GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 933
Commerce Committee Substitute Adopted 6/18/97

Short Title: Health Ins/Coverage & Netwks. (Public)

Sponsors:

Referred to:

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH STANDARDS FOR COVERAGE AND PROVIDER NETWORKS UNDER HEALTH INSURANCE POLICIES AND MANAGED CARE PLANS.

The General Assembly of North Carolina enacts:

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

"**§ 58-3-200. Miscellaneous insurance and managed care coverage and network provisions.**

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

(1) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.

b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define 'medically necessary services or supplies' in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and not for experimental, investigational, or cosmetic purposes.
(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
(3) Within generally accepted standards of medical care in the community.
(4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

(d) Services Outside Provider Networks. – No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's

approved health benefit plan unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.

(e) Nondiscrimination Against High-Risk Populations. – No insurer shall establish provider selection or contract renewal standards or procedures that are designed to avoid or otherwise have the effect of avoiding enrolling high-risk populations by excluding providers because they are located in geographic areas that contain high-risk populations or because they treat or specialize in treating populations that present a risk of higher than average claims or health care services utilization. This subsection does not prohibit an insurer from declining to select a provider or from not renewing a contract with a provider who fails to meet the insurer's selection criteria.

(f) Continuing Care Retirement Community Residents. – As used in this subsection, 'Medicare benefits' means medical and health products, benefits, and services used in accordance with Title XVIII of the Social Security Act. If an insured with coverage for Medicare benefits or similar benefits under a plan for retired federal government employees is a resident of a continuing care retirement community regulated under Article 64 of this Chapter, and the insured's primary care physician determines that it is medically necessary for the insured to be referred to a skilled nursing facility upon discharge from an acute care facility, the insurer shall not require that the insured relocate to a skilled nursing facility outside the continuing care retirement community if the continuing care retirement community:

(1) Is a Medicare certified skilled nursing facility.

(2) Agrees to be reimbursed at the insurer's contract rate negotiated with similar providers for the same services and supplies.

(3) Agrees not to bill the insured for fees over and above the insurer's contract rate.

(4) Meets all guidelines established by the insurer related to quality of care, including:

a. Quality assurance programs that promote continuous quality improvement.

b. Standards for performance measurement for measuring and reporting the quality of health care services provided to insureds.

c. Utilization review, including compliance with utilization management procedures.

d. Confidentiality of medical information.

e. Insured grievances and appeals from adverse treatment decisions.

f. Nondiscrimination.

(5) Agrees to comply with the insurer's procedures for referral authorization, risk assumption, use of insurer services, and other criteria applicable to providers under contract for the same services and supplies.

A continuing care retirement community that satisfies subdivisions (1) through (5) of this subsection shall not be obligated to accept, as a skilled nursing facility, any patient other than a resident of the continuing care retirement community and neither the insurer

nor the retirement community shall be allowed to list or otherwise advertise the skilled nursing facility as a participating network provider for Medicare benefits for anyone other than residents of the continuing care retirement community."

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

"**§ 58-3-205. Coverage required for emergency care.**

(a) 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 a prudent lay person, 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 any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.

b. Credit.

c. Disability income.

d. Long-term or nursing home care.

e. Medicare supplement.

f. Specified disease.

g. Dental or vision.

h. Coverage issued as a supplement to liability insurance.

i. Workers' compensation.

j. Medical payments under automobile or homeowners insurance.

k. Hospital income or indemnity.

l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(4) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(5) '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 (as provided in the Emergency Medical Treatment and Labor Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization of the person until the person is transferred.

(b) Every insurer shall provide coverage for emergency services at least to the extent necessary to screen and to stabilize the insured and shall not require prior authorization of the services if a prudent lay person 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 history and symptoms.

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

(1) A prudent lay person acting reasonably would have believed that a delay would worsen the emergency; or

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

(d) If an insurer has given prior authorization for emergency services, then the insurer 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 insured's health condition knowingly made by the provider of the emergency services or by the insured.

(e) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer 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 insurer.

(f) Both the emergency department and the insurer 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 insured'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.

(g) Insurers shall provide information to their insureds 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 insureds are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which insureds may receive medical care."

Section 3. This act applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

Section 4. This act becomes effective January 1, 1998.