
44 may be necessary in the transaction of the business of the PSO.

- 1 (9) 'Health plan contract' or 'Medicare contract' means a PSO's direct
2 contract with the United States Department of Health and Human
3 Services under section 1857 of the federal Social Security Act.
- 4 (10) 'Out-of-network services' means health care items or services that
5 are covered services under a PSO's Medicare contract and that are
6 provided to beneficiaries by health care providers that are not
7 participating providers in the PSO's network of health care
8 providers.
- 9 (11) 'Parent of a sponsoring provider' means the public or private
10 entity that owns or controls a controlling interest in the sponsoring
11 provider or that has the power to appoint a controlling number of
12 the governing board of a sponsoring provider or that has the power
13 to direct the management policy and decisions of the sponsoring
14 provider.
- 15 (12) 'Provider' or 'health care provider' means: (i) any individual that
16 is engaged in the delivery of health care services and that is
17 required by North Carolina law or regulation to be licensed to
18 engage in the delivery of these health care services and is so
19 licensed; (ii) any entity that is engaged in the delivery of health
20 care services and that is required by North Carolina law or
21 regulation to be licensed to engage in the delivery of these health
22 care services and is so licensed; or (iii) any entity that is owned or
23 controlled entirely by individuals or entities described in subparts
24 (i) or (ii) of this definition.
- 25 (13) 'Provider sponsored organization' or 'PSO' means a public or
26 private entity domiciled in this State, including a business
27 corporation, a nonprofit corporation, a partnership, a limited
28 liability company, a professional limited liability company, a
29 professional corporation, a sole proprietorship, a public hospital, a
30 hospital authority, a hospital district, or a body politic; (i) that is
31 established, organized, and operated by sponsoring providers; (ii)
32 in which physicians licensed pursuant to Article 1 of Chapter 90 of
33 the General Statutes or to the laws of any state of the United States
34 comprise no less than fifty percent (50%) of the governing board
35 or body, unless otherwise prohibited by law; and (iii) that provides
36 a substantial proportion of the services under each Medicare
37 contract directly through the sponsoring provider. The
38 requirement in subpart (ii) of this definition shall not preclude a
39 PSO that includes a tax-exempt hospital from adopting a bylaw
40 provision that provides a veto for the tax-exempt hospital over
41 actions of the PSO necessary to maintain the hospital's tax-exempt
42 status. A PSO shall not be out of compliance with the
43 requirement in subpart (ii) due to temporary vacancies on its
44 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

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

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

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

12 "§ 131E-278. Applicability of other laws.

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

19 "§ 131E-279. Approval.

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

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

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

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

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

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

19 "§ 131E-280. Applicants for license.

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

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

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

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

37 (4) A list of the names, addresses, and official positions of persons who
38 are to be responsible for the conduct of the affairs of the applicant
39 and of each sponsoring provider that holds greater than a five
40 percent (5%) interest in the PSO, respectively, including all
41 members of the respective boards of directors, boards of trustees,
42 executive committees, or other governing boards or committees,
43 the principal officers in the case of a corporation, and the partners
44 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.

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

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

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

16 (3) The PSO shall have at least seven hundred fifty thousand dollars
17 (\$750,000) in cash or equivalents on its balance sheet, except that
18 the Department may permit a PSO operating primarily in rural
19 areas to have a lesser amount held in cash or equivalents on its
20 balance sheets.

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

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

29 a. The timeliness of payment;

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

33 c. The availability of outside financial resources.

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

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

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

40 (3) If at least one million dollars (\$1,000,000) of the initial minimum
41 net worth requirement is met by cash or cash equivalents, then one
42 hundred percent (100%) of the book value of the PSO's intangible
43 assets up to twenty percent (20%) of the minimum net worth
44 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

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

3 (2) Deferred acquisition costs shall not be admitted.

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

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

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

15 "§ 131E-287. Reporting.

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

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

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

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

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

27 (1) The number of and reasons for grievances received from Medicare
28 beneficiaries enrolled with the PSO under the PSO's Medicare
29 contract regarding medical treatment. The report shall include the
30 number of covered lives, total number of grievances categorized by
31 reason for the grievance, the number of grievances referred to the
32 second level grievance review, the number of grievances resolved
33 at each level and their resolution and a description of the actions
34 that are being taken to correct the problems that have been
35 identified through grievances received. Every PSO shall file with
36 the Department, as part of its annual grievance report, a certificate
37 of compliance stating that the PSO has established and follows, for
38 its Medicare contract, grievance procedures that comply with G.S.
39 131E-314.

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

43 (3) The number of provider contracts between the PSO and network
44 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

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

- 3 (1) The evidence of coverage under the Medicare+Choice plan
4 provided by the PSO to Medicare beneficiaries under the terms of
5 the PSO's Medicare contract;
- 6 (2) An explanation of the utilization review criteria and treatment
7 protocol under which treatments are provided for conditions
8 specified by the prospective enrollee. This explanation shall be in
9 writing if so requested;
- 10 (3) If denied a recommended treatment, written reasons for the denial
11 and an explanation of the utilization review criteria or treatment
12 protocol upon which the denial was based;
- 13 (4) The plan's restrictive formularies or prior approval requirements
14 for obtaining prescription drugs, whether a particular drug or
15 therapeutic class of drugs is excluded from its formulary, and the
16 circumstances under which a nonformulary drug may be covered;
17 and
- 18 (5) The procedures and medically based criteria under the PSO's
19 Medicare contract for determining whether a specified procedure,
20 test, or treatment is experimental.

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

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

33 "§ 131E-288. Liquidity.

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

- 37 (1) The timeliness of payment;
- 38 (2) The extent to which the current ratio is maintained at one to one
39 or whether there is a change in the current ratio over a period of
40 time; and
- 41 (3) The availability of outside financial resources.

42 (b) The following corresponding remedies apply:

- 1 (1) If the PSO fails to pay obligations as they become due, the
2 Department shall require the PSO to initiate corrective action to
3 pay all overdue obligations.
- 4 (2) The Department may require the PSO to initiate corrective action
5 if either of the following is evident: (i) the current ratio declines
6 significantly; or (ii) there is a continued downward trend in the
7 current ratio. The corrective action may include a change in the
8 distribution of assets, a reduction of liabilities, or alternative
9 arrangements to secure additional funding requirements to restore
10 the current ratio to one to one.
- 11 (3) If there is a change in the availability of the outside resources, the
12 Department shall require the PSO to obtain funding from
13 alternative financial resources.
- 14 (c) Nothing in the foregoing liquidity requirements shall be interpreted to require
15 the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the
16 Department that it is able to pay its obligations as they become due and the current
17 ratio maintained by the PSO has neither declined significantly nor is on a continued
18 downward trend.
- 19 "§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.
- 20 (a) Except as otherwise provided in subsection (b) of this section, each PSO shall,
21 on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of
22 the greater of:
- 23 (1) Seven hundred fifty thousand dollars (\$750,000) cash or cash
24 equivalents; or
- 25 (2) Forty percent (40%) of the minimum net worth required.
- 26 (b) The Department may lower the threshold for minimum net worth held in cash
27 or cash equivalents by PSOs that operate primarily in rural areas.
- 28 (c) Cash or cash equivalents held to meet the net worth requirement shall be
29 current assets of the PSO.
- 30 "§ 131E-290. Prohibited practice.
- 31 (a) No provider sponsored organization or sponsoring provider, unless licensed as
32 an insurer under Chapter 58 of the General Statutes may use in its name, contracts,
33 or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other
34 words descriptive of the insurance, casualty, or surety business or deceptively similar
35 to the name or description of any insurance or surety corporation doing business in
36 this State.
- 37 (b) No provider sponsored organization or sponsoring provider shall engage in
38 any activity or conduct which is prohibited by the terms of the PSO's Medicare
39 contract.
- 40 (c) Unless otherwise preempted by federal law or mandated by the Medicare
41 program, a PSO shall not discriminate with respect to participation, reimbursement,
42 or indemnification as to any provider who is acting within the scope of the provider's
43 license or certification under applicable State law, solely on the basis of that license
44 or certification. This subsection does not preclude a PSO from including providers

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

4 **"§ 131E-291. Collaboration with local health departments.**

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

8 **"§ 131E-292. Coverage.**

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

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

18 **"§ 131E-293. Rates.**

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

22 **"§ 131E-294. Consumer protection and quality standards.**

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

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

37 **"§ 131E-295. Powers of insurers and medical service corporations.**

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

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

6 "§ 131E-296. Examinations.

