COMPARISON OF NC REGULATIONS AND STATUTES to HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

NAIC MDL - 74	PW Comments	SV Comments	
Section 1, Title	No comments	No comment	
Section 2, Purpose A. B.	11 NCAC 20.0201 has the requirements for written provider contracts. 11 NCAC 20.0301 and 20.0302 require carriers to develop and establish a methodology to determine the size and adequacy of provider network and performance targets for member accessibility by having written policies and performance targets.	i. Contracts – required by 20.0201 and 20.0204 ii. Policies and procedures – 20.0300 asks for methodology, it is similar as P&P; NCAC does not require public access	
Section 3, Definitions	"Authorized representative" is not defined in Chapter 20. "Balance billing" is not defined in Chapter 20. "Commissioner" is not defined in Chapter 20. "Covered benefit" is not defined in Chapter 20. "Covered person" is not defined in Chapter 20. Rather, "Member" is defined in Chapter 20. "Emergency medical condition" is not defined in Chapter 20. It is defined in NCGS 58-	A. Authorized rep – not in NCAC, acceptable B. Balance billing - not in NCAC, acceptable C. Commissioner – defined in many places in NCGS D. Covered benefit – not in NCAC, acceptable E. Covered person – same definition in NCGS 58-50-61; definition of member in 20.0101 appears to have same meaning; MDL definition acceptable	

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	3-190, which differs from the definition in the Model Act. "Emergency services" is not defined in Chapter 20. It is defined in NCGS 58-3-190, which differs from the definition in the Model Act. "Essential community provider or "ECP" is not defined in Chapter 20. "Facility" is included in the definition of "Health care provider" in 11 NCAC 20.0101(b)(2). "Health benefit plan" is not defined in Chapter 20. It is defined in NCGS 58-3- 167, which differs from the definition given in MDL-074. NCGS 58-3-167 specifically excludes dental or vision plans from the definition of "Health benefit plan". NCGS 58-3-167 also specifically excludes plans implemented or administered by the North Carolina or United States Department of Health and Human Services or any successor agency, or its representatives.	F. Emergency medical condition – differs from NCGS 58-3-190; if used will need to be changed in other sections of NCGS G. Emergency services – same as above in F. H. Essential community providers – not defined in NCAC or NCGS, acceptable I. Facility – not defined in NCAC or NCGS, acceptable J. Health benefit plan – this definition has the greatest impact on the extent of applicability of this law; it is wider than in NCGS 58-3-167 but maybe narrower than in 58-50-56 because it appears that it is limited to [physical, mental or behavioral] health care services], and does not include dental and vision; K. Health care professional – not defined but used in credentialing law 58-3-230; will be useful L. Health care provider – slightly different than 20.0101(b)(2) (which also includes providers registered under the state law, and providers types required to be registered) but by including all providers practicing within the scope of their practice under state law, it will apply to a larger	

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	Phyllis Wyrick May 12, 2016 "Health care professional" is not defined in Chapter 20. "Health care provider" is defined in 11 NCAC 20.0101(b)(2), which differs from the Model Act. "Health care provider" or "provider" are defined in 11 NCAC 20.0201(b)(2) and 20.0201(b)(10), respectively, but differ from the Model Act. "Health care services" is not defined in Chapter 20. "Health carrier" is not defined in Chapter 20. "Carrier" is defined in 11 NCAC 20.0101(b)(1). Also, "Network plan carrier" is defined in 11 NCAC 20.0101(b)(6). Both definitions differ from the Model Act. "Intermediary" is defined in 11 NCAC 20.0101(b)(4), which differs from the Model Act. “Limited scope dental plan” is not defined in 11 NCAC Chapter 20 or NCGS 58. “Limited scope vision plan” is not defined in 11 NCAC Chapter 20 or NCGS 58.	set of providers type – for example, there are additional applicable chapters of NCGS other than NCGS 90 and 131E (referenced in NCAC); M. Health care services – not defined in NCAC but defined similarly as in NCGS 58-50-61 and adding “mental or behavioral health condition, including mental health and substance use disorders.” Recommended N. “Health carrier” or “carrier”; this definition is different from the definition of carrier or network plan carrier in 20.0101(b)(6), but is acceptable – it includes insurers, HMOs, service corporations, any other entity providing a plan of health insurance, health benefits or health care services O. “Intermediary” – not the same definition as in 20.0101(b)(6); NOT recommended P. “Limited scope dental plan” – not defined in either NCAC or NCGS; unclear if it includes medical services for the mouth; NOT recommended Q. Limited scope vision plan - not defined in either NCAC or NCGS; unclear if it includes medical services for the eye; NOT recommended	

