



State Law Health Plan Requirements

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Authorization Requirements

- DOI authorizes insurers, both domestic and foreign, to operate within the state.
- Requirements include minimum capital and surplus deposits, financial projections, evidence of successful business operations, etc.
- Insurers then receive authority to underwrite certain types of insurance – including health insurance.

HMO Requirements

- Are incorporated under their own Article in Chapter 58 of the General Statutes
- Have minimum financial requirements
- Must have bylaws, rules, and regulations
- Must include a description of the HMO operations
- Must provide financial statements and feasibility plan with 3 years of projections
- Provide provider and administrative contracts

HMO Requirements

- Must describe
 - Insolvency protection provisions
 - Grievance procedures
 - Claims systems
 - Provider credentialing plan (see later slide)
 - Utilization review program
 - Quality Assurance program (see later slide)
 - Provider availability and accessibility standards (see later slide)

PPO Requirements

- In addition to the requirements the insurer must meet to be authorized to operate in this State, an insurer (other than an HMO) who wishes to provide insurance plans which encourage the use of preferred (participating/network) providers must obtain approval from DOI of their PPO operations.

PPO Requirements

- PPO Initial Operations Filings includes:
 - Provider and administrative contracts
 - Grievance procedures
 - Provider credentialing plan (see later slide)
 - Utilization review program
 - Provider availability and accessibility standards (see later slide)

PPO and HMO Provider Credentialing Plan (T11 NCAC 20.0400, et seq.)

- Used to assure accessibility and availability of services
- Each insurer shall develop and adopt a written credentialing plan that contains policies and procedures to support the credential verification program.
- Regulation standardizes the minimum information that must be included in a provider application for participation in a network

PPO and HMO Provider Credentialing Plan (T11 NCAC 20.0400, et seq.)

- Some items to be included in plan:
 - Organizational structure and staffing relative to credentialing activities
 - Purpose, goals and objectives of program
 - Procedures for verification of provider and facility credentials such as license, DEA certificate, Board Certification, Malpractice claim history, JCAHO accreditation, etc.

PPO and HMO Provider Credentialing Plan (T11 NCAC 20.0400, et seq.)

- Some items to be included in plan:
 - Procedure for querying recognized monitoring services such as the National Practitioner Data Bank
 - Procedures for termination and an appeal mechanism
 - Recredentialing policies and procedures
 - Plan for maintaining centralized files on each individual provider making application.

PPO and HMO Provider Availability and Accessibility Plan (T11 NCAC 20.0300, et seq.)

- Each insurer shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the members
- The plan shall provide for development of performance targets for the following:
 - # and type of primary care physicians, specialty care providers, hospitals, and other provider facilities.

PPO and HMO Provider Availability and Accessibility Plan (T11 NCAC 20.0300, et seq.)

- The plan shall provide for development of performance targets for the following:
 - Method to determine when the addition of providers to the network will be necessary based upon increase in membership
 - Method for arranging or providing health care services outside the service area when providers are not available in the area

PPO and HMO Provider Availability and Accessibility Plan (T11 NCAC 20.0300, et seq.)

- The plan shall establish performance targets for member accessibility to primary and specialty care physician services and hospital based services. Targets include:
 - Proximity
 - Availability to provide emergency services on a 24/7 basis
 - Emergency provisions within and outside area
 - Average or expected waiting time for urgent, routine, and special appointments.

PPO and HMO Provider Availability and Accessibility Plan (T11 NCAC 20.0300, et seq.)

- Insurers shall monitor compliance by site visits or review of information collected and shall evaluate provider accessibility and availability at least annually.
- GS 58-3-200(d) – No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.

HMO Quality Plan (T11 NCAC 20.0500, et seq.)

- HMOs shall have program designed to monitor, evaluate, improve and promote the quality of care and service provided through network providers and its own policies, procedures and performance.
- A written plan with purpose, goals, and specific services to be monitored must be developed
- Plan must include a plan for correction when issues arise
- HMO must annually evaluate its quality management program to assure compliance with the regulation and the HMOs internal standards, policies, and procedures.

Network Plan Reporting

- Annual report requires information on managed care plans which includes information on:
 - Membership
 - Grievances
 - Provider contracting changes
 - Utilization
 - Quality
 - Availability
 - Accessibility of Services
 - Performance targets
 - Information on plan to assure availability and accessibility

Questions?