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

12 "§ 131E-297. Hazardous financial condition.

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

- 19 (1) To reduce the total amount of present and potential liability for
20 benefits by reinsurance;
- 21 (2) To reduce the volume of new business being accepted;
- 22 (3) To reduce the expenses by specified methods;
- 23 (4) To suspend or limit the writing of new business for a period of
24 time;
- 25 (5) To require an increase to the provider sponsored organization's
26 net worth by contribution;
- 27 (6) To add or delete sponsoring providers;
- 28 (7) To increase the amount of payments from the PSO which
29 sponsoring providers agree to forego; or
- 30 (8) To require additional guaranties from sponsoring providers or from
31 parents of sponsoring providers.

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

39 "§ 131E-298. Protection against insolvency.

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

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

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

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

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

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

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

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

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

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

23 "§ 131E-299. Hold harmless agreements or special deposit.

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

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

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

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

- 1 uncovered expenditures for enrollees, including incurred but
2 not reported claims, and shall be calculated as of the first
3 day of the month and maintained for the remainder of the
4 month. If a PSO is not otherwise required to file a quarterly
5 report, it shall file a report within 45 days of the end of the
6 calendar quarter with information sufficient to demonstrate
7 compliance with this section; or
- 8 b. Maintain adequate insurance or a guaranty arrangement
9 approved in writing by the Department, to pay for any loss
10 to beneficiaries claiming reimbursement due to the
11 insolvency of the PSO. The Department shall approve a
12 guaranty arrangement if the guarantying organization is a
13 sponsoring provider, has been operating for at least 10 years
14 and has a net worth, including organization-related land,
15 buildings, and equipment of at least fifty million dollars
16 (\$50,000,000), unless the Department finds that the approval
17 of this guaranty may be financially hazardous to
18 beneficiaries.
- 19 (2) The deposit required under sub-subdivision a. of subdivision (1) of
20 this subsection is an admitted asset of the PSO in the
21 determination of net worth. All income from these deposits or
22 trust accounts shall be assets of the PSO and may be withdrawn
23 from the deposit or account quarterly with the approval of the
24 Department;
- 25 (3) A PSO that has made a deposit may withdraw that deposit or any
26 part of the deposit if (i) a substitute deposit of cash or securities of
27 equal amount and value is made, (ii) the fair market value exceeds
28 the amount of the required deposit, or (iii) the required deposit
29 under this subsection is reduced or eliminated. Deposits,
30 substitutions, or withdrawals may be made only with the prior
31 written approval of the Department;
- 32 (4) The deposit required under sub-subdivision a. of subdivision (1) of
33 this section is in trust and may be used only as provided under this
34 section. The Department may use the deposit of an insolvent PSO
35 for administrative costs associated with administering the deposit
36 and payment of claims of enrollees of the PSO.
- 37 (c) Whenever the reimbursements described in this section exceed ten percent
38 (10%) of the PSO's total costs for health care services over the immediately
39 preceding six months, the PSO shall file a written report with the Department
40 containing the information necessary to determine compliance with sub-subdivision a.
41 of subdivision (1) of subsection (b) of this section no later than 30 business days from
42 the first day of the month. Upon an adequate showing by the PSO that the
43 requirements of this section should be waived or reduced, the Department may waive

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

3 "§ 131E-300. Continuation of benefits.

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

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

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

15 (3) Insolvency reserves as the Department may require;

16 (4) Letters of credit acceptable to the Department;

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

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

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

24 "§ 131E-301. Insolvency.

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

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

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

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

9 **"§ 131E-302. Replacement coverage.**

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

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

25 **"§ 131E-303. Incurred but not reported claims.**

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

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

34 **"§ 131E-304. Suspension or revocation of license.**

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

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

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

- 1 (3) No longer maintains the financial reserve specified in G.S. 131E-
2 286 or is no longer financially responsible and may reasonably be
3 expected to be unable to meet its obligations to beneficiaries or
4 prospective beneficiaries;
5 (4) Knowingly or repeatedly fails or refuses to comply with any law or
6 rule applicable to the PSO or with any order issued by the
7 Department after notice and opportunity for a hearing;
8 (5) Has knowingly made to the Department any false statement or
9 report;
10 (6) Has sponsoring providers that fail to provide a substantial
11 proportion of the services under any health plan during any 12-
12 month period;
13 (7) Has itself or through any person on its behalf advertised or
14 merchandised its items or services in an untrue, misrepresentative,
15 misleading, or unfair manner;
16 (8) If continuing to operate would be hazardous to beneficiaries; or
17 (9) Has otherwise substantially failed to comply with this Article.

18 (b) A license shall be suspended or revoked only after compliance with G.S.
19 131E-305.

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

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

31 **"§ 131E-305. Administrative procedures.**

32 (a) When the Department has cause to believe that grounds for the denial of an
33 application for a license exist, or that grounds for the suspension or revocation of a
34 license exist, it shall notify the provider sponsored organization in writing specifically
35 stating the grounds for denial, suspension, or revocation and fixing a time of at least
36 30 days thereafter for a hearing on the matter.

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

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

4 "§ 131E-306. Department of Insurance.

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

15 "§ 131E-307. Penalties and enforcement.

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

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

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

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

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

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

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

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

4 **"§ 131E-308. Statutory construction and relationship to other laws.**

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

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

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

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

25 **"§ 131E-309. Filings and reports as public documents.**

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

30 **"§ 131E-310. Confidentiality of medical information.**

31 Any data or information pertaining to the diagnosis, treatment, or health of any
32 beneficiary or applicant obtained from the person or from any provider by any
33 provider sponsored organization or by any provider acting pursuant to its provider
34 contract with a provider sponsored organization shall be held in confidence and shall
35 not be disclosed to any person except to the extent that it may be necessary to carry
36 out the purposes of this Article; or upon the express consent of the beneficiary or
37 applicant; or pursuant to statute or court order for the production of evidence or the
38 discovery thereof; or in the event of claim or litigation between such person and the
39 provider sponsored organization wherein such data or information is pertinent. A
40 provider sponsored organization shall be entitled to claim any statutory privileges
41 against such disclosure which the provider who furnished such information to the
42 provider sponsored organization is entitled to claim.

43 **"§ 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

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

5 (d) This section applies to a medical review committee, including a medical
6 review committee appointed by one of the entities licensed under Articles 1 through
7 67 of Chapter 58 of the General Statutes.

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

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

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



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1455

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)
Page 1 of ____

H1455-ARM-02

Date _____, 1998

Comm. Sub. [Yes]
Amends Title []

Representative

- 1 moves to amend the bill on page 25, line 7,
- 2 by rewriting that line to read:
- 3 "Article. If the Department of Insurance accepts the request, it
- 4 shall undertake the"; and further
- 5 moves to amend the bill on page 25, lines 9-12,
- 6 by deleting the sentence that begins on line 9 with the word "The"
- 7 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/ *Greg 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 ~~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

1 A BILL TO BE ENTITLED
2 AN ACT TO CREATE MEDICARE PROVIDER SPONSORED ORGANIZATION
3 LICENSING.

4 The General Assembly of North Carolina enacts:

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

7 "ARTICLE 17.

8 "Provider Sponsored Organization Licensing.

9 "§ 131E-275. General provisions.

10 (a) The General Assembly acknowledges that section 1855, et seq., of the federal
11 Social Security Act permits provider sponsored organizations that are organized and
12 licensed under State law as risk-bearing entities, or that are otherwise certified as
13 such by the federal government, to be eligible to offer Medicare health insurance or
14 health benefits coverage in each state in which the provider sponsored organization
15 offers a Medicare+Choice plan. The General Assembly declares that provider
16 sponsored organizations are beneficial to North Carolina citizens who are Medicare
17 beneficiaries and should be encouraged, subject to appropriate regulation by the
18 Department of Health and Human Services. The General Assembly further declares
19 that, because provider sponsored organizations provide health care directly and
20 assume responsibility for the provision of health care services to Medicare
21 beneficiaries under the requirements of the federal Medicare program, they require
22 different regulatory oversight to protect the public than health maintenance
23 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.