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	"Network" is not defined in 11 NCAC Chapter 20. "Intermediary" or "intermediary organization" are both defined in 11 NCAC 20.0201(b)(4). “Network Plan” is not defined in 11 NCAC Chapter 20. “Health benefit plan is defined in NCGS 58-3-167(a)(1). "Participating provider" is not defined in Chapter 20. "Preferred provider" is defined in 11 NCAC 20.0201(b)(9). "Person" is not defined in Chapter 20. "Person" is not defined in Chapter 20. “Primary care” is not defined in 11 NCAC Chapter 20. "Primary care professional" is not defined in Chapter 20. “Specialist” is not defined in 11 NCAC Chapter 20. “Specialty care” is not defined in 11 NCAC Chapter 20. “Telemedicine” or “Telehealth” are not defined in 11 NCAC Chapter 20. “Tiered network” is not defined in 11 NCAC Chapter 20. “To Stabilize” is defined in NCGS 58-3-190(5) and 58-50-61(a)(16).	R. Network - neutral S. Network Plan – different from “preferred provider benefit plan” in 58-50-56 (definition incorporated in 12.1800), different from “health care plan” in 58-67-5 (definition also incorporated in 12.1400), and “PPO benefit plan” in 20.0101(b)(8); NOT recommended T. Participating provider – similar (missing “implied contract”) to definition in 58-67-5(l) but applies to all carriers and consequently references coinsurance; Recommended U. “Person” – 58-67-5 much more limiting in included person and also excludes individuals, and professional organizations; NOT recommended V. Primary Care W. Primary care professional X. Specialist Y. Specialty care Z. Telemedicine or Telehealth – not defined in NCAC and chapter 58; Recommended AA. Tiered network, not defined in NCAC	

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	"Transfer" is not defined in 11 NCAC Chapter 20. Phyllis Wyrick May 12, 2016 Section 4. Applicability and Scope The Applicability and Scope in Chapter 20 differs in its description. Currently, limited scope dental plans and limited scope vision plans are subject to 11 NCAC Chapter 20. Multiple Employer Welfare Arrangements ("MEWAs) are not subject to 11 NCAC	and Chapter 58, Recommended BB. To stabilize – different from 58-3-190; NOT recommended CC. To transfer – not defined; neutral	
Section 4, Applicability and scope	The Applicability and Scope in Chapter 20 differs in its description. Currently, limited scope dental plans and limited scope vision plans are subject to 11 NCAC Chapter 20. Multiple Employer Welfare Arrangements ("MEWAs) are not subject to 11 NCAC Chapter 20. Chapter 20 does not consider accreditation by nationally recognized private accrediting entities. MDL-074 applies to all health carriers that offer	A. Excludes excepted benefit plans; 58-50-56(a)(3) includes all benefit plans with benefit differentials; B. Needs discussion	

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	network plan, but does not require compliance by limited scope dental plans or limited scope vision plans		
Section 5, Network Adequacy	A. 11 NCAC 20.0300 has broad requirements for carriers to determine the size, adequacy, and availability of the provider network necessary to serve the carrier's members. MDL-074 specifies "appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, including children and adults without unreasonable travel or delay". It also includes the ability of the network to include the needs of low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency. Additionally, it includes health care service delivery options, i.e., telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care, to	A. not as complete as NCAC, but adds underserved 1.Addressed in 20.0301(a) and 20.0302(a) 2. Addressed in 20.0302(2)	

