CHAPTER 20 - MANAGED CARE HEALTH BENEFIT PLANS

SECTION .0100 - MANAGED CARE DEFINITIONS

11 NCAC 20 .0101 SCOPE AND DEFINITIONS

(a) Scope.

(1) Sections .0200, .0300, and .0400 of this Chapter shall apply to HMOs, licensed insurers offering PPO benefit plans, and any other entity that is a network plan carrier as defined in this Rule.

(2) Sections .0500 and .0600 of this Chapter shall apply only to HMOs.

(3) Nothing in this Chapter shall apply to service corporations offering benefit plans pursuant to G.S. 58-65-25 or G.S. 58-65-30 that do not have any differences in copayments, coinsurance, or deductibles based on the use of network versus non-network providers.

(b) Definitions. As used in this Chapter:

(1) "Carrier" means a network plan carrier.

(2) "Health care provider" means any person who is licensed, registered, or certified pursuant to Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9b); or a pharmacy.

(3) "Health maintenance organization" or "HMO" has the same meaning as in G.S. 58-67-5(f).

(4) "Intermediary" or "intermediary organization" means 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.

(5) "Member" means an individual who is insured by a network plan carrier.

(6) "Network plan carrier" means an insurer, health maintenance organization, or any other entity acting as an insurer as defined in G.S. 58-1-5(3) that provides reimbursement or provides or arranges to provide health care services and uses increased copayments, deductibles, or other benefit reductions for services rendered by non-network providers to encourage members to use network providers.

(7) "Network provider" means any health care provider participating in a network utilized by a network plan carrier.

(8) "PPO benefit plan" means a benefit plan that is offered by a hospital or medical service corporation or network plan carrier, pursuant to G.S. 58-50-56, in which plan:

(A) either or both of the following features are present:

(i) utilization review or quality management programs are used to manage the provision of covered services; or

(ii) enrollees are given incentives via benefit differentials to limit the receipt of covered services to those furnished by participating providers; and

(B) health care services are provided by participating providers who are paid on negotiated or discounted fee-for-service bases or have agreed to accept special reimbursement or other terms for health care services under a contract with the hospital or medical service corporation or network plan carrier.

(9) "Provider" means a health care provider.

(10) "Quality management" means a program of reviews, studies, evaluations, and other activities used to monitor and enhance the quality of health care and services provided to members.

(11) "Service area" means the geographic area in North Carolina as described by the HMO pursuant to G.S. 58-67-10(c)(11) where an HMO enrolls persons who either work in the service area, reside in the service area, or work and reside in the service area, as approved by the Commissioner pursuant to G.S. 58-67-20.

(12) "Service corporation" means a medical or hospital service corporation operating pursuant to Article 65 of Chapter 58 of the General Statutes.

(13) "Single service HMO" means an HMO that undertakes to provide or arrange for the delivery of a single type or single group of health care services to a defined population on a prepaid or capitated basis, except for a member's responsibility for non-covered services, coinsurance, copayments, or deductibles.

(14) "Utilization review" has the same meaning as in G.S. 58-50-61(17).

History Note: *Authority G.S. 58-2-40(1); 58-50-61; 58-65-1; 58-67-150;*

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