- 1 (9) 'Health plan contract' or 'Medicare contract' means a PSO's direct
2 contract with the United States Department of Health and Human
3 Services under section 1857 of the federal Social Security Act.
- 4 (10) 'Out-of-network services' means health care items or services that
5 are covered services under a PSO's Medicare contract and that are
6 provided to beneficiaries by health care providers that are not
7 participating providers in the PSO's network of health care
8 providers.
- 9 (11) 'Parent of a sponsoring provider' means the public or private
10 entity that owns or controls a controlling interest in the sponsoring
11 provider or that has the power to appoint a controlling number of
12 the governing board of a sponsoring provider or that has the power
13 to direct the management policy and decisions of the sponsoring
14 provider.
- 15 (12) 'Provider' or 'health care provider' means: (i) any individual that
16 is engaged in the delivery of health care services and that is
17 required by North Carolina law or regulation to be licensed to
18 engage in the delivery of these health care services and is so
19 licensed; (ii) any entity that is engaged in the delivery of health
20 care services and that is required by North Carolina law or
21 regulation to be licensed to engage in the delivery of these health
22 care services and is so licensed; or (iii) any entity that is owned or
23 controlled entirely by individuals or entities described in subparts
24 (i) or (ii) of this definition.
- 25 (13) 'Provider sponsored organization' or 'PSO' means a public or
26 private entity domiciled in this State, including a business
27 corporation, a nonprofit corporation, a partnership, a limited
28 liability company, a professional limited liability company, a
29 professional corporation, a sole proprietorship, a public hospital, a
30 hospital authority, a hospital district, or a body politic; (i) that is
31 established, organized, and operated by sponsoring providers; (ii)
32 in which physicians licensed pursuant to Article 1 of Chapter 90 of
33 the General Statutes or to the laws of any state of the United States
34 comprise no less than fifty percent (50%) of the governing board
35 or body, unless otherwise prohibited by law; and (iii) that provides
36 a substantial proportion of the services under each Medicare
37 contract directly through the sponsoring provider. The
38 requirement in subpart (ii) of this definition shall not preclude a
39 PSO that includes a tax-exempt hospital from adopting a bylaw
40 provision that provides a veto for the tax-exempt hospital over
41 actions of the PSO necessary to maintain the hospital's tax-exempt
42 status. A PSO shall not be out of compliance with the
43 requirement in subpart (ii) due to temporary vacancies on its
44 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

- 1 substantial financial rewards or penalties based on group
2 performance in meeting the targets; or
3 (4) Agree to provide a complex or extended course of treatment that
4 requires the substantial coordination of care by sponsoring
5 providers in different specialties offering a complementary mix of
6 services, for a fixed, predetermined payment, when the costs of
7 that course of treatment for any individual patient can vary greatly
8 due to the individual patient's treatment or other factors; or
9 (5) Agree to any other arrangement that the Department determines to
10 provide for the sharing of substantial financial risk by the
11 sponsoring providers.

12 **"§ 131E-278. Applicability of other laws.**

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

19 **"§ 131E-279. Approval.**

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

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

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

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

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

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

19 **"§ 131E-280. Applicants for license.**

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

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

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

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

37 (4) A list of the names, addresses, and official positions of persons who
38 are to be responsible for the conduct of the affairs of the applicant
39 and of each sponsoring provider that holds greater than a five
40 percent (5%) interest in the PSO, respectively, including all
41 members of the respective boards of directors, boards of trustees,
42 executive committees, or other governing boards or committees,
43 the principal officers in the case of a corporation, and the partners
44 or members in the case of a partnership or association;

- 1 (5) A copy of any contract form made or to be made between any
2 class of providers and the PSO and a copy of any contract form
3 made or to be made between third-party administrators, marketing
4 consultants, or persons listed in subdivision (3) of this subsection
5 and the PSO;
- 6 (6) A statement generally describing the provider sponsored
7 organization, its sponsoring providers, its health care plan or plans,
8 facilities, and personnel;
- 9 (7) A copy of the hospital license of each sponsoring provider that is a
10 hospital, a copy of the license to practice medicine of each
11 sponsoring provider or owner of a sponsoring provider that is a
12 licensed physician, and a copy of the health care service or facility
13 license held by any other licensed sponsoring provider;
- 14 (8) Financial statements showing the applicant's assets, liabilities,
15 sources of financial support, and the financial statements of each
16 sponsoring provider that holds greater than a five percent (5%)
17 interest in the PSO showing the sponsoring provider's assets,
18 liabilities, and sources of support. If the applicant's or any such
19 sponsoring provider's financial affairs are audited by independent
20 certified public accountants, a copy of the applicant's or
21 sponsoring provider's most recent regular certified financial
22 statement shall be considered to satisfy this requirement unless the
23 Department directs that additional or more recent financial
24 information is required for the proper administration of this
25 Article;
- 26 (9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-
27 297, 131E-298, and 131E-299 are guaranteed by one or more
28 guarantors:
- 29 a. Documentation that each guarantor meets the following
30 requirements:
- 31 1. The guarantor is a legal entity authorized to conduct
32 business in North Carolina.
- 33 2. The guarantor is not under federal bankruptcy or
34 State receivership or rehabilitation proceedings.
- 35 3. The guarantor has a net worth, not including other
36 guarantees, intangibles, and restricted reserves, equal
37 to three times the amount of the PSO's guarantee.
- 38 b. Financial statements showing each guarantor's assets,
39 liabilities, and source of financial support.
- 40 c. If a guarantor's financial affairs are audited by independent
41 certified public accountants, a copy of the guarantor's most
42 recent regular audited financial statement shall be
43 considered to satisfy this requirement unless the Department

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

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

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

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

18 (12) A description of the procedures to be implemented to meet the
19 protection against insolvency requirements of G.S. 131E-298; and

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

22 **"§ 131E-281. Additional information.**

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

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

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

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

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

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

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

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

44 **"§ 131E-282. Issuance of license.**

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

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

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

16 (3) The PSO shall have at least seven hundred fifty thousand dollars
17 (\$750,000) in cash or equivalents on its balance sheet, except that
18 the Department may permit a PSO operating primarily in rural
19 areas to have a lesser amount held in cash or equivalents on its
20 balance sheets.

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

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

29 a. The timeliness of payment;

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

33 c. The availability of outside financial resources.

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

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

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

40 (3) If at least one million dollars (\$1,000,000) of the initial minimum
41 net worth requirement is met by cash or cash equivalents, then one
42 hundred percent (100%) of the book value of the PSO's intangible
43 assets up to twenty percent (20%) of the minimum net worth
44 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.

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

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

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

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

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

20 **"§ 131E-284. Modifications.**

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

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

39 **"§ 131E-285. Deposits.**

40 (a) At the time of application, the Department shall require a deposit of one
41 hundred thousand dollars (\$100,000) in cash or securities or a combination thereof
42 for all provider sponsored organizations. The deposits shall be included in the
43 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

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

3 (2) Deferred acquisition costs shall not be admitted.

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

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

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

15 **"§ 131E-287. Reporting.**

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

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

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

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

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

27 (1) The number of and reasons for grievances received from Medicare
28 beneficiaries enrolled with the PSO under the PSO's Medicare
29 contract regarding medical treatment. The report shall include the
30 number of covered lives, total number of grievances categorized by
31 reason for the grievance, the number of grievances referred to the
32 second level grievance review, the number of grievances resolved
33 at each level and their resolution and a description of the actions
34 that are being taken to correct the problems that have been
35 identified through grievances received. Every PSO shall file with
36 the Department, as part of its annual grievance report, a certificate
37 of compliance stating that the PSO has established and follows, for
38 its Medicare contract, grievance procedures that comply with G.S.
39 131E-314.

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

43 (3) The number of provider contracts between the PSO and network
44 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

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

- 3 (1) The evidence of coverage under the Medicare+Choice plan
4 provided by the PSO to Medicare beneficiaries under the terms of
5 the PSO's Medicare contract;
- 6 (2) An explanation of the utilization review criteria and treatment
7 protocol under which treatments are provided for conditions
8 specified by the prospective enrollee. This explanation shall be in
9 writing if so requested;
- 10 (3) If denied a recommended treatment, written reasons for the denial
11 and an explanation of the utilization review criteria or treatment
12 protocol upon which the denial was based;
- 13 (4) The plan's restrictive formularies or prior approval requirements
14 for obtaining prescription drugs, whether a particular drug or
15 therapeutic class of drugs is excluded from its formulary, and the
16 circumstances under which a nonformulary drug may be covered;
17 and
- 18 (5) The procedures and medically based criteria under the PSO's
19 Medicare contract for determining whether a specified procedure,
20 test, or treatment is experimental.

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

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

33 **"§ 131E-288. Liquidity.**

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

- 37 (1) The timeliness of payment;
- 38 (2) The extent to which the current ratio is maintained at one to one
39 or whether there is a change in the current ratio over a period of
40 time; and
- 41 (3) The availability of outside financial resources.