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	include technological and specialty care services available to persons requiring technologically advanced or specialty care services. B. 11 NCAC 20.0300 requires the carriers to establish methodologies to determine network sufficiency. MDL-074 requires the commissioner to establish and determine network sufficiency criteria. C. 11 NCAC 20.0301(3) requires carriers to arrange for	B. Commissioner shall establish sufficiency by reference to any reasonable criteria; NCAC only asks for methodology, but categories are similar as follows: i. As in 20.0301(a) ii. as in 20.0301(a) iii. as in 20.0302(a) iv. as in 20.0302(a) v. as in 20.0302(4) vi. hours of operations – as in 20.0404 vii. needs of low income persons – not in NCAC viii. telemedicine or telehealth, mobile clinics, centers of excellence, etc not addressed in NCAC ix. The volume of technological and specialty	

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	providing health care services outside of the service area at in-network benefit levels when providers are not available in the area. 20.0302(3) requires carriers to establish written policies and performance targets for emergency provisions within and outside of the service area at in-network benefit levels. 1. Would be good. It expands our requirements to unreasonable travel or delay. 2. Covered by NCGS 58-3-223; NCGS 58-3-235, and NCGS 58-3-240, however, dental plans and vision plans are excluded by NCGS 58-3-167. MDL-074 extends it to non-participating providers. 3. Would be good. 4. Would be good. 5. Would be good. 6. Would be good. 7. Would be good.	care services available to serve the needs of covered persons requiring technologically advanced or specialty care services. Not in NCAC C. Vaguely provided in 58-3-200(d) but this is more detailed; Recommended	

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	D. This is covered in 11 NCAC 20.0301; 20.0302; 20.0304. E. This is covered in NCGS 58-50-56 which only applies to PPOs; 11 NCAC 20.0601 which only applies to HMO. F. Would be good.	D. Covered in 20.0301, 20.0302, 20.0304 E. Covered in 58-50-56 for PPOs; 58-67-10(d)(1) for HMOs; MDL allows trade secret status for access plans F. Plan shall contain: (1) How to use network and telemedicine – recommended (2) Referrals – covered in58-50-61 (3) Ongoing monitoring of adequacy – required by 20.0304 (4) Network criteria – provided in 20.0400 (5) Needs of covered persons – recommended (6) Satisfaction with services – covered somewhat in NCGS 58-50-61(e)(2) (7) Informing covered persons of plans features – recommended but some are provided in 58-50-61(m), 12.1404, 12.1804 (8) Coordination of care - recommended (9) Procedures to change PCP -	

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		recommended (10) Continuity of care – recommended as 58-67-88 is applicable to HMOs only (11) access to specialist and ancillary providers in participating hospitals	
6. Requirements for Health Carriers and Participating Providers	A. This is covered in provider contracting, pursuant to 11 NCAC 20.0202(15). B. This is covered in provider contracting, pursuant to 11 NCAC 20.0202(8) but only applies to HMOs. The next to the last sentence omits "in advance" pursuant to 11 NCAC 20.0202(8). C. This is covered in provider contracting, pursuant to 11 NCAC 20.0202(5b) but only applies to HMOs. Our reg requires "inpatient care shall be continued until the patient is ready for discharge". MDL-074 expands the	A. Provided in NCGS 58-50-56(f) and 20.0202(15); acceptable B. Prohibition on balance billing – no mandated text but is required for HMO plans per 58-67-120 and 20.0202(8); indirectly for PPOs by requiring providers to accept contracted rate in 58-50-56(a)(2) C. Prohibition on balance billing in case of continuation – for HMO - 58-67-115 and 20.0202(5)(b) require continuation until the patient is ready for d/c and for the period until the premium is paid but are silent on balance billing prohibition; for non POS HMO, 58-67-88, only if provider agrees to accept contracted rate;	

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	requirement to covered persons in an active course of treatment or totally disabled. D. No comment. E. No comment. F. F1 Includes standards for selecting and tiering of participation providers. F2 no comment. F3 no comment. F4 no comment. F5 no comment.	MDL language recommended D. Survival – for HMOs implied by 58-67-115(a) E. Provider prohibited to collect from the insured – for HMO same effect as 58-67-115; recommended F. i. Requirements for standards for all provider types - covered in 20.0400, could be used for tiers - acceptable ii. Should be used for carriers and intermediaries, in accordance with state credentialing law – covered in 20.0400, 58-3-230 and via NCAC 20.0204; acceptable iii. discrimination in credentialing of certain types of providers – not available in NC laws; recommended iv. not in NC law, but makes sense with (3) above v. not in NC law but makes sense with (3)	

