

Article 67.

Health Maintenance Organization Act.

§ 58-67-1. Short title.

This Article may be cited as the Health Maintenance Organization Act of 1979. (1977, c. 580, s. 1; 1979, c. 876, s. 1.)

§ 58-67-5. Definitions.

- (a) "Commissioner" means the Commissioner of Insurance.
- (b) "Enrollee" means an individual who is covered by an HMO.
- (c) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.
- (d) "Health care plan" means any arrangement whereby any person undertakes on a prepaid basis to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services on a prepaid basis through insurance or otherwise.
- (e) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.
- (f) "Health maintenance organization" or "HMO" means any person who undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles. For the purposes of 11 U.S.C. § 109(b) (2) and (d), an HMO is a domestic insurance company.
- (g) "Person" includes associations, trusts, or corporations, but does not include professional associations, or individuals.
- (h) "Provider" means any physician, hospital, or other person that is licensed or otherwise authorized in this State to furnish health care services.
- (i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60.
- (j) "Working capital" means the excess of current assets over current liabilities; provided that the only borrowed funds that may be included in working capital must be those borrowed funds that are repayable only from net earned income and must be repayable only with the advance permission of the Commissioner.
- (k) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the HMO; or in the case of an individual contract, the person in whose name the contract is issued.
- (l) "Participating provider" means a provider who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the HMO, other than copayment or deductible.
- (m) "Insolvent" or "insolvency" means that the HMO has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(n) "Carrier" means an HMO, an insurer, a nonprofit hospital or medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

(o) "Discontinuance" means the termination of the contract between the group contract holder and an HMO due to the insolvency of the HMO and does not mean the termination of any agreement between any individual enrollee and the HMO.

(p) "Uncovered expenditures" means the amounts owed or paid to any provider who provides health care services to an enrollee and where such amount owed or paid is (i) not made pursuant to a written contract that contains the "hold harmless" provisions defined in G.S. 58-67-115; or (ii) not guaranteed or insured by a guaranteeing organization or insurer under the terms of a written guarantee or insurance policy that has been determined to be acceptable to the Commissioner. "Uncovered expenditures" includes amounts owed or paid to providers directly from the HMO as well as payments made by a medical group, independent practice association, or any other similar organization to reimburse providers for services rendered to an enrollee. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 1; 1989, c. 776, ss. 2, 3, 15; 1991, c. 195, s. 4; c. 720, s. 40; 2001-417, s. 13; 2003-212, s. 19.)

§ 58-67-10. Establishment of health maintenance organizations.

(a) Notwithstanding any law of this State to the contrary, any person may apply to the Commissioner for a license to establish and operate a health maintenance organization in compliance with this Article. No person shall establish or operate a health maintenance organization in this State, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a license under this Article. A foreign corporation may qualify under this Article, subject to its full compliance with Article 16 of this Chapter.

(b) (1) It is specifically the intention of this section to permit such persons as were providing health services on a prepaid basis on July 1, 1977, or receiving federal funds under Section 254(c) of Title 42, U.S. Code, as a community health center, to continue to operate in the manner which they have heretofore operated.

(2) Notwithstanding anything contained in this Article to the contrary, any person can provide health services on a fee for service basis to individuals who are not enrollees of the organization, and to enrollees for services not covered by the contract, provided that the volume of services in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) This Article shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(3a) This Article does not apply to any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives, pursuant to 42 U.S.C. § 1396n or Chapter 108A of the General Statutes, a provider sponsored organization or other organization certified, qualified, or otherwise approved by the Division of Health Benefits of the Department of Health and Human Services pursuant to

Article 17 of Chapter 131E of the General Statutes, or to any provider of health care services participating in such a prepaid health service or capitation arrangement. Article; provided, however, that to the extent this Article applies to any such person acting as a subcontractor to a Health Maintenance Organization licensed in this State, that person shall be considered a single service Health Maintenance Organization for the purpose of G.S. 58-67-20(4), G.S. 58-67-25, and G.S. 58-67-110.

(4) Except as provided in paragraphs (1), (2), (3), and (3a) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this Article.

(c) Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall be set forth or be accompanied by the following:

- (1) A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto. Any proposed articles of incorporation for the formation of a domestic health maintenance organization shall be filed with the Commissioner. The Commissioner shall examine the proposed articles. If the Commissioner finds that the proposed articles meet the requirements of the insurance laws of this State and otherwise determines that the articles should be approved, the Commissioner shall place a certificate of approval on the articles and submit the approved articles to the Secretary of State;
- (2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;
- (3) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;
- (4) A copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in subdivision (3) of this subsection and the HMO;
- (5) A statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel;
- (6) A copy of the form of evidence of coverage to be issued to the enrollees;
- (7) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;
- (8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this Article;