42 (b) The following corresponding remedies apply:

- 1 (1) If the PSO fails to pay obligations as they become due, the
2 Department shall require the PSO to initiate corrective action to
3 pay all overdue obligations.
- 4 (2) The Department may require the PSO to initiate corrective action
5 if either of the following is evident: (i) the current ratio declines
6 significantly; or (ii) there is a continued downward trend in the
7 current ratio. The corrective action may include a change in the
8 distribution of assets, a reduction of liabilities, or alternative
9 arrangements to secure additional funding requirements to restore
10 the current ratio to one to one.
- 11 (3) If there is a change in the availability of the outside resources, the
12 Department shall require the PSO to obtain funding from
13 alternative financial resources.
- 14 (c) Nothing in the foregoing liquidity requirements shall be interpreted to require
15 the PSO to maintain a current ratio of one to one if the PSO can demonstrate to the
16 Department that it is able to pay its obligations as they become due and the current
17 ratio maintained by the PSO has neither declined significantly nor is on a continued
18 downward trend.
- 19 **"§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.**
- 20 (a) Except as otherwise provided in subsection (b) of this section, each PSO shall,
21 on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of
22 the greater of:
- 23 (1) Seven hundred fifty thousand dollars (\$750,000) cash or cash
24 equivalents; or
- 25 (2) Forty percent (40%) of the minimum net worth required.
- 26 (b) The Department may lower the threshold for minimum net worth held in cash
27 or cash equivalents by PSOs that operate primarily in rural areas.
- 28 (c) Cash or cash equivalents held to meet the net worth requirement shall be
29 current assets of the PSO.
- 30 **"§ 131E-290. Prohibited practice.**
- 31 (a) No provider sponsored organization or sponsoring provider, unless licensed as
32 an insurer under Chapter 58 of the General Statutes may use in its name, contracts,
33 or literature any of the words 'insurance', 'casualty', 'surety', 'mutual', or any other
34 words descriptive of the insurance, casualty, or surety business or deceptively similar
35 to the name or description of any insurance or surety corporation doing business in
36 this State.
- 37 (b) No provider sponsored organization or sponsoring provider shall engage in
38 any activity or conduct which is prohibited by the terms of the PSO's Medicare
39 contract.
- 40 (c) Unless otherwise preempted by federal law or mandated by the Medicare
41 program, a PSO shall not discriminate with respect to participation, reimbursement,
42 or indemnification as to any provider who is acting within the scope of the provider's
43 license or certification under applicable State law, solely on the basis of that license
44 or certification. This subsection does not preclude a PSO from including providers

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

4 **"§ 131E-291. Collaboration with local health departments.**

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

8 **"§ 131E-292. Coverage.**

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

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

18 **"§ 131E-293. Rates.**

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

22 **"§ 131E-294. Consumer protection and quality standards.**

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

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

37 **"§ 131E-295. Powers of insurers and medical service corporations.**

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

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

6 **"§ 131E-296. Examinations.**

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

12 **"§ 131E-297. Hazardous financial condition.**

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

- 19 (1) To reduce the total amount of present and potential liability for
20 benefits by reinsurance;
- 21 (2) To reduce the volume of new business being accepted;
- 22 (3) To reduce the expenses by specified methods;
- 23 (4) To suspend or limit the writing of new business for a period of
24 time;
- 25 (5) To require an increase to the provider sponsored organization's
26 net worth by contribution;
- 27 (6) To add or delete sponsoring providers;
- 28 (7) To increase the amount of payments from the PSO which
29 sponsoring providers agree to forego; or
- 30 (8) To require additional guaranties from sponsoring providers or from
31 parents of sponsoring providers.

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

39 **"§ 131E-298. Protection against insolvency.**

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

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

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

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

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

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

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

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

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

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

23 **"§ 131E-299. Hold harmless agreements or special deposit.**

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

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

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

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

- 1 uncovered expenditures for enrollees, including incurred but
2 not reported claims, and shall be calculated as of the first
3 day of the month and maintained for the remainder of the
4 month. If a PSO is not otherwise required to file a quarterly
5 report, it shall file a report within 45 days of the end of the
6 calendar quarter with information sufficient to demonstrate
7 compliance with this section; or
8 b. Maintain adequate insurance or a guaranty arrangement
9 approved in writing by the Department, to pay for any loss
10 to beneficiaries claiming reimbursement due to the
11 insolvency of the PSO. The Department shall approve a
12 guaranty arrangement if the guarantying organization is a
13 sponsoring provider, has been operating for at least 10 years
14 and has a net worth, including organization-related land,
15 buildings, and equipment of at least fifty million dollars
16 (\$50,000,000), unless the Department finds that the approval
17 of this guaranty may be financially hazardous to
18 beneficiaries.
19 (2) The deposit required under sub-subdivision a. of subdivision (1) of
20 this subsection is an admitted asset of the PSO in the
21 determination of net worth. All income from these deposits or
22 trust accounts shall be assets of the PSO and may be withdrawn
23 from the deposit or account quarterly with the approval of the
24 Department;
25 (3) A PSO that has made a deposit may withdraw that deposit or any
26 part of the deposit if (i) a substitute deposit of cash or securities of
27 equal amount and value is made, (ii) the fair market value exceeds
28 the amount of the required deposit, or (iii) the required deposit
29 under this subsection is reduced or eliminated. Deposits,
30 substitutions, or withdrawals may be made only with the prior
31 written approval of the Department;
32 (4) The deposit required under sub-subdivision a. of subdivision (1) of
33 this section is in trust and may be used only as provided under this
34 section. The Department may use the deposit of an insolvent PSO
35 for administrative costs associated with administering the deposit
36 and payment of claims of enrollees of the PSO.
37 (c) Whenever the reimbursements described in this section exceed ten percent
38 (10%) of the PSO's total costs for health care services over the immediately
39 preceding six months, the PSO shall file a written report with the Department
40 containing the information necessary to determine compliance with sub-subdivision a.
41 of subdivision (1) of subsection (b) of this section no later than 30 business days from
42 the first day of the month. Upon an adequate showing by the PSO that the
43 requirements of this section should be waived or reduced, the Department may waive

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

3 **"§ 131E-300. Continuation of benefits.**

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

- 9 (1) Insurance to cover the expenses to be paid for benefits after an
10 insolvency;
- 11 (2) Provisions in provider contracts that obligate the provider to
12 provide services for the duration of the period after the PSO's
13 insolvency for which premium payment has been made and until
14 the beneficiaries' discharge from inpatient facilities;
- 15 (3) Insolvency reserves as the Department may require;
- 16 (4) Letters of credit acceptable to the Department;
- 17 (5) Additional guaranties from a sponsoring provider of the PSO or
18 from the parent of a sponsoring provider;
- 19 (6) Legally binding obligations of sponsoring providers to forego
20 payment from the PSO for services provided to beneficiaries in
21 order to avoid the insolvency of the PSO; and
- 22 (7) Any other arrangements to assure that benefits are continued as
23 specified.

24 **"§ 131E-301. Insolvency.**

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

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

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

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

9 **"§ 131E-302. Replacement coverage.**

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

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

25 **"§ 131E-303. Incurred but not reported claims.**

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

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

34 **"§ 131E-304. Suspension or revocation of license.**

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

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

42 (2) Issues evidences of coverage or uses a schedule of premiums for
43 health care services that do not comply with Medicare or Medicaid
44 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.

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

4 "§ 131E-306. Department of Insurance.

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

12 "§ 131E-307. Penalties and enforcement.

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

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

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

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

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

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

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

1 "§ 131E-308. Statutory construction and relationship to other laws.

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

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

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

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

22 "§ 131E-309. Filings and reports as public documents.

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

27 "§ 131E-310. Confidentiality of medical information.

28 Any data or information pertaining to the diagnosis, treatment, or health of any
29 beneficiary or applicant obtained from the person or from any provider by any
30 provider sponsored organization or by any provider acting pursuant to its provider
31 contract with a provider sponsored organization shall be held in confidence and shall
32 not be disclosed to any person except to the extent that it may be necessary to carry
33 out the purposes of this Article; or upon the express consent of the beneficiary or
34 applicant; or pursuant to statute or court order for the production of evidence or the
35 discovery thereof; or in the event of claim or litigation between such person and the
36 provider sponsored organization wherein such data or information is pertinent. A
37 provider sponsored organization shall be entitled to claim any statutory privileges
38 against such disclosure which the provider who furnished such information to the
39 provider sponsored organization is entitled to claim.

