North Carolina Department of Insurance
Jim Long, Commissioner

BULLETIN

Number 97-B-3

TO: **All Managed Care Network Plan Carriers**

FROM: **Managed Care And Health Benefits Division**

RE: **Intermediaries and Other Contractors Providing Services to Network Plan Carriers: Requirements for Preferred Provider Organization Networks; Utilization Review Organizations; and Third Party Administrators**

DATE: **October 7, 1997**

ATTENTION: **Chief Executive Officer**

As a result of the managed care rules contained in Chapter 20 of Title 11 of the North Carolina Administrative Code that became effective October 1, 1996 (the "Managed Care Rules"), Network Plan Carriers contracting with "intermediaries" for provider networks and provider credentialing now have explicit regulatory requirements relating to their use of such arrangements. The North Carolina Department of Insurance (the "Department") has prepared this Bulletin to alert you to these regulatory provisions. In addition, this Bulletin also reminds Network Plan Carriers of their obligations under regulations governing Utilization Review and statutes governing Third Party Administrators.

Definition of Network Plan Carrier

Section .0101(6) of the Managed Care Rules defines Network Plan Carrier as an insurer, health maintenance organization or any other entity acting as an insurer that (1) provides reimbursement for health care services or (2) provides or arranges health care services and (3) encourages members to use network providers by means of benefit reductions (including increased copayments or deductibles) for services obtained from non-network providers. Sections .0200, provider contacts, .0300, provider accessibility and availability and .0400, provider credentials, apply to HMOs, licensed insurers offering PPO benefit plans and any other entity falling within the definition of Network Plan Carrier. While this Bulletin is applicable to all entities falling within the Network Plan Carrier definition, HMOs are advised to consult North Carolina Department of Insurance Bulletin 97-B-1 for additional requirements applicable to HMOs.

Responsibilities Of Network Plan Carriers Contracting With Provider Network Organizations (Freestanding PPOs)

Provider network companies, also known as Freestanding PPOs, that contract with a Network Plan Carrier to provide the network of providers used in conjunction with the carrier's PPO, HMO or other applicable managed care product, fall under the definition of "Intermediary Organization" in Section .0101(4) of the Managed Care Rules. Freestanding PPOs are no longer required to register with nor will they receive PPO

certification from the Department.* Rather, Network Plan Carriers contracting with these Intermediary Organizations are required to file information related to these entities and the intermediary relationship with the Managed Care and Health Benefits Division ("MCHB Division") to demonstrate compliance. Insurance Companies offering PPO products are required to complete a PPO filing for the MCHB Division's approval. Annual renewals of the PPO filing are required. PPO certificates will no longer be issued by the Department. Pertinent requirements are as follows:

- Pursuant to Section .0204, the Network Plan Carrier must file its intermediary contract form(s) (the boilerplate for agreements between the Network Plan Carrier and the Intermediary Organization) with and have the form approved by the MCHB Division before any such contract is executed. In addition, the intermediary contract must comply with all other requirements of Section .0204 and applicable requirements of Section .0202. Non-HMO Network Plan Carriers must also file their intermediary's form provider contract(s) (the boilerplate for agreements between the Intermediary Organization and the various providers accessed by the carrier's members) for approval by the MCHB Division.

- To facilitate the compliance process, the Network Plan Carrier will be permitted to submit the certification required by Section .0204 at the time the carrier enters an intermediary relationship, rather than at the time the carrier's form intermediary contract is filed. The certification must state that the Intermediary Organization with which the carrier is contracting is obligated to comply with applicable statutes and regulations and with the carrier's own policies and procedures. The certification must also confirm that the Network Plan Carrier will monitor such compliance on an on-going basis and that the carrier retains all legal responsibility to oversee services offered and financial responsibility to plan members. The Network Plan Carrier may use the Intermediary Contract Notification and Certification form accompanying this Bulletin or a substantially similar form of the carrier's own design.

- All requirements of Title 11, Chapter 20 of the North Carolina Administrative Code that apply to the use of intermediaries and delegation of activities, including those relating to health care provider contracts, verification of health care provider credentials, and network availability and accessibility, apply to a Network Plan Carrier's use of an Intermediary Organization's provider network.