- (9) A financial feasibility plan, which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or a recognized actuarial consultant, a projection of balance sheets, cash flow statements, showing any capital expenditures, purchase and sale of investments and deposits with the State, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year; and a statement as to the sources of working capital as well as any other sources of funding;
 - (10) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;
 - (11) A statement reasonably describing the geographic area or areas to be served;
 - (12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 58-67-110;
 - (13) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances; and
 - (14) Such other information as the Commissioner may require to make the determinations required in G.S. 58-67-20.
- (d) (1) A health maintenance organization shall file a notice describing any significant modification of the operation set out in the information required by subsection (c) of this section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Changes subject to the terms of this section include expansion of service area, changes in provider contract forms and group contract forms where the distribution of risk is significantly changed, and any other changes that the Commissioner describes in properly promulgated rules. Every HMO shall report to the Commissioner for his information material changes in the provider network, the addition or deletion of Medicare risk or Medicaid risk arrangements and the addition or deletion of employer groups that exceed ten percent (10%) of the health maintenance organization's book of business or such other information as the Commissioner may require. Such information shall be filed with the Commissioner within 15 days after implementation of the reported changes. Every HMO shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.
- (1a) Any proposed change to the articles of incorporation shall be filed with the Commissioner. The Commissioner shall examine the proposed change to the articles. If the Commissioner determines that the proposed change should be approved, the Commissioner shall place a certificate of approval on the change and submit the approved change to the Secretary of State.

- (2) The Commissioner may promulgate rules and regulations exempting from the filing requirements of subdivision (1) those items he deems unnecessary. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1983, c. 386, s. 1; 1985 (Reg. Sess., 1986), c. 1027, s. 49; 1987, c. 631, ss. 6, 7; 1989, c. 776, ss. 4-8; 1991, c. 720, ss. 41, 69; 1993, c. 529, s. 7.2; 1993 (Reg. Sess., 1994), c. 769, s. 25.48; 1997-443, s. 11A.118(a); 1998-227, s. 2; 2005-215, s. 23; 2019-81, s. 15(a).)

§ 58-67-11. Additional HMO application information.

(a) In addition to the information filed under G.S. 58-67-10(c), each application shall include a description of the following:

- (1) The program to be used to evaluate whether the applicant's provider network is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay.
 - (2) The program to be used for verifying provider credentials.
 - (3) The quality management program to assure quality of care and health care services managed and provided through the health care plan.
 - (4) The utilization review program for the review and control of health care services provided or paid for.
 - (5) The applicant's provider network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees.
- (b) G.S. 58-67-10(d) applies to the information specified in this section. (1997-519, s. 1.2.)

§ 58-67-12. Commissioner use of consultants and other professionals.

(a) The Commissioner may contract with consultants and other professionals to expedite and complete the application process, examinations, and other regulatory activities required under this Article. Costs of contracts entered into under this section shall be reimbursed by the applicant or licensee.

(b) Contracts under this section for financial, legal, examination, and other services shall not be subject to any of the following:

- (1) G.S. 114-2.3.
- (2) G.S. 147-17.
- (3) Articles 3, 3C, and 8 of Chapter 143 of the General Statutes and any rules and procedures adopted under those Articles concerning procurement, contracting, and contract review. (2018-49, s. 2(c).)

§ 58-67-13: Reserved for future codification purposes.

§ 58-67-14: Reserved for future codification purposes.

§ 58-67-15. Health maintenance organization of bordering states may be admitted to do business; reciprocity.

A federally qualified health maintenance organization approved and regulated under the laws of a state bordering this State may be admitted to do business in this State by satisfying the Commissioner that it is fully and legally organized under the laws of that state, and that it complies with all requirements for health maintenance organizations organized within this State; provided

that the bordering state has a law or regulation substantially similar to this section. (1985, c. 666, s. 69.)

§ 58-67-20. Issuance and continuation of license.

(a) Before issuing or continuing any such license, the Commissioner of Insurance may make such an examination or investigation as he deems expedient. The Commissioner of Insurance shall issue a license upon the payment of the application fee prescribed in G.S. 58-67-160 and upon being satisfied on the following points:

- (1) The applicant is established as a bona fide health maintenance organization as defined by this Article;
- (2) The rates charged and benefits to be provided are fair and reasonable;
- (3) The amounts provided as working capital are repayable only out of earned income in excess of amounts paid and payable for operating expenses and expenses of providing services and such reserve as the Department of Insurance deems adequate, as provided hereinafter;
- (4) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the license and that the health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. Such working capital shall initially be a minimum of one million five hundred thousand dollars (\$1,500,000) for any full service medical health maintenance organization. Initial working capital for a single service health maintenance organization shall be a minimum of one hundred thousand dollars (\$100,000) or such higher amount as the Commissioner shall determine to be adequate.

(b) In making the determinations required under this section, the Commissioner shall consider:

- (1) The financial soundness of the health care plan's arrangements for health care services and the schedule of premiums used in connection therewith;
- (2) The adequacy of working capital;
- (3) Any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan;
- (4) Any agreement with providers for the provision of health care services; and
- (5) Any firm commitment of federal funds to the health maintenance organization in the form of a grant, even though such funds have not been paid to the health maintenance organization, provided that the health maintenance organization certifies to the Commissioner that such funds have been committed, that such funds are to be paid to the health maintenance organization with a current fiscal year and that such funds may be used directly for operating purposes and for the benefit of enrollees of the health maintenance organization.