40 "§ 131E-311. Conflicts; severability.

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

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

5 **"§ 131E-312. Regulations.**

6 This Article shall be self-implementing. No later than six months after the date of
7 enactment of this Article, the Department may adopt rules consistent with this Article
8 to authorize and regulate provider sponsored organizations to contract directly with
9 the federal Medicare program to provide health care services to the beneficiaries of
10 such programs. The Department shall issue permanent rules and, may issue
11 temporary rules, to the extent these rules may be necessary. The Department shall
12 limit its regulation of provider sponsored organizations to the licensing and regulating
13 of these organizations as risk bearing entities contracting directly with the Medicare
14 program and to the consumer protection and quality standards as provided in G.S.
15 131E-294, and shall not regulate any matters described in 42 U.S.C. § 1395W-
16 26(b)(3), or any successor thereof.

17 **"§ 131E-313. Utilization review and grievances.**

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

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

- 24 "(b) (1) It is specifically the intention of this section to permit such persons
25 as were providing health services on a prepaid basis on July 1,
26 1977, or receiving federal funds under Section 254(c) of Title 42,
27 U.S. Code, as a community health center, to continue to operate in
28 the manner which they have heretofore operated.
- 29 (2) Notwithstanding anything contained in this Article to the contrary,
30 any person can provide health services on a fee for service basis to
31 individuals who are not enrollees of the organization, and to
32 enrollees for services not covered by the contract, provided that
33 the volume of services in this manner shall not be such as to affect
34 the ability of the health maintenance organization to provide on an
35 adequate and timely basis those services to its enrolled members
36 which it has contracted to furnish under the enrollment contract.
- 37 (3) This Article shall not apply to any employee benefit plan to the
38 extent that the Federal Employee Retirement Income Security Act
39 of 1974 preempts State regulation thereof.
- 40 (3a) This Article does not apply to any prepaid health service or
41 capitation arrangement implemented or administered by the
42 Department of Health and Human Services or its representatives,
43 pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General
44 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.

1 (d) This section applies to a medical review committee, including a medical
2 review committee appointed by one of the entities licensed under Articles 1 through
3 67 of Chapter 58 of the General Statutes.

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

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

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

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

1 (2) 'Chemical dependency' has the same meaning as defined in G.S.
2 58-65-75

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

6 (b) No ~~hospital, medical, dental or health service~~ corporation governed by this
7 Chapter shall, solely because an individual to be insured has or had a mental illness
8 or chemical dependency:

9 (1) Refuse to issue or deliver to that individual any individual or
10 group hospital, dental, medical or health service contract in this
11 State that affords benefits or coverage for medical treatment or
12 service for physical illness or injury;

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

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

17 (c) Nothing in this section prevents any hospital or medical plan from excluding
18 from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency
19 which has existed previous to coverage of the individual by the hospital or medical
20 plan or from refusing to issue or deliver to that individual any policy because of the
21 underwriting of any physical condition whether or not related to ~~mental illness or~~
22 chemical dependency.

23 ~~(d) This section applies only to group contracts covering 20 or more employees.~~

24 (d) Every group insurance certificate or group subscriber contract under a hospital
25 or medical plan subject to this Article shall provide to its insureds benefits for the
26 necessary care and treatment of mental illness that are not less favorable than benefits
27 for physical illness generally. Benefits for treatment of mental illness shall be subject
28 to the same limits as are benefits for physical illness generally. For purposes of this
29 subsection, 'limits' includes durational limits, deductibles, coinsurance factors,
30 copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any
31 other dollar limits or fees for covered services.

32 (e) The service corporation may use a case management program for mental illness
33 benefits to evaluate and determine medically necessary and medically appropriate
34 care and treatment for each patient, provided that the program complies with rules
35 adopted by the Commissioner of Insurance. These rules shall ensure that case
36 management programs are not designed to avoid the requirements of this section
37 concerning parity between the benefits for mental illness and those for physical illness
38 generally.

39 (f) Subsections (d) and (e) of this section apply only to group contracts covering 5
40 or more employees. The remainder of this section applies only to group contracts
41 covering 20 or more employees.

42 (g) Subsections (d) and (e) of this section shall not apply to a subscriber contract
43 or certificate if the service corporation demonstrates to the Commissioner that

1 compliance has increased the cost of the contract or certificate by two percent (2%)
2 or more on an annual basis."

3 Section 4. G.S. 58-67-75 reads as rewritten:

4 "**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

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

6 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-
7 3(21); and

8 (2) 'Chemical dependency' has the same meaning as defined in G.S.
9 58-67-70

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

13 (b) No health maintenance organization governed by this Chapter shall, solely
14 because an individual has or had a mental illness or chemical dependency:

15 (1) Refuse to enroll that individual in any health care plan covering
16 physical illness or injury;

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

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

21 (c) Nothing in this section prevents any health maintenance organization from
22 excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical
23 dependency which has existed previous to coverage of the individual by the health
24 maintenance organization or from refusing to issue or deliver to that individual any
25 policy because of the underwriting of any physical condition whether or not related
26 to ~~mental illness or~~ chemical dependency.

27 ~~(d) This section applies only to group contracts covering 20 or more employees.~~

28 (d) Every health maintenance organization that issues a health care plan on a
29 group basis for medical and hospitalization care shall provide to its insureds benefits
30 for the necessary care and treatment of mental illness that are not less favorable than
31 benefits for physical illness generally. Benefits for treatment of mental illness shall be
32 subject to the same limits as are benefits for physical illness generally. For purposes
33 of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors,
34 copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any
35 other dollar limits or fees for covered services.

36 (e) A health maintenance organization may use a case management program for
37 mental illness benefits to evaluate and determine medically necessary and medically
38 appropriate care and treatment for each patient, provided that the program complies
39 with rules adopted by the Commissioner of Insurance. These rules shall ensure that
40 case management programs are not designed to avoid the requirements of this section
41 concerning parity between the benefits for mental illness and those for physical illness
42 generally.

43 (f) This section applies only to group contracts covering five or more employees.

1 (g) Subsections (d) and (e) of this section shall not apply to a health care plan if
2 the HMO demonstrates to the Commissioner that compliance has increased the cost
3 of the plan by two percent (2%) or more on an annual basis."

4 Section 5. This act is effective when it becomes law and applies to
5 contracts issued, delivered, or renewed on or after January 1, 1998. This act expires
6 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

1 A BILL TO BE ENTITLED
 2 AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL
 3 ILLNESS.

4 The General Assembly of North Carolina enacts:

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

7 "(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and
 8 approved under G.S. 58-50-125 shall provide coverage for the treatment of mental
 9 illness that is at least equal to the coverage required by G.S. 58-3-220. The plan may
 10 use a case management program in accordance with G.S. 58-3-220."

11 Section 2.(a) The following are repealed: G.S. 58-51-55(b1) and (c), 58-
 12 65-90(b1) and (c), and 58-67-75(b1) and (c).

13 (b) G.S. 58-51-55(d) reads as rewritten:

14 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to group health~~
 15 ~~insurance contracts covering more than 50 employees. The remainder of this~~ This
 16 section applies only to group health insurance contracts covering 20 or more
 17 employees. For purposes of this section, 'group health insurance contracts' include
 18 MEWAs, as defined in G.S. 58-49-30(a)."

19 (c) G.S. 58-65-90(d) reads as rewritten:

1 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to subscriber~~
2 ~~contracts covering more than 50 employees. The remainder of this~~ This section
3 applies only to group contracts covering 20 or more employees."

4 (d) G.S. 58-67-75(d) reads as rewritten:

5 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to group~~
6 ~~contracts covering more than 50 employees. The remainder of this~~ This section
7 applies only to group contracts covering 20 or more employees."

8 Section 3. Chapter 58 of the General Statutes is amended by adding the
9 following new section to read:

10 **"§ 58-3-220. Mental illness benefits coverage.**

11 (a) Mental Parity Requirement. -- A health insurer shall provide in each group
12 health benefit plan benefits for the necessary care and treatment of mental illness that
13 are no less favorable than benefits for physical illness generally. Benefits for
14 treatment of mental illness shall be subject to the same limits as benefits for physical
15 illness generally. For purposes of this subdivision, 'limits' includes durational limits,
16 deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual
17 and lifetime dollar limits, and any other dollar limits or fees for covered services.

