GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H **1**

HOUSE BILL 285

Short Title: Managed Care Changes/AB. (Public)

Sponsors: Representatives Nye; Mosley, Cox, Edwards, Gibson, Goodwin, Haire, Horn, Jeffus, Luebke, McLawhorn, Melton, Mosley, Tucker, and Warren.

Referred to: Rules, Calendar and Operations of the House.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO IMPROVE NORTH CAROLINA'S LAWS ON MANAGED CARE, PERTAINING TO PAYMENT OBLIGATIONS FOR COVERED SERVICES, PROVIDER DIRECTORIES, DISCLOSURE, ACCESS TO CERTAIN PROVIDERS, TRANSITION CARE, INDEPENDENT REVIEW OF GRIEVANCES, CLAIM PAYMENTS, PROVIDER TERMINATION, AND HEALTH BENEFIT PLAN REPORTING.

The General Assembly of North Carolina enacts:

PART I. DEFINITIONS.

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

"**§ 58-3-220. Definitions.**

(a) As used in this section and in G.S. 58-3-225, 58-3-230, 58-3-235, 58-3-240, 58-3-245, and 58-3-250:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by

another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, 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.
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' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter."

PART II. PAYMENT OBLIGATIONS FOR COVERED SERVICES.

Section 2. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-225. Payment obligations for covered services.**

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a means other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage, plan summaries, and explanation of benefits, how it determines its payment obligations and the payment obligations of the insured. The explanation shall describe any intermediate steps in making the determinations to inform the insured of how the insurer arrives at the amount that determines the payment obligations of each party.

(b) The explanation shall indicate:

(1) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service.

(2) Which party is responsible for filing a claim or bill with the insurer.
(3) Whether the insured may be liable for paying any excess amount.

(c) If an insured is liable for an amount that differs from a stated fixed dollar co-payment, or from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than actual charges, the evidence of coverage, benefit summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: 'NOTICE: Your actual expenses for covered services may substantially exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges are not used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations'."

PART III. PROVIDER DIRECTORY INFORMATION.

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

"**§ 58-3-230. Provider directories.**

(a) As used in this section, 'updated directory information' means the current participation status of a provider, information known to the insurer indicating that a provider is not currently accepting new patients, and other information included in a printed provider directory.

(b) An insurer that uses a network of contracting health care providers for its health benefit plans shall provide a copy of its current provider directory, including any specialty directory, to all insureds on the effective date of initial coverage and shall make these directories available to current and prospective insureds upon request. Updated directory information reflecting the most current information available to the insurer shall be available to insureds by telephone and may also be made available by other media.

(c) Each directory shall include, in addition to the name, address, telephone number, and area of specialty for each health care provider and facility in its provider network, an indication of whether the provider:

(1) May be selected as a primary care provider.
(2) Is or is not currently accepting new patients.
(3) Has any other restrictions that would limit an insured's access to that provider.

The directory shall also include the date of its publication and instructions on how a current or prospective insured can obtain information about changes in the provider network or a provider's ability to accept new patients that may have occurred since the most recent printing of the directory.

(d) The directory shall include all of the types of licensed or certified health care providers with which the insurer contracts directly or with whom the insurer has access through a contract with an intermediary organization. If a contracting provider requests, the names of any allied health care providers who practice and deliver primary care services under the supervision of the contracting provider and whose services are covered

by virtue of the carrier's contract with the supervising provider. These allied providers shall be listed as part of the directory listing for the contracting provider.

(e) An insurer may maintain separate directories for specialty services, such as mental health, substance abuse, or centers of excellence, but shall make each of its directories available to current and prospective insureds in accordance with this section."

PART IV. REQUIRED HEALTH PLAN DISCLOSURE REQUIREMENTS.

Section 4. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-235. Health plan disclosure requirements.**

At the time of application for and delivery of a health benefit plan, the insurer shall deliver to the applicant and insured a clear and concise description of the coverage provided by the plan. The description shall be printed on a form prescribed by the Commissioner. The description shall include:

(1) Definitions of terms used in the health benefit plan.

(2) A brief description of the principal benefits or coverage provided, including any coverage exclusions or limitations.

(3) A brief description of how coverage determinations are made, including whether factors other than medical necessity and coverage exclusions and limitations are considered.

(4) A brief explanation of insurer and insured payment responsibilities, including how plan allowances, such as 'usual and customary charges,' are developed.

(5) A brief explanation of provider network limitations and requirements, including requirements for the use of subnetworks, when prior authorization or precertification is required, and how tertiary and quaternary care are arranged.

(6) Tax and health plan accreditation status of the insurer.

(7) A statement that the outline is a summary of the health benefit plan and that the health benefit plan should be examined to determine health benefit plan provisions."

PART V. ACCESS TO SPECIALTY CARE PROVIDERS.

Section 5. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-240. Access to specialty care providers.**

(a) Each insurer offering a health benefit plan that does not allow direct access to all specialists shall have a procedure by which an insured may receive an extended or standing referral to a specialist. The procedure shall provide for an extended or standing referral to a specialist if the insured's primary care provider determines in consultation with a specialist that the insured needs continuing care from a specialist to treat a serious or chronic disease or condition. The referral shall be made under a treatment plan approved by the insurer in consultation with the primary care provider, the specialist, and

the insured or the insured's designee. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care provider regularly reports on the care provided and the progress of the insured. A standing referral does not authorize a specialist to provide primary care or provide the coordination of care that is provided by a primary care provider.