(c) A license shall be denied only after compliance with the requirements of G.S. 58-67-155. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1983, c. 386, s. 2; 1987, c. 631, ss. 2, 4, 8; 1987 (Reg. Sess., 1988), c. 975, s. 1; 2003-212, s. 26(n).)

§ 58-67-25. Deposits.

(a) The Commissioner shall require a minimum deposit of five hundred thousand dollars (\$500,000) for all full service medical health maintenance organizations or such higher amount as he deems necessary for the protection of enrollees.

(b) The Commissioner shall require a minimum deposit of twenty-five thousand dollars (\$25,000) for all single service health maintenance organizations or such higher amount as he deems necessary for the protection of enrollees.

(c) All deposits required by this section shall be administered in accordance with the provisions of Article 5 of this Chapter. (1987, c. 631, s. 3; 2005-215, s. 18.)

§ 58-67-30. Management and exclusive agreements; custodial agreements.

(a) No health maintenance organization shall enter into an exclusive agency, management, or custodial agreement unless the agreement is first filed with the Commissioner and approved under this section within 45 days after filing or such reasonable extended period as the Commissioner shall specify by notice that is given within the 45 day period.

(b) The Commissioner shall disapprove an agreement submitted under subsection (a) of this section if the Commissioner determines that the agreement:

- (1) Subjects the health maintenance organization to excessive charges;
- (2) Extends for an unreasonable period of time;
- (3) Does not contain fair and adequate standards of performance;
- (4) Enables persons under the contract to manage the health maintenance organization who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the health maintenance organization with due regard for the interests of its enrollees, creditors, or the public; or
- (5) Contains provisions that impair the interests of the organization's enrollees, creditors, or the public. (1987, c. 631, s. 10; 2001-223, s. 20.5.)

§ 58-67-35. Powers of health maintenance organizations.

(a) The powers of a health maintenance organization include, but are not limited to the following:

- (1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;
- (2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;
- (3) The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;
- (4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;
- (5) The contracting with an insurance company licensed in this State, or with a hospital or medical service corporation authorized to do business in this State,

for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

- (6) The offering and contracting for the provision or arranging of, in addition to health care services, of:
- a. Additional health care services;
 - b. Indemnity benefits, covering out-of-area or emergency services;
 - c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and
 - d. Point-of-service products, for which an HMO may precertify out-of-plan covered services on the same basis as it precertifies in-plan covered services, and for which the Commissioner shall adopt rules governing:
 1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);
 2. Product limitations, which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d).
 3. Deposit and other financial requirements; and
 4. Other requirements for marketing and administering those products.
- (b) (1) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner prior to the exercise of any power granted in subsections (a)(1) or (2). The Commissioner shall disapprove such exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commissioner does not disapprove within 30 days of the filing, it shall be deemed approved.
- (2) The Commissioner may promulgate rules and regulations exempting from the filing requirement of subdivision (1) those activities having a de minimis effect. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1991 (Reg. Sess., 1992), c. 837, s. 8; 1997-519, s. 3.18; 2001-334, s. 8.2.)

§ 58-67-40: Repealed by Session Laws 2003-212, s. 20, effective October 1, 2003.

§ 58-67-45. Fiduciary responsibilities.

Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees. (1977, c. 580, s. 1; 1979, c. 876, s. 1.)

§ 58-67-50. Evidence of coverage and premiums for health care services.

- (a) (1) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan

through an insurance policy or a contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer or the hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commissioner.

(3) An evidence of coverage shall contain:

a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in G.S. 58-67-65(a); and

b. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of:

1. The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

2. Any limitations on the services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

3. Where and in what manner information is available as to how services may be obtained;

4. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

5. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints;

6. A description of the reasons, if any, for which an enrollee's enrollment may be terminated for cause, which reasons may include behavior that seriously impairs the health maintenance organization's ability to provide services or an inability to establish and maintain a satisfactory physician-patient relationship after reasonable efforts to do so have been made.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of subsection (b) unless it is subject to the jurisdiction of the Commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subsection (c) shall be applicable.

(b) (1) Premium approval. – No schedule of premiums for coverage for health care services, or any amendment to the schedule, shall be used in conjunction with any health care plan until a copy of the schedule or amendment has been filed with and approved by the Commissioner.

- (2) Individual coverage. – Premiums shall be established in accordance with actuarial principles for various categories of enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any premium revisions for nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 months. As an alternative to giving this guarantee for nongroup enrollee coverage, the premium or premium revisions may be made applicable to all similar categories of enrollee coverage at one time if the health maintenance organization chooses to apply for the premium revision with respect to the categories of coverages no more frequently than once in any 12-month period. The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the HMO has given written notice of the premium revision to the enrollee 45 days before the effective date of the revision. The enrollee must then pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision. In adopting the rules under this subsection, the Commissioner may require identification of the types of rating methodologies used by filers and may also address standards for data in HMO rate filings for initial filings, filings by recently licensed HMOs, and rate revision filings; data requirements for service area expansion requests; policy reserves used in rating; incurred loss ratio standards; and other recognized actuarial principles of the NAIC, the American Academy of Actuaries, and the Society of Actuaries.
- (3) Group coverage. – Employer group premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate, or unfairly discriminatory, and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any revisions to the premiums for employer group coverage shall be guaranteed for a period of not less than 12 months. No premium revision shall become effective for any category of group coverage unless the HMO has given written notice of the premium revision to the master group contract holder upon receipt of the group's finalized benefits or 45 days before the effective date of the revision, whichever is earlier. The master group contract holder thereafter must pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision.