18 (b) Weighted Averages. -- If the plan contains annual limits, lifetime limits, co-
19 payments, deductibles, or coinsurance only on selected physical illness and injury
20 benefits, and these benefits do not represent substantially all of the physical illness
21 and injury benefits under the plan, the insurer may impose limits on the mental
22 health benefits based on a weighted average of the respective annual, lifetime, co-
23 payment, deductible, or coinsurance limits on the selected physical illness and injury
24 benefits. The weighted average shall be calculated in accordance with rules adopted
25 by the Commissioner.

26 (c) Case Management. -- An insurer may use a case management program for
27 mental illness benefits to evaluate and determine medically necessary and medically
28 appropriate care and treatment for each patient, provided that the program complies
29 with rules adopted by the Commissioner of Insurance. These rules shall ensure that
30 case management programs are not designed to avoid the requirements of this section
31 for parity between the benefits for mental illness and those for physical illness
32 generally.

33 (d) Exceptions. -- This section does not apply to either of the following:

- 34 (1) A group health benefit plan covering fewer than five employees.
35 (2) Any other group health benefit plan if the insurer demonstrates to
36 the Commissioner that compliance with this section has increased
37 the cost of the policy by two percent (2%) or more on an annual
38 basis. If the group health plan or contract granted an exemption
39 under this section nevertheless wants to offer limited mental illness
40 benefits coverage and there are 50 or more employees in the plan,
41 the plan may not provide a lesser lifetime or annual dollar
42 limitation than is provided under the plan for physical illness
43 generally, unless providing parity in annual and lifetime limits
44 increases the plan's cost by one percent (1%) or more.

1 (e) Definitions. -- As used in this section:

2 (1) 'Health benefit plan' has the same meaning as in G.S. 58-3-190 and
3 includes a blanket health policy or blanket accident and health
4 policy.

5 (2) 'Insurer' has the same meaning as in G.S. 58-3-190.

6 (3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with
7 a diagnosis found in the Diagnostic and Statistical Manual of
8 Mental Disorders DSM-IV or the International Classification of
9 Diseases ICD/9/CM, or a later edition of those manuals."

10 Section 4. This act becomes effective January 1, 1999, and applies to
11 contracts issued, delivered, or renewed on or after that date. This act expires
12 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.

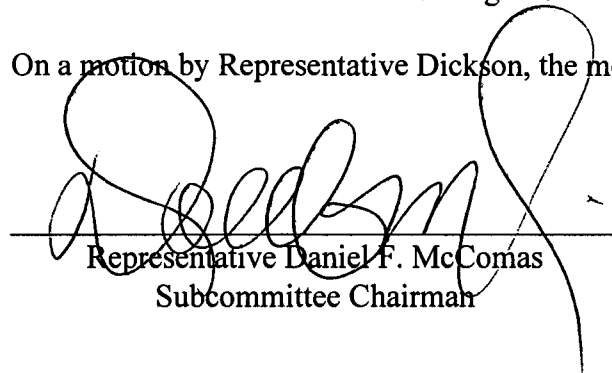
After their remarks, each speaker entertained questions from the Subcommittee. Perri Morgan was instructed to provide further information to the Subcommittee regarding how many employees and employers of the National Federation of Independent Businesses would be affected statewide by the bill's more 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.

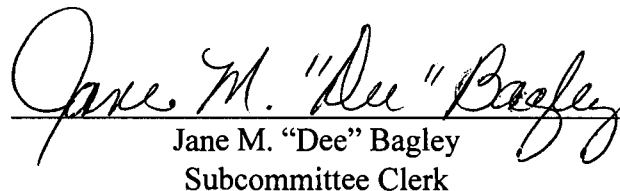
Ron Bachman, an Actuary with Price, Waterhouse, Coopers, was recognized to entertain any questions from the Subcommittee.

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

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
B. MICHAEL HERMAN	HEALTH INSURANCE ASSOCIATION OF AMERICA
Robert PASCHAL	YONG, MADOLE + HENDERSON, P.A.
Wendy Mayford	BCBSNC
Kim W. Fox	BCBSNC
Amey Jo Bain	Smith Anderson
Leahie Hicks	NCNA
Dan Hill	Hel Chesson & Assoc.
Fred Joyner	N.C. ^{CORP} LIFE Underwriters
"	N.C. Assoc. of HEALTH Underwriters
PERRI MORGAN	NEIB
John Bowditch	Zeb Alley P.A.
Rene Mahoney	NC ASSN OF HEALTH PLANS
Marilyn Webb	Invited by Chairman McComas to speak.
Randy Job	APAC
Brian Blatz	Mid South Clinic Co
Griffey Jones	Morris & Van Allen
Ann Case	NCRMA
Jane Preston	"
Andy Ellen	"
Padma Deshpande	Champion Lat'l Corporation
George Reed	NC Council of Churches
Jim Tott	MHA/NC
Liz Jordan	MHA/Mecklenburg County
Theresa Cotton	TRC/DO/SA
Joyce Peters	JPSOC/MANNA
Cindy Parker	Bone & Associates
KEN KUKURA	DUPONT
Alma Szader	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[illegible]

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

- 1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL
3 ILLNESS.
4 The General Assembly of North Carolina enacts:
5 Section 1. G.S. 58-50-155 is amended by adding the following new
6 subsection to read:
7 "(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and
8 approved under G.S. 58-50-125 shall provide coverage for the treatment of mental
9 illness that is at least equal to the coverage required by G.S. 58-3-220. The plan may
10 use a case management program in accordance with G.S. 58-3-220."
11 Section 2.(a) The following are repealed: G.S. 58-51-55(b1) and (c), 58-
12 65-90(b1) and (c), and 58-67-75(b1) and (c).
13 (b) G.S. 58-51-55(d) reads as rewritten:
14 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to group health~~
15 ~~insurance contracts covering more than 50 employees. The remainder of this~~ This
16 section applies only to group health insurance contracts covering 20 or more
17 employees. For purposes of this section, 'group health insurance contracts' include
18 MEWAs, as defined in G.S. 58-49-30(a)."
19 (c) G.S. 58-65-90(d) reads as rewritten:

1 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to subscriber~~
2 ~~contracts covering more than 50 employees. The remainder of this This section~~
3 ~~applies only to group contracts covering 20 or more employees."~~

4 (d) G.S. 58-67-75(d) reads as rewritten:

5 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to group~~
6 ~~contracts covering more than 50 employees. The remainder of this This section~~
7 ~~applies only to group contracts covering 20 or more employees."~~

8 Section 3. Chapter 58 of the General Statutes is amended by adding the
9 following new section to read:

10 **"§ 58-3-220. Mental illness benefits coverage.**

11 (a) Mental Parity Requirement. -- A health insurer shall provide in each group
12 health benefit plan benefits for the necessary care and treatment of mental illness that
13 are no less favorable than benefits for physical illness generally. Benefits for
14 treatment of mental illness shall be subject to the same limits as benefits for physical
15 illness generally. For purposes of this subdivision, 'limits' includes durational limits,
16 deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual
17 and lifetime dollar limits, and any other dollar limits or fees for covered services.

18 (b) Weighted Averages. -- If the plan contains annual limits, lifetime limits, co-
19 payments, deductibles, or coinsurance only on selected physical illness and injury
20 benefits, and these benefits do not represent substantially all of the physical illness
21 and injury benefits under the plan, the insurer may impose limits on the mental
22 health benefits based on a weighted average of the respective annual, lifetime, co-
23 payment, deductible, or coinsurance limits on the selected physical illness and injury
24 benefits. The weighted average shall be calculated in accordance with rules adopted
25 by the Commissioner.

26 (c) Case Management. -- An insurer may use a case management program for
27 mental illness benefits to evaluate and determine medically necessary and medically
28 appropriate care and treatment for each patient, provided that the program complies
29 with rules adopted by the Commissioner of Insurance. These rules shall ensure that
30 case management programs are not designed to avoid the requirements of this section
31 for parity between the benefits for mental illness and those for physical illness
32 generally.

33 (d) Exceptions. -- This section does not apply to either of the following:

34 (1) A group health benefit plan covering fewer than five employees.

35 (2) Any other group health benefit plan if the insurer demonstrates to
36 the Commissioner that compliance with this section has increased
37 the cost of the policy by two percent (2%) or more on an annual
38 basis. If the group health plan or contract granted an exemption
39 under this section nevertheless wants to offer limited mental illness
40 benefits coverage and there are 50 or more employees in the plan,
41 the plan may not provide a lesser lifetime or annual dollar
42 limitation than is provided under the plan for physical illness
43 generally, unless providing parity in annual and lifetime limits
44 increases the plan's cost by one percent (1%) or more.