- A Network Plan Carrier is responsible for its own compliance, the compliance of the intermediary, and for on-going monitoring of the intermediary's performance. The fact of an intermediary's compliance does not excuse a carrier's failure to monitor the intermediary's performance. The mere act of monitoring an intermediary's performance does not relieve a carrier from its responsibility to demand corrective action, terminate a contract or rescind delegation, if necessary.

Responsibilities Of Network Plan Carriers Contracting With Utilization Review Organizations

An independent Utilization Review Organization ("URO") providing services to Network Plan Carriers is no longer required to register with the MCHB Division. Rather, carriers that use utilization review in their benefit plans, whether such functions are conducted in-house or delegated, are required to file information

*In addition to the Department's requirements applicable to insurance carriers, the Industrial Commission requires all managed care plans, carriers and free-standing PPOs involved in self-funded Workers Compensation to comply with all statutes, regulations and Department requirements applicable to managed care entities. Therefore, Freestanding PPOs involved in self-funded Workers Compensation shall continue to submit PPO filings to the MCHB Division and update such information annually.

annually with the Department to demonstrate compliance.† Network Plan Carriers have always been subject to regulations that apply to utilization review activities. Through December 31, 1997, the requirements of Chapter 12, Title 11 of the North Carolina Administrative Code apply to utilization review activities. These provisions include:

- Network Plan Carriers must meet all requirements of Section .0900 when they perform utilization review functions themselves.

- As provided in Section .0903(a), no carrier may contract with an entity to perform utilization review unless that entity complies with Section .0900.

- Pursuant to Section .0903, on or before April 1 of each year, the carrier must file with the MCHB Division a certification that the carrier and/or the entity with which it contracts to perform utilization review are in compliance with Section .0900.

- Summary reporting of utilization review activities, as specified in Section .0917, is due to the MCHB Division on or before April 1 of each year. Reporting should include activities performed by contracted entities as well as the carrier's own activities.

- A Network Plan Carrier is responsible for its own compliance, the compliance of any contracted entity, and for on-going monitoring of the contracted entity's performance. The fact of a contracting entity's compliance does not excuse a carrier's failure to monitor that entity's performance. The mere act of monitoring a contracted entity's performance does not relieve a carrier from its responsibility to demand corrective action, terminate a contract or rescind delegation, if necessary.

Effective January 1, 1998, new statutory provisions related to utilization review, in particular NCGS §58-50-61, will apply.

Responsibilities Of Network Plan Carriers Contracting With Third Party Administrators

- In cases where a Network Plan Carrier contracts with an entity that acts in the capacity of a Third Party Administrator ("TPA"), such entity must be licensed by the Department.

- Pursuant to NCGS 58-56-26(b), it is the sole responsibility of the Network Plan Carrier to provide for competent administration of its programs, whether the administration is done in-house or delegated to a licensed TPA.

- Pursuant to NCGS 58-56-26(c), in cases where a TPA administers benefits for more than 100 certificate holders on behalf of a Network Plan Carrier, the carrier shall, at least semiannually, conduct a review of the operations of the TPA. At least one semiannual review shall be an on-site audit of the operations of the TPA.

† The Industrial Commission requires all managed care plans, carriers and free-standing UROs involved in self-funded Workers Compensation to comply with all statutes, regulations and Department requirements applicable to utilization review entities.

Responsibility Of Network Plan Carriers To Notify All Intermediaries Of This Bulletin

Each Network Plan Carrier is required to distribute a photocopy of this Bulletin to all Intermediary Organizations, UROs, and TPAs with which the carrier contracts and notify the Department that such distribution has been accomplished. Notification to the Department must include: a list of the name of each entity to which a copy of this Bulletin was sent. Intermediary certifications should also be provided for these existing intermediary relationships. Carriers are permitted to omit from such certifications those contract requirements that are not contained in intermediary contracts executed **before October 1, 1996.**[‡] This information shall be submitted to the Department within 30 days of the Network Plan Carrier's receipt of this Bulletin and shall be directed to the attention of:

Managed Care And Health Benefits Division
North Carolina Department Of Insurance
PO Box 26387
Raleigh, NC 27611

Notice to newly contracted intermediaries and the Department shall continue on an ongoing basis.

To assist you in your compliance efforts, definitions of PPOs, UROs, TPAs, and intermediaries, along with examples of each, are attached. Should you have any questions regarding your responsibilities, you may contact DeAnne J. Nelson, Assistant Deputy Commissioner, Managed Care and Health Benefits Division, at (919) 715-0526.