(c) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsection (a) of this section are met and any schedule of premiums if the requirements of subsection (b) of this section are met. It shall be unlawful to issue the form or to use the schedule of premiums until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the Commissioner does not approve or disapprove any form or schedule of premiums within 90 days after the filing for forms and within 45 days after the filing for premiums, they shall be deemed to be approved.

(d) The Commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(e) Every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Data Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 9; 1989, c. 485, s. 59; 1991, c. 195, s. 1; c. 644, s. 13; c. 720, s. 36; 1995, c. 193, s. 59; 1997-474, s. 3; 1997-519, s. 1.3; 2001-334, ss. 8.1, 17.4; 2001-487, ss. 106(a), 106(b); 2008-124, s. 5.3; 2009-173, s. 1.)

§ 58-67-55. Statements filed with Commissioner.

Every HMO subject to this Article is subject to G.S. 58-2-165. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1999-244, s. 12.)

§ 58-67-60. Investments.

With the exception of investments made in accordance with G.S. 58-67-35(a)(1) and (2) and G.S. 58-67-35(b), the funds of a health maintenance organization shall be invested or maintained only in securities, other investments, or other assets permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commissioner may permit. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 2001-223, s. 8.18.)

§ 58-67-65. Prohibited practices.

(a) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this Article:

- (1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.
- (2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any

benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

- (3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, premiums, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(b) Article 63 of this Chapter applies to health maintenance organizations and their agents and representatives.

(c) An enrollee may not be cancelled or not renewed because of any deterioration in the health of the enrollee.

(d) No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(e) The HMO shall not refuse to enroll employees except when they can demonstrate they are unable to arrange adequate services.

(f) No health maintenance organization shall refuse to enroll an individual or refuse to continue enrollment of an individual in a health care plan; limit the amount, extent, or kinds of health care plans available to an individual; or charge an individual a different rate for the same health plan, because of the race, color, or national or ethnic origin of that individual. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1989, c. 485, s. 24; 1999-244, s. 14.)

§ 58-67-66. Collaboration with local health departments.

A health maintenance organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health. (1997-474, s. 4.)

§ 58-67-70. Coverage for chemical dependency treatment.

(a) As used in this section, the term "chemical dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) On and after January 1, 1985, every health maintenance organization that writes a health care plan on a group basis and that is subject to this Article shall offer benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits under the health care plan generally. Except as provided in subsection (c) of this section, benefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits under the health care plan generally.

(c) Every group health care plan that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars (\$8,000) is subject to the following conditions:

- (1) The plan shall provide, for each 12-month period, a minimum benefit of eight thousand dollars (\$8,000) for the necessary care and treatment of chemical dependency.
- (2) The plan shall provide a lifetime minimum benefit of sixteen thousand dollars (\$16,000) for the necessary care and treatment of chemical dependency for each enrollee.

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group health care plans shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

- (1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
 - a. Chemical dependency units in facilities licensed after October 1, 1984;
 - b. Medical units;
 - c. Psychiatric units; and
- (2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
 - a. Chemical dependency units in psychiatric hospitals;
 - b. Chemical dependency hospitals;
 - c. Residential chemical dependency treatment facilities;
 - d. Social setting detoxification facilities or programs;
 - e. Medical detoxification facilities or programs; and
- (3) Duly licensed physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C.

Provided, however, that nothing in this subsection shall prohibit any plan from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group that rejects the coverage in writing.

(f) Notwithstanding any other provision of this section or Article, any health maintenance organization subject to this Article that becomes a qualified health maintenance organization under Title XIII of the United States Public Health Service Act shall provide the benefits required under that federal Act, which shall be deemed to constitute compliance with the provisions of this section; and any health maintenance organization may provide that the benefits provided under this section must be obtained through providers affiliated with the health maintenance organization.

(g) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(h) Subsection (g) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10). (1983 (Reg. Sess., 1984), c. 1110, s. 9; 1985, c. 589, s. 43(a), (b); 1989, c. 175, s. 3; 1991, c. 720, s. 64; 2009-382, s. 22.)

§ 58-67-74. Coverage for certain treatment of diabetes.

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after October 1, 1997, that is subject to this Article, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The health maintenance organization shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.

(b) For the purposes of this section, "physician" is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes. (1997-225, s. 3.)

§ 58-67-75. No discrimination against mentally ill or chemically dependent individuals.

(a) Definitions. – As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-67-70, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5 or subsequent editions published by the American Psychiatric Association.

(b) Coverage of Physical Illness. – No health maintenance organization governed by this Chapter shall, solely because an individual has or had a mental illness or chemical dependency:

(1) Refuse to enroll that individual in any health care plan covering physical illness or injury;

(2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or

(3) Reduce physical illness or injury coverages or benefits for that individual.

(b1) [Expired October 1, 2001.]