1 (e) Definitions. -- As used in this section:

2 (1) 'Health benefit plan' has the same meaning as in G.S. 58-3-190 and
3 includes a blanket health policy or blanket accident and health
4 policy.

5 (2) 'Insurer' has the same meaning as in G.S. 58-3-190.

6 (3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with
7 a diagnosis found in the Diagnostic and Statistical Manual of
8 Mental Disorders DSM-IV or the International Classification of
9 Diseases ICD/9/CM, or a later edition of those manuals."

10 Section 4. This act becomes effective January 1, 1999, and applies to
11 contracts issued, delivered, or renewed on or after that date. This act expires
12 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:

Referred to:

March 17, 1997

- 1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL
3 ILLNESS.
4 The General Assembly of North Carolina enacts:
5 Section 1. G.S. 58-50-155 is amended by adding the following new
6 subsection to read:
7 "(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and
8 approved under G.S. 58-50-125 shall provide coverage for the treatment of mental
9 illness that is at least equal to the coverage required by G.S. 58-51-55. The plan may
10 use a case management program in accordance with G.S. 58-51-55.
11 Section 2. G.S. 58-51-55 reads as rewritten:
12 **"§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**
13 (a) As used in this section, the term:
14 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-
15 3(21); and
16 (2) 'Chemical dependency' has the same meaning as defined in G.S.
17 58-51-50
18 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders
19 ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a
20 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

1 (2) 'Chemical dependency' has the same meaning as defined in G.S.
2 58-65-75

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

6 (b) No ~~hospital, medical, dental or health service~~ corporation governed by this
7 Chapter shall, solely because an individual to be insured has or had a mental illness
8 or chemical dependency:

9 (1) Refuse to issue or deliver to that individual any individual or
10 group hospital, dental, medical or health service contract in this
11 State that affords benefits or coverage for medical treatment or
12 service for physical illness or injury;

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

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

17 (c) Nothing in this section prevents any hospital or medical plan from excluding
18 from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency
19 which has existed previous to coverage of the individual by the hospital or medical
20 plan or from refusing to issue or deliver to that individual any policy because of the
21 underwriting of any physical condition whether or not related to ~~mental illness or~~
22 chemical dependency.

23 ~~(d) This section applies only to group contracts covering 20 or more employees.~~

24 (d) Every group insurance certificate or group subscriber contract under a hospital
25 or medical plan subject to this Article shall provide to its insureds benefits for the
26 necessary care and treatment of mental illness that are not less favorable than benefits
27 for physical illness generally. Benefits for treatment of mental illness shall be subject
28 to the same limits as are benefits for physical illness generally. For purposes of this
29 subsection, 'limits' includes durational limits, deductibles, coinsurance factors,
30 copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any
31 other dollar limits or fees for covered services.

32 (e) The service corporation may use a case management program for mental illness
33 benefits to evaluate and determine medically necessary and medically appropriate
34 care and treatment for each patient, provided that the program complies with rules
35 adopted by the Commissioner of Insurance. These rules shall ensure that case
36 management programs are not designed to avoid the requirements of this section
37 concerning parity between the benefits for mental illness and those for physical illness
38 generally.

39 (f) Subsections (d) and (e) of this section apply only to group contracts covering 5
40 or more employees. The remainder of this section applies only to group contracts
41 covering 20 or more employees.

42 (g) Subsections (d) and (e) of this section shall not apply to a subscriber contract
43 or certificate if the service corporation demonstrates to the Commissioner that

1 compliance has increased the cost of the contract or certificate by two percent (2%)
2 or more on an annual basis."

3 Section 4. G.S. 58-67-75 reads as rewritten:

4 "**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

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

6 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-
7 3(21); and

8 (2) 'Chemical dependency' has the same meaning as defined in G.S.
9 58-67-70

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

13 (b) No health maintenance organization governed by this Chapter shall, solely
14 because an individual has or had a mental illness or chemical dependency:

15 (1) Refuse to enroll that individual in any health care plan covering
16 physical illness or injury;

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

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

21 (c) Nothing in this section prevents any health maintenance organization from
22 excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical
23 dependency which has existed previous to coverage of the individual by the health
24 maintenance organization or from refusing to issue or deliver to that individual any
25 policy because of the underwriting of any physical condition whether or not related
26 to ~~mental illness or~~ chemical dependency.

27 ~~(d) This section applies only to group contracts covering 20 or more employees.~~

28 (d) Every health maintenance organization that issues a health care plan on a
29 group basis for medical and hospitalization care shall provide to its insureds benefits
30 for the necessary care and treatment of mental illness that are not less favorable than
31 benefits for physical illness generally. Benefits for treatment of mental illness shall be
32 subject to the same limits as are benefits for physical illness generally. For purposes
33 of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors,
34 copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any
35 other dollar limits or fees for covered services.

36 (e) A health maintenance organization may use a case management program for
37 mental illness benefits to evaluate and determine medically necessary and medically
38 appropriate care and treatment for each patient, provided that the program complies
39 with rules adopted by the Commissioner of Insurance. These rules shall ensure that
40 case management programs are not designed to avoid the requirements of this section
41 concerning parity between the benefits for mental illness and those for physical illness
42 generally.

43 (f) This section applies only to group contracts covering five or more employees.

1- (g) Subsections (d) and (e) of this section shall not apply to a health care plan if
2 the HMO demonstrates to the Commissioner that compliance has increased the cost
3 of the plan by two percent (2%) or more on an annual basis."

4 Section 5. This act is effective when it becomes law and applies to
5 contracts issued, delivered, or renewed on or after January 1, 1998. This act expires
6 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.

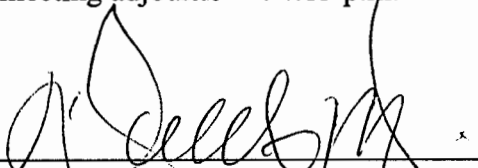
A question was raised as to where the bill would go after it was voted on by the Standing Subcommittee. Representative Dockham, Chairman of

the Insurance Committee, stated that it was his understanding that it would be reported to the House Floor.

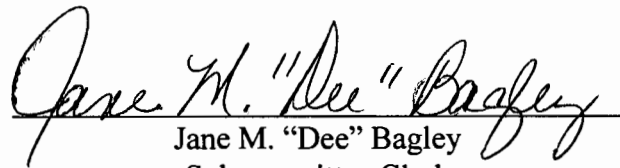
Representative Luebke questioned Representative McComas' directive to the Special Subcommittee to reach a consensus, and expressed his fear that all bills were not capable of that in terms of their content. Representative McComas clarified that he stated to most, if not all members of the Standing Subcommittee. 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 SHEETHOUSE INSURANCE/Subcommittee on HealthAUGUST 5, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Kevin Harely	NCBA
IGBT PASchal	Young, Thores
NANCIE BRYAN	NC Alliance for the Mentally Ill
Shirley Thibod	NAMI-NC
Katherine Peters	NC Psychiatric Assoc.
Polly Williams	AARP
Ballard Everett	NAMI-NC
Gail Pruditt	NCNA
Joe Donoran	NAMI-NC
Aphanie Gilmore	NAMI-NC
Joanna McFarland	NAMI-NC
Bonita Brewer	Capital Strategies
Robert Bone	Bone & Assoc.
W. P. Meade	The Herndon Group, DVC.
Myra J. Jorgensen	NAMI LP NC Inc.
Ron V. Galt	NAMI NC
Chas Pitt, Jr.	MHA/NC
Larry Sainture	MHA/DC
Phyllis Hedden	Covenant w/ NC Children
Anne Case	NCRMA
Nancy Bradley	NCCBI
Sandra J. Sanders	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

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL
3 ILLNESS.

4 The General Assembly of North Carolina enacts:

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

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

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

12 **"§ 58-51-55. No discrimination against the mentally ill and chemically dependent.**

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

14 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-
15 3(21); and

16 (2) 'Chemical dependency' has the same meaning as defined in G.S.
17 58-51-50

18 with a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders
19 ~~DSM-3-R~~ DSM-IV or the International Classification of Diseases ICD/9/CM, or a
20 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

1 (2) 'Chemical dependency' has the same meaning as defined in G.S.
2 58-65-75

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

6 (b) No ~~hospital, medical, dental or health service~~ corporation governed by this
7 Chapter shall, solely because an individual to be insured has or had a mental illness
8 or chemical dependency:

9 (1) Refuse to issue or deliver to that individual any individual or
10 group hospital, dental, medical or health service contract in this
11 State that affords benefits or coverage for medical treatment or
12 service for physical illness or injury;

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

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

17 (c) Nothing in this section prevents any hospital or medical plan from excluding
18 from coverage any physical illness or injury ~~or mental illness~~ or chemical dependency
19 which has existed previous to coverage of the individual by the hospital or medical
20 plan or from refusing to issue or deliver to that individual any policy because of the
21 underwriting of any physical condition whether or not related to ~~mental illness or~~
22 chemical dependency.

