GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 455*
Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97
Third Edition Engrossed 4/30/97

Short Title: Improve HMO Services. (Public)

Sponsors:

Referred to:

March 24, 1997

A BILL TO BE ENTITLED

AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, AND REDUCING THE APPROVAL PERIOD FOR RATE FILINGS.

The General Assembly of North Carolina enacts:

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-170.1. Treatment discussions not limited.**

(a) A health benefit plan shall not limit either of the following:

(1) The participating plan provider's ability to discuss with an enrollee the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.

(2) The participating plan provider's professional obligations to patients as specified under the provider's professional license.

(b) Nothing in this section shall be construed to:

(1) Prevent a health benefit plan from prohibiting disclosure of financial trade secrets by contracted parties not affecting patient care.

(2) Expand or revise the scope of benefits covered by a health benefit plan.

(c) As used in this section, 'health benefit plan' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation plan contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA."

Section 2. Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-190. Coverage required for emergency care.**

(a) Every entity providing a health benefit plan shall provide coverage for emergency services at least to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting symptoms.

(b) With respect to emergency services provided by a health care provider who is not under contract with the plan, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the plan because of circumstances beyond the control of the covered person.

(c) If a health benefit plan has given prior authorization for emergency services, then the plan shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. A health benefit plan shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the health benefit plan.

(e) Both the emergency department and the health benefit plan shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or, with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Health benefit plans shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the '911' system and other telephone access systems utilized to access prehospital emergency services.
(3) Any cost-sharing provisions for emergency medical services.
(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:
(1) 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
a. Placing the health of an individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.
(2) 'Emergency services' means health care items and services furnished or required to screen for and treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.
(3) 'Health benefit plan' means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA.
(4) 'To stabilize' means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases [reference Section 1867 (EMTALA-Emergency Medical Treatment and Labor Act)]."

Section 3. G.S. 58-67-50(c) reads as rewritten:

"(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 ~~60~~ 45 days after the filing for premiums, they shall be deemed to be approved."

Section 4. Section 2 of this act becomes effective January 1, 1998, and applies to health benefit plans issued, renewed, or amended on or after that date. The remainder of this act becomes effective July 1, 1997.