(c) Chemical Dependency Coverage Not Required. – Nothing in this section requires an HMO to offer coverage for chemical dependency, except as provided in G.S. 58-67-70.

(d) Applicability. – This section applies only to group contracts, other than excepted benefits as defined in G.S. 58-68-25. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-50A-1.

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care. (1989, c. 369, s. 2; 1991, c. 720, s. 83; 1997-259, s. 23; 1999-132, s. 4.4; 2007-268, s. 4; 2015-271, s. 4; 2019-202, s. 8; 2020-69, s. 3(h).)

§ 58-67-76. Coverage for mammograms and cervical cancer screening.

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

- (1) One or more mammograms a year, as recommended by a physician, for any woman who is determined to be at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
 - a. The woman has a personal history of breast cancer;
 - b. The woman has a personal history of biopsy-proven benign breast disease;
 - c. The woman's mother, sister, or daughter has or has had breast cancer; or
 - d. The woman has not given birth prior to the age of 30;
- (2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;
- (3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and
- (4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission.

(e) Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets

accreditation standards adopted by the North Carolina Medical Care Commission. (1991, c. 490, s. 3; 2003-186, s. 4.)

§ 58-67-77. Coverage for prostate-specific antigen (PSA) tests.

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, that is subject to this Article, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer.

(b) As used in this section, "prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer" means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

(c) Coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer shall be provided when recommended by a physician. (1993, c. 269, s. 3.)

§ 58-67-78. Coverage of certain prescribed drugs for cancer treatment.

(a) No health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

- (1) The National Comprehensive Cancer Network Drugs & Biologics Compendium;
- (2) The Micromedex DrugDex System;
- (3) The Elsevier Gold Standard's Clinical Pharmacology; or
- (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition. (1993, c. 506, s. 4.3; 2009-170, s. 3; 2023-133, s. 2(c).)

§ 58-67-79. Coverage for reconstructive breast surgery following mastectomy.

(a) Every health care plan written by a health maintenance organization that is subject to this Article and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery following a mastectomy. The coverage shall include coverage for all stages and

revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

(1) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

(2) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

(1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;

(2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;

(3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;

(4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or

(5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every subscriber under the plan upon enrollment and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber. (1997-312, s. 3; 1999-351, s. 3.3; 2001-334, s. 13.3.)

§ 58-67-80. Meaning of terms "accident", "accidental injury", and "accidental means".

(a) Effective October 1, 1989, this section applies to all health maintenance organization plans under this Article.

(b) "Accident", "accidental injury", and "accidental means" shall be defined to imply "result" language and shall not include words that establish an accidental means test. (1989, c. 485, s. 12.)

§ 58-67-85. Master group contracts, filing requirement; required and prohibited provisions.

(a) A health maintenance organization may issue a master group contract with the approval of the Commissioner of Insurance provided the contract and the individual certificates issued to members of the group, shall comply in substance to the other provisions of this Article. Any such

contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner of Insurance. If the master group contract is issued, altered or modified, the enrollees' contracts issued in pursuance thereof are altered or modified accordingly, all laws and clauses in the enrollees' contracts to the contrary notwithstanding. Nothing in this Article shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of enrollees thereto.

(b), (c) Repealed by Session Laws 1997-259, s. 18.

(d) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(d1) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.

(e) Whenever an employer master group contract replaces another group contract, whether the contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is:

- (1) Each person who is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and
- (2) Each person not covered under the succeeding corporation's plan of benefits in accordance with (e)(1) must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan. (1989, c. 775, s. 5; 1991, c. 720, ss. 38, 88; 1991 (Reg. Sess., 1992), c. 837, s. 4; 1993, c. 408, ss. 5, 5.1; 1995, c. 507, s. 23A.1(f); 1997-259, s. 18; 2005-223, s. 2(b).)

§ 58-67-88. Continuity of care.

(a) Definitions. – As used in this section:

- (1) "Ongoing special condition" means:
 - a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
 - b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
 - c. In the case of pregnancy, pregnancy from the start of the second trimester.

d. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

(2) "Terminated or termination". – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section if the individual has filed a claim with the HMO for services provided by the terminated provider or the individual is otherwise known by the HMO to be a patient of the provider.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are undergoing treatment from a provider for an ongoing special condition and are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual on the date of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery,

transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section, or at the time of enrollment in the new plan under subdivision (c)(1) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

- (1) When care is provided pursuant to subdivision (b)(2) of this section, the provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full. When care is provided pursuant to subdivision (c)(2) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the HMO and the insured for all covered services.
 - (2) The provider agrees to comply with the quality assurance programs of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided. The quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the patient.
 - (3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.
 - (4) The insured or the insured's representative notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section, that the insured elects to continue receiving treatment by the provider.
 - (5) The provider agrees to discontinue providing services at the end of the transition period pursuant to this section and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.
- (i) Construction. – Nothing in this section:

- (1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, requires the coverage of benefits not provided under the new policy under which the person is covered.
- (2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.
- (3) Prohibits an HMO from extending any transitional period beyond that specified in this section.
- (4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description. (2001-446, s. 1.)

§ 58-67-90. Licensing and regulation of agents.