23 ~~(d) This section applies only to group contracts covering 20 or more employees.~~

24 (d) Every group insurance certificate or group subscriber contract under a hospital
25 or medical plan subject to this Article shall provide to its insureds benefits for the
26 necessary care and treatment of mental illness that are not less favorable than benefits
27 for physical illness generally. Benefits for treatment of mental illness shall be subject
28 to the same limits as are benefits for physical illness generally. For purposes of this
29 subsection, 'limits' includes durational limits, deductibles, coinsurance factors,
30 copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any
31 other dollar limits or fees for covered services.

32 (e) The service corporation may use a case management program for mental illness
33 benefits to evaluate and determine medically necessary and medically appropriate
34 care and treatment for each patient, provided that the program complies with rules
35 adopted by the Commissioner of Insurance. These rules shall ensure that case
36 management programs are not designed to avoid the requirements of this section
37 concerning parity between the benefits for mental illness and those for physical illness
38 generally.

39 (f) Subsections (d) and (e) of this section apply only to group contracts covering 5
40 or more employees. The remainder of this section applies only to group contracts
41 covering 20 or more employees.

42 (g) Subsections (d) and (e) of this section shall not apply to a subscriber contract
43 or certificate if the service corporation demonstrates to the Commissioner that

1 compliance has increased the cost of the contract or certificate by two percent (2%)
2 or more on an annual basis."

3 Section 4. G.S. 58-67-75 reads as rewritten:

4 "**§ 58-67-75. No discrimination against the mentally ill and chemically dependent.**

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

6 (1) 'Mental illness' has the same meaning as defined in G.S. 122C-
7 3(21); and

8 (2) 'Chemical dependency' has the same meaning as defined in G.S.
9 58-67-70

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

13 (b) No health maintenance organization governed by this Chapter shall, solely
14 because an individual has or had a mental illness or chemical dependency:

15 (1) Refuse to enroll that individual in any health care plan covering
16 physical illness or injury;

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

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

21 (c) Nothing in this section prevents any health maintenance organization from
22 excluding from coverage any physical illness or injury ~~or mental illness~~ or chemical
23 dependency which has existed previous to coverage of the individual by the health
24 maintenance organization or from refusing to issue or deliver to that individual any
25 policy because of the underwriting of any physical condition whether or not related
26 to ~~mental illness or~~ chemical dependency.

27 ~~(d) This section applies only to group contracts covering 20 or more employees.~~

28 (d) Every health maintenance organization that issues a health care plan on a
29 group basis for medical and hospitalization care shall provide to its insureds benefits
30 for the necessary care and treatment of mental illness that are not less favorable than
31 benefits for physical illness generally. Benefits for treatment of mental illness shall be
32 subject to the same limits as are benefits for physical illness generally. For purposes
33 of this subsection, 'limits' includes durational limits, deductibles, coinsurance factors,
34 copayments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any
35 other dollar limits or fees for covered services.

36 (e) A health maintenance organization may use a case management program for
37 mental illness benefits to evaluate and determine medically necessary and medically
38 appropriate care and treatment for each patient, provided that the program complies
39 with rules adopted by the Commissioner of Insurance. These rules shall ensure that
40 case management programs are not designed to avoid the requirements of this section
41 concerning parity between the benefits for mental illness and those for physical illness
42 generally.

43 (f) This section applies only to group contracts covering five or more employees.

1 (g) Subsections (d) and (e) of this section shall not apply to a health care plan if
2 the HMO demonstrates to the Commissioner that compliance has increased the cost
3 of the plan by two percent (2%) or more on an annual basis."

4 Section 5. This act is effective when it becomes law and applies to
5 contracts issued, delivered, or renewed on or after January 1, 1998. This act expires
6 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

- 1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE PARITY IN HEALTH INSURANCE FOR MENTAL
3 ILLNESS.
4 The General Assembly of North Carolina enacts:
5 Section 1. G.S. 58-50-155 is amended by adding the following new
6 subsection to read:
7 "(a2) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and
8 approved under G.S. 58-50-125 shall provide coverage for the treatment of mental
9 illness that is at least equal to the coverage required by G.S. 58-3-220. The plan may
10 use a case management program in accordance with G.S. 58-3-220."
11 Section 2.(a) The following are repealed: G.S. 58-51-55(b1) and (c), 58-
12 65-90(b1) and (c), and 58-67-75(b1) and (c).
13 (b) G.S. 58-51-55(d) reads as rewritten:
14 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to group health~~
15 ~~insurance contracts covering more than 50 employees. The remainder of this~~ This
16 section applies only to group health insurance contracts covering 20 or more
17 employees. For purposes of this section, 'group health insurance contracts' include
18 MEWAs, as defined in G.S. 58-49-30(a)."
19 (c) G.S. 58-65-90(d) reads as rewritten:

1 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to subscriber~~
2 ~~contracts covering more than 50 employees. The remainder of this~~ This section
3 applies only to group contracts covering 20 or more employees."

4 (d) G.S. 58-67-75(d) reads as rewritten:

5 "(d) Applicability. -- ~~Subsection (b1) of this section applies only to group~~
6 ~~contracts covering more than 50 employees. The remainder of this~~ This section
7 applies only to group contracts covering 20 or more employees."

8 Section 3. Chapter 58 of the General Statutes is amended by adding the
9 following new section to read:

10 **"§ 58-3-220. Mental illness benefits coverage.**

11 (a) Mental Parity Requirement. -- A health insurer shall provide in each group
12 health benefit plan benefits for the necessary care and treatment of mental illness that
13 are no less favorable than benefits for physical illness generally. Benefits for
14 treatment of mental illness shall be subject to the same limits as benefits for physical
15 illness generally. For purposes of this subdivision, 'limits' includes durational limits,
16 deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual
17 and lifetime dollar limits, and any other dollar limits or fees for covered services.

18 (b) Weighted Averages. -- If the plan contains annual limits, lifetime limits, co-
19 payments, deductibles, or coinsurance only on selected physical illness and injury
20 benefits, and these benefits do not represent substantially all of the physical illness
21 and injury benefits under the plan, the insurer may impose limits on the mental
22 health benefits based on a weighted average of the respective annual, lifetime, co-
23 payment, deductible, or coinsurance limits on the selected physical illness and injury
24 benefits. The weighted average shall be calculated in accordance with rules adopted
25 by the Commissioner.

26 (c) Case Management. -- An insurer may use a case management program for
27 mental illness benefits to evaluate and determine medically necessary and medically
28 appropriate care and treatment for each patient, provided that the program complies
29 with rules adopted by the Commissioner of Insurance. These rules shall ensure that
30 case management programs are not designed to avoid the requirements of this section
31 for parity between the benefits for mental illness and those for physical illness
32 generally.

33 (d) Exceptions. -- This section does not apply to either of the following:

34 (1) A group health benefit plan covering fewer than five employees.

35 (2) Any other group health benefit plan if the insurer demonstrates to
36 the Commissioner that compliance with this section has increased
37 the cost of the policy by two percent (2%) or more on an annual
38 basis. If the group health plan or contract granted an exemption
39 under this section nevertheless wants to offer limited mental illness
40 benefits coverage and there are 50 or more employees in the plan,
41 the plan may not provide a lesser lifetime or annual dollar
42 limitation than is provided under the plan for physical illness
43 generally, unless providing parity in annual and lifetime limits
44 increases the plan's cost by one percent (1%) or more.

1 (e) Definitions. -- As used in this section:

2 (1) 'Health benefit plan' has the same meaning as in G.S. 58-3-190 and
3 includes a blanket health policy or blanket accident and health
4 policy.

5 (2) 'Insurer' has the same meaning as in G.S. 58-3-190.

6 (3) 'Mental illness' has the same meaning as in G.S. 122C-3(21), with
7 a diagnosis found in the Diagnostic and Statistical Manual of
8 Mental Disorders DSM-IV or the International Classification of
9 Diseases ICD/9/CM, or a later edition of those manuals."

10 Section 4. This act becomes effective January 1, 1999, and applies to
11 contracts issued, delivered, or renewed on or after that date. This act expires
12 October 1, 2002.