[‡] While the Department has not required modification of intermediary contracts entered into prior to October 1, 1996, should companies involved in such a prior-existing intermediary relationship execute a new contract with one another or materially modify the existing contract after October 1, 1996, this new or modified contract must incorporate the requirements of the Managed Care Rules.

ATTACHMENT I

DEFINITIONS

Definition Of Preferred Provider Organization (PPO)

Any entity that contracts with health care providers, that also contracts with an Network Plan Carrier, insurer, or other entity offering a health benefit plan, or another PPO network used by a Network Plan Carrier or insurer, will be considered to be a PPO. The term "intermediary" as used in Title 11, Chapter 20 of the North Carolina administrative code, includes a PPO. An affiliate of your company or another Network Plan Carrier or insurer that provides network services is considered a PPO or intermediary.

Examples of PPOs include provider-based organizations, such as PHOs and IPAs, as well as freestanding networks that are not provider-based.

Contracts with chains that operate from multiple locations , such as nursing home or pharmacy chains, will not normally be considered to be a PPO. Contracts with these entities would be viewed as provider contracts. However, if unusual circumstances exist, a Network Plan Carrier should check with the Department to verify their status.

Definition Of Utilization Review Organization (URO)

Any entity that performs utilization review functions on behalf of a Network Plan Carrier, insurer, or any entity offering a health benefit plan will be considered to be a URO. An affiliate of your Network Plan Carrier or another Network Plan Carrier or insurer is considered a URO.

UROs may provide their services as part of a benefit carveout (e.g., a company administering all aspects of your vision benefit), as part of a PPO network (e.g., a PPO network delivers care and performs utilization review for services delivered by its contracted providers to determine whether services are medically necessary), or under an agreement to provide only utilization review services for some or all services sought under a Network Plan Carrier's plan.

Definition Of Third Party Administrator

Because of the broad definition of the term "third party administrator" as defined in NCGS 58-56-2(5), questions have arisen as to whether IPAs, provider networks, and other intermediary contractors are acting as a TPA when they receive payment directly from a Network Plan Carrier (either on a capitated[§] or fee-for-service basis) and distribute funds to their own contracted providers (either on a capitated or fee-for-service basis).

Network Plan Carrier intermediaries that meet <u>each</u> of the following criteria will <u>not</u> be deemed to be adjusting or settling claims, and therefore will not be required to be licensed as TPA:

- *The contracts between the intermediary and its providers and between the intermediary and the Network Plan Carrier stipulate that the Network Plan Carrier's payment to the intermediary*

[§] HMOs are the only carriers authorized to compensate providers on a capitated basis. Only an intermediary doing business with an HMO may distribute funds on a capitated basis to the intermediary's contracted providers that participate in such a network. Nothing in this bulletin is meant nor should it be construed to permit other types of carriers or intermediaries doing business with non-HMO carriers to make capitated payments.

constitutes payment in full for covered services and prohibit the billing of members for covered services, except for copayments and deductibles stipulated in the members' benefit policy issued by the Network Plan Carrier.

- *The intermediary does not directly or indirectly receive claims from the Network Plan Carrier's members, adjudicate claims from the Network Plan Carrier's members, or disburse funds to the Network Plan Carrier's members.*
- *The intermediary distributes funds only to its own contracting providers, in accordance with written agreements. Such payment is made in return for medical services rendered by the intermediary's contracted providers directly to enrollees of a Network Plan Carrier contracting with the intermediary, in which arrangement the provider has agreed to participate.*
- *Network Plan Carrier member eligibility determinations are made by the Network Plan Carrier, not the intermediary.*
- *Neither the provider nor the intermediary determines whether or not a service is covered under the benefit plan; all such determinations are made only by the Network Plan Carrier. (Network Plan Carriers may provide intermediaries with a list of covered and non-covered services or have them perform utilization review, but only the Network Plan Carrier is responsible for determining coverage.)*
- *Providers who participate in an intermediary's network but also contract directly with a Network Plan Carrier submit their claims and encounter information directly to the Network Plan Carrier. (i.e., the intermediary does not submit claims to the Network Plan Carrier on behalf of a provider in cases where services are rendered pursuant to a separate direct contract between the Network Plan Carrier and the provider.)*

Intermediaries may <u>not</u> make payment to providers for services rendered to Network Plan Carrier members unless such provider has a written contract with the intermediary. If payment is made by an intermediary to a provider without such a contract, the intermediary will be deemed to have made claims payment. If the intermediary pays such a claim to a non-contracting provider out of a capitation pool, it will be deemed to be engaged in the business of insurance. Both of these activities require licensure from the Department of Insurance.