Every agent of any HMO authorized to do business in this State under this Article is subject to the licensing provisions of Article 33 of this Chapter and all other provisions in this Chapter applicable to life and accident and health or sickness insurance producers. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1985 (Reg. Sess., 1986), c. 928, s. 5; 1987, c. 629, s. 3; 1999-244, s. 8; 2022-46, s. 14(ffff).)

§ 58-67-95. Powers of insurers, hospitals, prepaid health plans, and medical service corporations.

(a) Upon demonstration to the Commissioner of compliance with this Article, an insurance company licensed in this State, a prepaid health plan licensed to do business in this State, or a hospital or medical service corporation authorized to do business in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Article. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, hospital or medical service corporations, prepaid health plans, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the arranging of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(b) Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 66 of this Chapter, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance

organizations for health care services rendered by providers pursuant to the health care plan. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 2018-49, s. 2(d).)

§ 58-67-100. Examinations.

(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every five years. Examinations shall otherwise be conducted under G.S. 58-2-131 through G.S. 58-2-134.

(b) Repealed by Session Laws 1997-519, s. 1, effective January 1, 1998.

(c) Repealed by Session Laws 1995, c. 360, s. 2(m).

(d) Instead of conducting an examination, the Commissioner may accept the report of an examination made by the HMO regulator of another state. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1995, c. 360, s. 2(m); 1997-519, s. 1.4; 1999-132, s. 11.10; 2007-127, s. 16.)

§ 58-67-105. Hazardous financial condition.

(a) Whenever the financial condition of any health maintenance organization indicates a condition such that the continued operation of the health maintenance organization might be hazardous to its enrollees, creditors, or the general public, then the Commissioner may order the health maintenance organization to take such action as may be reasonably necessary to rectify the existing condition, including but not limited to one or more of the following steps:

- (1) To reduce the total amount of present and potential liability for benefits by reinsurance;
- (2) To reduce the volume of new business being accepted;
- (3) To reduce the expenses by specified methods;
- (4) To suspend or limit the writing of new business for a period of time; or
- (5) To require an increase to the health maintenance organization's net worth by contribution.

(b) The Commissioner may adopt rules to set uniform standards and criteria for the early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public, and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section. (1987, c. 631, s. 5.)

§ 58-67-110. Protection against insolvency.

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-67-25.

(b) Each full service health maintenance organization shall maintain a minimum net worth equal to the greater of one million dollars (\$1,000,000) or the amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter. Each single service health maintenance organization shall maintain a minimum net worth equal to the greater of fifty thousand dollars (\$50,000) or that amount required pursuant to the risk-based capital provisions of Article 12 of this Chapter.

(c), (d) Repealed by Session Laws 2003-212, s. 21, effective October 1, 2003.

(e) Every full service medical health maintenance organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider:

- (1) A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.
- (2) A conversion policy or policies that will be offered by an insurer to the enrollees in the event of the health maintenance organization's insolvency.
- (3) Any other arrangements offering protection against insolvency that the Commissioner may require. (1987, c. 631, s. 5; 1989, c. 776, ss. 11, 12; 2003-212, s. 21.)

§ 58-67-115. Hold harmless agreements or special deposit.

(a) Unless the HMO maintains a special deposit in accordance with subsection (b) of this section, each contract between every HMO and a participating provider of health care services shall be in writing and shall set forth that in the event the HMO fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the HMO. No other provisions of such contracts shall, under any circumstances, change the effect of such a provision. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the HMO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the HMO shall maintain a special deposit in cash or cash equivalent as follows:

- (1) Every HMO that has incurred uncovered health care expenditures in an amount that exceeds ten percent (10%) of its total expenditures for health care services for the immediately preceding six months, shall do either of the following:
 - a. Calculate as of the first day of every month and maintain for the remainder of the month, cash or cash equivalents acceptable to the Commissioner, as an account to cover claims for uncovered health care expenditures at least equal to one hundred twenty percent (120%) of the sum of the following:
 1. All claims for uncovered health care expenditures received for reimbursement, but not yet processed; and
 2. All claims for uncovered health care expenditures denied for reimbursement during the previous 60 days; and
 3. All claims for uncovered health care expenditures approved for reimbursement, but not yet paid; and
 4. An estimate for uncovered health care expenditures incurred, but not reported; and
 5. All claims for uncovered emergency services and uncovered services rendered outside the service area.
 - b. Maintain adequate insurance, or a guaranty arrangement approved in writing by the Commissioner, to pay for any loss to enrollees claiming reimbursement due to the insolvency of the HMO. The Commissioner shall approve a guaranty arrangement if the guaranteeing organization

has been in operation for at least 10 years and has a net worth, including organization-related land, buildings, and equipment, of at least fifty million dollars (\$50,000,000); unless the Commissioner finds that the approval of such guaranty may be financially hazardous to enrollees. In order to qualify under the terms of this subsection, the guaranteeing organization shall (i) submit to the jurisdiction of this State for actions arising under the guarantee; (ii) submit certified, audited annual financial statements to the Commissioner; and (iii) appoint the Commissioner to receive service of process in this State.

