SECTION .0600 - HEALTH MAINTENANCE ORGANIZATION FILINGS AND STANDARDS

11 NCAC 16 .0601 DEFINITIONS

(a) The definitions contained in G.S. 58-67-5 shall apply in this Section.

(b) As used in this Section:

(1) "Adjusted community rating" means a rating method that allows an HMO to prospectively establish premium rates based upon the expected revenue requirements for individual groups and to take into account a group's historical utilization, intensity, or cost experience.

(2) "Capitated" means covered health care services are provided by an HMO, medical group, or institution based on a prepaid fixed amount per enrollee regardless of the actual value of those services.

(3) "Community rating" means a general method of establishing premiums for financing health care in which an individual's rate is based on the actual or anticipated average cost of health services used by all HMO members in a specified service area.

(4) "Community rating by class" means a modification of community rating whereby individual groups may have different rates depending on the composition by age, gender, number of family members covered, geographic area, or industry.

(5) "Contingency reserve" means the unassigned funds held over and above any known or estimated liabilities of an HMO for the protection of its enrollees against the insolvency of the HMO.

(6) "Contract type" means a classification of the members into categories, usually based on enrolled dependent status, such as subscriber only, subscriber with one dependent, and subscriber with two or more dependents.

(7) "Credibility rating" means a rating method that establishes premium rates based upon the assignment of a level of credibility to an HMO group's historical utilization, intensity, or cost experience.

(8) "Fee-for-service" means payment for health care services is made on a retrospective basis based on the actual value of those services.

(9) "Full-service HMO" means an HMO that provides a comprehensive range of medical services, including hospital and physician services.

(10) "HMO expansion request" means all materials submitted for the purpose of obtaining authority to operate an HMO in a new or expanded geographic area in this State.

(11) "HMO model type" means a classification that describes the manner in which physicians are affiliated with the HMO and the contractual and payment arrangements with hospitals, and includes types such as group, network, staff, independent practice association, and point-of-service.

(12) "HMO rate filing" means an initial HMO rate filing, an HMO expansion request, or an HMO rate revision filing.

(13) "HMO rate revision filing" means all materials submitted for the purpose of making a revision to an existing schedule of premiums.

(14) "Incurred loss ratio" means the ratio of total medical expenses, including the change in claim reserves to total earned premium revenues.

(15) "Initial HMO rate filing" means all materials submitted for the purpose of obtaining a certificate of authority to operate an HMO in this State.

(16) "Single-service HMO" means an HMO that undertakes to provide or arrange for the delivery of a single or limited type of health care service to a defined population on a prepaid basis.

History Note: *Authority G.S. 58-67-50(b); 58-67-150;*
Eff. April 1, 1995;
Readopted Eff. October 1, 2018.