Network Plan Carriers should review the definition of TPA provided in NCGS 58-56-2(5). An intermediary that engages in any activities that could in any way be included in the definition of a TPA should contact the Department of Insurance to determine whether licensing is required.

<u>Definition of Intermediary</u>

Any entity that employs or contracts with health care providers for the provision of health care services, and that also contracts with a network plan carrier or its intermediary. An intermediary is, therefore, any entity that contracts with or employs health care providers and in turn, contracts with carriers such as HMOs and insurance companies to make this provider network available to the carrier's members or covered persons.

Under this definition, a variety of entities would qualify as intermediaries. Some typical examples would include preferred provider organizations which contract with providers then in turn "lease" this network to an insurance company; a single-service managed care organization that, in addition to other services, provides a carrier access to its specialized provider network (e.g., mental health or chiropractic); an independent practice association (IPA) which employs or contracts with individual providers and group practices then contracts with a carrier to allow the carrier's members to receive services from the IPA's

provider network; and a physician-hospital organization (PHO) that contracts with carriers on behalf of its physician and/or hospital members. Other entities may also meet the definition of "intermediary".

The term "intermediary" is not intended, however, to reach every contractual arrangement into which a health care provider may enter. For example, an entity that contracts with physicians or physician practices to perform certain administrative or practice management functions, but does not enter into participating provider contracts on behalf of those providers would not be considered an intermediary. Likewise, entities that are composed *of providers, as distinguished from those that exist as entities separate from the providers they represent, would not be considered intermediaries. For example, group practices and professional associations (P.A.), both composed of providers, would not be considered intermediaries when they enter into participating provider agreements as a practice rather than having each individual provider in the practice or P.A. sign a separate participating provider agreement.*

ATTACHMENT II

Intermediary Contract Notification and Certification
(Bracketed information should be omitted by insurance carriers)

Pursuant to 11 NCAC 20.0601(c) [and 20.0204], _____, a/an _____ duly licensed and authorized to do business in the State of North Carolina, ("Carrier") hereby provides notification that Carrier has entered into an intermediary relationship with the entity named below and certifies the following to the Commissioner of the North Carolina Department of Insurance:

1) Carrier contracts with _____, an intermediary under the provisions of 11 NCAC 20.0101(b)(4), ("Intermediary") to perform or provide the following services: _____ (the "Services").

2) Carrier's contract with Intermediary obligates Intermediary to comply with all statutes and regulations which apply to Carrier and the Services, including 11 NCAC 20.0200, et seq., and includes provisions addressing the following:
   (a) Intermediary's obligation not to subcontract for its services without Carrier's written permission;
   (b) Carrier's retention of the right to approve or disapprove the participation of individual providers in the network made available to Carrier's plan members;
   (c) Intermediary's obligation to make available to Carrier and the Department of Insurance all provider contracts and subcontracts; and
   (d) compliance, to the extent applicable, with the provisions of 11 NCAC 20.0204(b)(6).

4) Carrier has examined all Intermediary's provider contracts related to the Services and has found that all such contracts comply with applicable provisions of 11 NCAC 20.0202, including provisions addressing the following:
   (a) whether contract and related appendices constitute the entire agreement between the parties;
   (b) definitions of technical insurance or managed care terms;
   (c) term of the contract;
   (d) requirements, if any, for written notice of termination and grounds for termination;
   (e) providers' continuing obligations in the event of termination of the contract or the insolvency of Carrier or Intermediary;
   (f) requirement that each provider (i) maintain credentials sufficient to meet Carrier's credentialing requirements and (ii) provide notification of changes in the status of such professional credentials;
   (g) obligation that the provider (or Intermediary on behalf of the provider) maintain acceptable levels of professional liability insurance and provide Carrier timely notification of changes in its coverage;
   (h) for prepaid plans, prohibition against billing network plan members for covered services, except for specified coinsurance, copayments and applicable deductibles;