- (2) Whenever the reimbursements described in this subsection exceed ten percent (10%) of the HMO's total costs for health care services over the immediately preceding six months, the HMO shall file a written report with the Commissioner containing the information necessary to determine compliance with sub-subdivision (b)(1)a. of this section with its financial statements filed pursuant to G.S. 58-2-165. Upon an adequate showing by the HMO that the requirements of this section should be waived or reduced, the Commissioner may waive or reduce these requirements to such an amount as he deems sufficient to protect enrollees of the HMO consistent with the intent and purpose of this Article.
- (3) Any cash or cash equivalents maintained pursuant to the terms of this section shall be maintained as a special deposit controlled by and administered by the Commissioner in accordance with the provisions of G.S. 58-5-1. (1989, c. 776, s. 13; 2005-215, s. 19.)

§ 58-67-120. Continuation of benefits.

(a) The Commissioner shall require that each HMO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to enrollees who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commissioner may require:

- (1) Insurance to cover the expenses to be paid for benefits after an insolvency;
- (2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the HMO's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;
- (3) Insolvency reserves such as the Commissioner may require;
- (4) Letters of credit acceptable to the Commissioner;
- (5) Any other arrangements to assure that benefits are continued as specified above. (1989, c. 776, s. 13.)

§ 58-67-125. Enrollment period.

(a) In the event of an insolvency of an HMO upon order of the Commissioner, all other carriers that participated in the enrollment process with the insolvent HMO at a group's last regular enrollment period shall offer such group's enrollees of the insolvent HMO a 30-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such enrollees of the

insolvent HMO the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(b) If no other carrier had been offered to some groups enrolled in the insolvent HMO, or if the Commissioner determines that the other health benefit plan or plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent HMO, then the Commissioner shall allocate the insolvent HMO's group contracts for such groups among all other HMOs that operate within a portion of the insolvent HMO's service area, taking into consideration the health care delivery resources of each HMO. Each HMO to which a group or groups are so allocated shall offer such group or groups that HMO's existing coverage that is most similar to each group's coverage with the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology.

(c) The Commissioner shall also allocate the insolvent HMO's nongroup enrollees who are unable to obtain other coverage among all HMOs that operate within a portion of the insolvent HMO's service area, taking into consideration the health care delivery resources of each such HMO. Each HMO to which nongroup enrollees are allocated shall offer such nongroup enrollees that HMO's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology. Successor HMOs that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes. (1989, c. 776, s. 13.)

§ 58-67-130. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior HMO contract or policy providing such hospital, medical or surgical expense or service benefits, shall immediately cover all enrollees who were validly covered under the previous HMO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance. (1989, c. 776, s. 13.)

§ 58-67-135. Incurred but not reported claims.

(a) Every HMO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such HMO is or may be liable; and to provide for the expense of adjustment or settlement of such claims.

(b) Such liabilities shall be computed in accordance with rules adopted by the Commissioner upon reasonable consideration of the ascertained experience and character of the HMO. (1989, c. 776, s. 13.)

§ 58-67-140. Suspension or revocation of license.

(a) The Commissioner may suspend or revoke an HMO license if the Commissioner finds that the HMO:

- (1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.
- (2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with G.S. 58-67-50.
- (3) Is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
- (4) Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.
- (5) Is operating in a manner that would be hazardous to its enrollees.
- (6) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.
- (7) Repealed by Session Laws 2015-92, s. 7, effective June 19, 2015.

(b) A license shall be suspended or revoked only after compliance with G.S. 58-67-155.

(c) When an HMO license is suspended, the HMO shall not, during the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

(d) When an HMO license is revoked, the HMO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the HMO. The HMO shall engage in no advertising or solicitation. The Commissioner may, by written order, permit such further operation of the HMO as the Commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1997-519, s. 1.5; 2003-212, ss. 22, 23, 26(1); 2015-92, s. 7.)

§ 58-67-145. Rehabilitation, liquidation, or conservation of health maintenance organization.

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies, except that the provisions of Article 48 of this Chapter shall not apply to health maintenance organizations. The Commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon one or more grounds set out in Article 30 of this Chapter or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1989, c. 452, s. 2; c. 776, s. 14; 1998-211, s. 5; 2018-120, s. 1.2(a).)

§ 58-67-150. Regulations.

The Commissioner may, after notice and hearing, promulgate reasonable rules and regulations as are necessary or proper to carry out the provisions of this Article. Such rules and regulations shall be subject to review in accordance with G.S. 58-67-155. (1977, c. 580, s. 1; 1979, c. 876, s. 1.)

§ 58-67-155. Administrative procedures.

(a) When the Commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the Commissioner shall take action as is deemed advisable or written findings which shall be mailed to the health maintenance organization. The action of the Commissioner shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Commissioner in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes of this State shall apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b). (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 827, s. 1.)

§ 58-67-160. Fees.