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	G. NC doesn't require this. H. This is covered in provider contracting, pursuant to 11 NCAC 20.0202(15). I. This is covered in NCGS 58-3-265. J. This is covered in provider contracting, pursuant to 11 NCAC 20.0202(16). K. This is covered in provider contracting pursuant to 11 NCAC 20.0202(11). MDL-074 expands for covered person's right to see, obtain copies of or amend their medical and health records. L. This is covered in provider contracting pursuant to 11 NCAC 20.0202(4). 1a. MDL-074 specifically refers to removal of provider or provider leaving	above G. requirement to get credentialing plan approved and available to public – approval covered in 58-67-10 for HMOs and 58-50-56 for PPOs; but no requirement to make it public; acceptable H. Notification to providers of company's P&Ps – covered in 20.0202(15) I. Prohibition on inducements to providers - covered in 58-3-265 J. Prohibition on treatment discussion with covered persons – covered in 58-3-176 and 20.0202(16) K. Make records available to regulatory agencies – covered in 20.0202(11) but not the covered person's right to see and amend records L. Termination of provider - covered in 20.0202(4) but i. (a) 20.0202 has no 60 day notice; draft	

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	network without cause (specifically focused on tiered network plans). 2. New definitions – active course of treatment; life-threatening health condition; serious acute condition. New requirements for carriers to establish procedures to transition covered person during an active course of treatment for continuity of care, when a provider leaves or is removed from the network. M. This is covered in provider contracting pursuant to 11 NCAC 20.0202(19). N. This is covered in provider contracting pursuant to 11 NCAC 20.0202(13). O. This is covered in provider contracting pursuant to 11 NCAC 20.0202(8). P. Would be good. Q. This is covered in provider contracting pursuant to 11 NCAC 20.0202(10). MDL-074 has more specific detail. R. This is covered in provider contracting pursuant to 11	note makes a good point about terminating provider in the middle of benefit year; (b) 30 days notice to covered person in active treatment only required for HMO members for “ongoing special condition” per 58-67-88; (c) no requirement to notify all covered person of terminated PCP; recommended ii. New definitions make sense and are wider than provided in 58-67-88 (HMO only) iii. Continuity of care approval – again, only for HMO in 58-67-88; Recommended M. Prior written consent of both parties prior to assignment and delegation – cleaner than 20.0202(19), more protective to providers – recommended N. No discrimination based on source of payment – covered in 20.0202(13) O. Obligation to pay copay etc and non-covered services – covered in 20.0202(8) P. No penalty for reporting – not in NC laws; recommended Q. Verification on member eligibility including grace period – in 20.0202(10) but no	

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	NCAC 20.0202(18). S. This is covered in provider contracting pursuant to 11 NCAC 20.0202(2). Good to add specific requirements about not conflicting with network plan or Act. T. Would be very good to have.	mention of grace period R. Provider dispute process – not required by NC laws but 20.0202(18) requires description in contract if any available S. Contract requirements not in conflict with benefit plan and MDL - not required in NC laws but 20.0202(2) requires a disclosure if definitions are different T. Notification to provider i. of incorporated documents – only partially covered in 20.0202(15) and 58-50-270 et seq; Recommended ii. of inclusion in network – not required, recommended	
Section 7, Requirements for Participating Facilities with Non-Participating Facility-Based Providers	A. Defines “facility-based provider”. B. Would be good to have. C. Would be good to have. D. Would be good to have. “Payment Responsibility Notice”. E. Would be good to have. F. Would be good to have. G. Would be good to have. Provider Mediation Process.	A. Facility Based Providers – definition acceptable B. Coverage description – 58-3-200(d) provides better protection if there is no option to use in-network providers, otherwise useful C. No balance billing for emergency covered in 58-3-190 and more beneficial to the covered person – NOT recommended D. Limitation on balance billing but may	