(i) responsibility, if any, for collecting applicable deductibles, copayments, coinsurance and fees for noncovered services;
(j) responsibility for arranging call or backup coverage in accordance with Carrier's provider accessibility standards;
(k) Carrier's or Intermediary's obligation to provide a member eligibility verification mechanism;
(l) requirements regarding patient records, including maintenance standards, confidentiality, and accessibility;
(m) obligation to cooperate in member grievance procedures;
(n) obligation not to discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or insurance coverage; and
(o) obligation to comply with Carrier's utilization management, quality assessment, credential verification, and provider sanctions programs, with the proviso that such programs shall not override the professional or ethical responsibilities of a provider or interfere with a provider's ability to provide information or assistance to patients.

5) Carrier has developed policies and procedures related to Intermediary's performance of the Services and shall monitor such performance, as well as Intermediary's statutory and regulatory compliance, on an on-going basis.

6) Carrier has examined Intermediary's policies and procedures related to the Services and has found them to be in compliance with applicable statutes and regulations, as well as Carrier's own policies and procedures.

7) Carrier has developed policies and procedures, and has obtained all contractual provisions necessary and appropriate to enable it to take those actions necessary to maintain compliance with applicable statutes and regulations, including the ability to (i) demand that Intermediary take corrective action, (ii) terminate the intermediary relationship, and (iii) rescind delegation.

8) Carrier retains ultimate responsibility for services provided to its members.

9) Carrier retains financial responsibility to its members.

10) Carrier retains ultimate responsibility for compliance with all applicable statutes and regulations related its activities as a network plan carrier, whether or not those activities are delegated.

By:_____

Name:_____

Title:_____

Date:_____

DEPARTMENT OF INSURANCE
State of North Carolina

JIM LONG
COMMISSIONER OF INSURANCE

P. O. Box 26387
RALEIGH, N. C. 27611

MANAGED CARE
AND
HEALTH BENEFITS
DIVISION
TECHNICAL SERVICES GROUP
PHONE: (919) 715-0526
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Memorandum

DATE: October 7, 1997

TO: Chief Executive Officers,
All Managed Care Network Plan Carriers

FROM: North Carolina Department of Insurance
Managed Care & Health Benefits Division

RE: North Carolina Department of Insurance
Bulletin Number 97-B-3

Attached is North Carolina Department of Insurance Bulletin Number 97-B-3, entitled Intermediaries and Other Contractors Providing Services to Network Plan Carriers: Requirements for Preferred Provider Organization Networks; Utilization Review Organizations; and Third Party Administrators. Accompanying Bulletin 97-B-3 are (1) Attachment I, Definitions, which defines key terms used in the bulletin and (2) Attachment II, Intermediary Contract Notification and Certification form, which has been developed by the Managed Care and Health Benefits Division to assist you in creating appropriate intermediary certifications. You may use this form or a substantially similar one developed by your company. Many of you may have previously received this attachment from the Department as form number DOI/HMOCERT/081897 or DOI/INSCERT/081897.

Earlier this year, the Department prepared Bulletin 97-B-1 to assist HMOs in their efforts to comply with 11 NCAC 20.000. In an effort to offer similar assistance to other managed care network plan carriers, the Department has prepared the attached Bulletin 97-B-3. Those of you who received Bulletin 97-B-1 will notice that the information contained in the attached bulletin is similar, although not identical. The contents have been modified to address non-HMO network plan carrier compliance, as well as HMO compliance. Bulletin 97-B-3 also has been updated to address several frequently asked questions that arose in the wake of the initial bulletin and to incorporate the Managed Care and Health Benefits Division's June 9, 1997 memorandum regarding the definition of intermediary under the new rules. Companies that received the earlier bulletin and complied with its requirements will probably find that Bulletin 97-B-3 requires no additional action on their part. In the event that any requirements contained in Bulletin 97-B-3 conflict with those in Bulletin 97-B-1, HMOs should follow the requirements of Bulletin 97-B-1, which are specifically applicable to HMOs.

Please review this information carefully and incorporate it, as appropriate, into your compliance and intermediary contracting activities. Should you have any questions regarding information contained in this Bulletin or the accompanying attachments, please contact DeAnne J. Nelson, Assistant Deputy Commissioner, Managed Care & Health Benefits Division, at (919) 715-0526.