Every health maintenance organization subject to this Article shall pay to the Commissioner a fee of five hundred dollars (\$500.00) for filing an application for a license and an annual license continuation fee of two thousand dollars (\$2,000) for each license. The license shall continue in full force and effect, subject to timely payment of the annual license continuation fee in accordance with G.S. 58-6-7 and subject to any other applicable provisions of the insurance laws of this State. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1989 (Reg. Sess., 1990), c. 1069, s. 6; 1995, c. 507, s. 11A(c); 1999-435, s. 6; 2003-212, s. 26(m); 2005-424, s. 1.6; 2009-451, s. 21.10(a).)

§ 58-67-165. Penalties and enforcement.

(a) The Commissioner may, in addition to or in lieu of suspending or revoking a license under G.S. 58-67-140, proceed under G.S. 58-2-70, provided that the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article or any other provision of this Chapter that expressly applies to health maintenance organizations shall be guilty of a Class 1 misdemeanor.

(c) (1) If the Commissioner shall for any reason have cause to believe that any violation of this Article or any other provision of this Chapter that expressly applies to health maintenance organizations has occurred or is threatened, the Commissioner may give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

- (2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances.
- (d) (1) The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article or any other provision of this Chapter that expressly applies to health maintenance organizations.
- (2) Within 30 days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices have occurred that are in violation of this Article or any other provision of this Chapter that expressly applies to health maintenance organizations. The hearing shall be conducted under Article 3A of Chapter 150B of the General Statutes, and judicial review shall be available as provided by Article 4 of Chapter 150B of the General Statutes.

(e) In the case of any violation of the provisions of this Article or any other provision of this Chapter that expressly applies to health maintenance organizations, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued under subsection (d) of this section, the Commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1985, c. 666, s. 52; 1987, c. 827, s. 1; 1993, c. 539, s. 470; 1994, Ex. Sess., c. 24, s. 14(c); 2001-5, s. 1.)

§ 58-67-170. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this Chapter, provisions of the insurance laws and service corporation laws do not apply to any health maintenance organization licensed under this Article. This subsection does not apply to an insurer or service corporation licensed and regulated under the insurance laws or the service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated under this Article or any other provision of this Chapter that expressly applies to health maintenance organizations.

(b) Solicitation of enrollees by a health maintenance organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this Article shall not be deemed to be practicing medicine or dentistry and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine and dentistry; provided, however, that this exemption does not apply to individual providers under contract with or employed by the health maintenance organization. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1985, c. 30; 2001-5, s. 2.)

§ 58-67-171. Other laws applicable to HMOs.

The following provisions of this Chapter are applicable to HMOs that are subject to this Article are as follows:

- G.S. 58-2-125 Authority over all insurance companies; no exemptions from license.
- G.S. 58-2-150 Oath required for compliance with law.
- G.S. 58-2-155 Investigation of charges.

- G.S. 58-2-160 Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
- G.S. 58-2-162 Embezzlement by insurance producers or administrators.
- G.S. 58-2-185 Record of business kept by companies and insurance producers; Commissioner may inspect.
- G.S. 58-2-190 Commissioner may require special reports.
- G.S. 58-2-195 Commissioner may require records, reports, etc., for agencies, insurance producers, and others.
- G.S. 58-2-200 Books and papers required to be exhibited.
- G.S. 58-3-50 Companies must do business in own name; emblems, insignias, etc.
- G.S. 58-3-100(c),(e) Insurance company licensing provisions.
- G.S. 58-3-115 Twisting with respect to insurance policies; penalties.
- G.S. 58-7-21 Credit allowed a domestic ceding insurer.
- G.S. 58-7-26 Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of G.S. 58-7-21.
- G.S. 58-7-30 Insolvent ceding insurer.
- G.S. 58-7-31 Life and health reinsurance agreements.
- G.S. 58-7-46 Notification to Commissioner for president or chief executive officer changes.
- G.S. 58-7-73 Dissolution of insurers.
- Part 7 of Article 10 Annual Financial Reporting.
- G.S. 58-50-35 Notice of nonpayment of premium required before forfeiture.
- G.S. 58-51-15(a)(2)b Accident and health policy provisions.
- G.S. 58-51-17 Portability for accident and health insurance.
- G.S. 58-51-25 Policy coverage to continue as to children with an intellectual or physical disability or dependent students on medically necessary leave of absence.
- G.S. 58-51-35 Insurers and others to afford coverage to children with an intellectual or physical disability.
- G.S. 58-51-45 Policies to be issued to any person possessing the sickle-cell trait or hemoglobin C trait.
- G.S. 58-62 Life and Health Insurance Guaranty Association.
(1999-244, s. 2; 2005-215, s. 20; 2009-382, s. 7; 2009-384, s. 4; 2018-47, s. 7(f); 2018-120, s. 1.2(b); 2022-46, ss. 4, 14(gggg).)

§ 58-67-175. Filings and reports as public documents.

All applications, filings and reports required under this Article shall be treated as public documents. (1977, c. 580, s. 1; 1979, c. 876, s. 1.)

§ 58-67-180. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Article; or upon the express consent of the enrollee or applicant; or pursuant to statute; or pursuant to court order for the production of evidence or the

discovery thereof; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1999-272, s. 1.)

§ 58-67-185. Severability.

If any section, term, or provision of this Article shall be adjudged invalid for any reason, such judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect. (1977, c. 580, s. 1; 1979, c. 876, s. 1.)