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	H. Would be good to have. I. Would be good to have. J. Does not apply to stand-alone dental or vision plans. K. Would be good to have.	allow provider to balance bill up to $500 – no option is as favorable as 58-3-190 and 58-3-200; NOT recommended E. Carrier must develops payment process for OON – not covered in NC laws; useful F. Benchmark for OON payment – not provided in NC laws – useeful G. Provider Mediation Process – not provided in NC laws; should take place in NC(e); reasonable H. No binding arbitration/mediation for covered person – NC standard I. Enforcing agency – resonable J. Applicability – not applicable to excepted benefits K. Regulation – reasonable	
Section 8, Disclosure and Notice Requirements	A. Would be good to have. B. Would be good to have	A. Notice by carrier to covered person at time of notification about a possibility of OON service – still less favorable than the prohibition of penalty in 58-3-200(d) B. Notification by facility – as above in (A)	

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Section 9, Provider Directories	A. This is covered pursuant to NCGS 58-3-245. MDL-074 requires updating provider directory at least monthly vs. NCGS 58-3-245 requires at least once a year. B. MDL-074 requires more detailed information, i.e., gender, languages spoken other than English, accepting new patients, etc.	A. must be available electronically, also to the general public, updated monthly, disclosure of tierring criteria, applicability to each benefit plan, and more; 58-3-245 does not require all that information proactively; acceptable B. C, and D Required information for directories – not substantially different from 58-3-245(b), acceptable	
Section 10, Intermediaries	This section includes provision the same as 11 NCAC 20.0204. A. 20.0204(b)(1). B. 20.0204(b)(2). C. 20.0204(b)(4). D. 20.0205(b)(5). E. 20.0204(b)(6). F. 20.0204(b)(6). G. No comment. H. This would be good. I. This would be good.	A. Intermediaries and their providers must comply with Section 6 – not as specific as 20.0204(b)(1) which requires explicitly inclusion in the provider contract B. Oversight of services – MDL more demanding than 20.0204(b)(2) C. Approval of network providers – covered in 20.0204(b)(4) D. Maintenance of contracts by the carrier – covered in 20.0204(b)(5) which also gives the option for keeping contract with the intermediary E. UM and claims data – covered in	

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		20.0204(b)(6)(A) and 20.0204(c) F. Record maintenance – covered in 20.0204(b)(6)(C) if intermediary is paying claims G. Access of books by commissioner - covered in 20.0204(b)(6)(C) if intermediary is paying claims H. Assignment of contract in case of insolvency – not covered by NC laws I. Carrier's responsibility for delegated function to intermediary – covered in 20.0204(a) and (b)(7)	
Section 11 Filing Requirements and State Administration	A. 20.0201. Included in our PPO Network Filings. B. 20.0203. C. 58-3-151. D. 20.0202(11) and 20.0204(b)(6).	A. Provider contracts – must be filed with commissioner but no prior approval requirement; 20.0201, 58-50-56, and 58-67-10 require prior approval B. Material changes must be filed – 20.0203 requires prior approval C. Deemer – 58-3-151, 58-50-56(b), D. Maintenance of carrier's and intermediaries' contracts – not explicit for carrier's contracts in NC laws and regs; 20.0204(b)(5) for intermediary contracts	

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Section 12 Contracting	A. This would be good. B. 20.0201. C. 20.0201 and 20.0204(b)(7).	A. Carrier retains responsibility to covered persons and for compliance with the law – not required by NC laws and regs B. Written contracts subject to review (but not prior review) – 20.0201 requires written contracts and prior approval C. Compliance with law – 20.0201 and 20.0204(b)(7)	
Section 13 Enforcement	A. 20.0507 for HMOs only. MDL-074 requires a modification filing. B. This would be good.	A. Corrective action plan – 20.0507 only for HMO B. Commissioner not to intervene regarding the action to include or not include a provider in network – not provided in NC laws and regs	
Section 14 Regulation	We already have most of them in Chapter 20	Depending on the extent of the new NC law, additional rules may be required	
Section 15 Penalties	Wouldn't we have a hearing first? Should be "is subject to….".	No comment	
Section 16 Separability	This would be good	Reasonable	
Section 17	A. No comment.	No comment	

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Effective Date	B. No comment. C. No comment. D. No comment.		