(b) Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a pediatrician as the primary care provider for the insured's children who are under the age of 18. If a child under age 18 requires the services of a specialist for the treatment of a life-threatening or degenerative and disabling condition or disease, the insurer shall give due consideration, in consultation with the primary care provider and a specialist, to the medical need for treatment by a specialist who has subspecialty training in pediatrics.

(c) This section does not require:

(1) An insurer to cover the services of a nonparticipating pediatrician or specialist whose services would otherwise not be covered.

(2) In-network levels of coverage to be applied when the nonparticipating provider's services would otherwise be covered at a lower level of benefits, if a participating pediatrician or specialist with a pediatric subspecialty is reasonably available to the insured.

(d) Each insurer shall have a procedure by which a new insured, upon being covered by a health benefit plan, or an existing insured upon diagnosis, with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling condition or disease who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would most appropriately be coordinated by that specialist, the insurer shall allow access to that specialist. The referral shall be made under a treatment plan approved by the insurer, in consultation with the primary care provider, the specialist, and the insured or the insured's designee. The specialist may treat the insured upon a single referral from the insurer or the insured's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. If an insurer makes or allows a referral under this section to a nonparticipating specialist because no participating specialist who is capable of providing the services necessary under the treatment plan is reasonably available, the services provided under the approved treatment plan shall be allowed at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network.

(e) This section does not require an insurer to allow an insured to have a nonparticipating specialist unless the insurer cannot offer reasonable access to a contracted provider without unreasonable delay, taking into account the medical factors

of an individual case. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers.

(f) Each insurer shall include a clear description of the insured's rights to direct access to specialty care providers in its evidence of coverage and summary plan description."

PART VI. DIRECT ACCESS TO CERTAIN PROVIDERS.

Section 6. Article 3 of Chapter 58 of the General Statues is amended by adding a new section to read:

"**§ 58-3-245. Direct access to certain providers.**

In addition to the direct access to providers of obstetrical and gynecological services pursuant to G.S. 58-51-38, every insurer shall allow every insured direct access without prior referral to the services of optometrists, ophthalmologists, and dentists, within the benefits provided by the plan pertaining to these services, for the same co-payment and usual and customary fee as for the primary care provider. Every insurer shall allow every insured direct access after one initial referral to the services of providers treating chronic conditions or complaints, within the benefits provided by the plan pertaining to these services."

PART VII. PROVIDER NETWORKS: TRANSITION PERIODS AND EXPANDED ACCESS TO SPECIALTY CARE.

Section 7. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Access to transition care.**

(a) Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide a minimum of 90 days' transition coverage to each insured who is an established patient of a participating health care provider who will no longer participate in the plan network. If an insured's health care provider leaves or is terminated from an HMO's provider network, the HMO shall allow the insured to continue to be treated by that provider for up to 90 days, or, for an insured who is beyond the first trimester of a pregnancy, until the conclusion of postpartum care. Except in the case of a pregnancy that is beyond the first trimester, this section is complied with if there is a contractual obligation for the insurer and the provider to provide a minimum notice of cancellation or nonrenewal that will allow an insured to receive care for 90 days before the termination of the contract. The period of transition coverage is deemed to commence on the date that the HMO notifies the insured that the insured's provider will no longer participate in the network.

(b) Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to insureds who are newly covered under a new or existing group contract because of an involuntary change in health plans, during which time they may continue to receive care from a provider authorized to treat them under the previous insurer's plan and have access to prescription drugs covered under the formulary

of the previous insurer's plan. Persons eligible for transition coverage are those who are in the second or third trimester of pregnancy or undergoing treatment for a condition or disease that is chronic, degenerative and disabling, or life-threatening. In the case of a member who is beyond the first trimester of a pregnancy at the time of the involuntary plan change, the insurer shall provide for transition coverage until the conclusion of postpartum care. For all other persons eligible, the transition coverage shall be provided for a minimum period of 90 days. Eligibility and the commencement of the transition period shall be determined by the date on which the insured signed the application or enrollment form for the new insurer. Coverage during the transition period is the responsibility of the new insurer.

(c) Coverage of continued services during a transition coverage period may be made contingent upon the provider's agreement to:

(1) Continue to accept reimbursement for services under the same terms that were provided for in the provider's contract that has been or will be terminated.

(2) Comply with the insurer's requirements for quality assurance.

(3) Refer within the insurer's provider network.

(4) Comply with the insurer's established requirements for participating providers, including member hold harmless provisions, and other policies and procedures, such as data submission and obtaining precertification for certain services.

In the case of an insured's involuntary change of health plans, coverage of services from a provider who contracts with the insured's previous insurer shall be based on the new insurer's provider contracts for comparable services. Except as provided in subsection (b) of this section, nothing in this section requires an insurer to cover services that would not be covered if a member had not been in a transition coverage period. An insurer does not have to offer transition coverage if the insurer terminated the provider's contract for reasons relating to quality of care.

(d) Each HMO shall include a clear description of an insured's rights to transition coverage in its evidence of coverage and summary plan description."

PART VIII. INDEPENDENT REVIEW OF MEMBER GRIEVANCES.

Section 8.1. G.S. 58-50-62(f) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or

her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees or representatives of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. ~~All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.~~

(3) In addition to other requirements listed in this subsection, all of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who, through clinical experience, have appropriate expertise in the treatment of medical conditions similar to the medical condition under review and knowledge of the recommended service or treatment under review, including at least one clinical peer of the health care provider requesting the service or treatment in question. Panel members may not have any material professional, financial, or familial affiliation with the insurer or any officer, director, or employee of the insurer; or with any provider involved in the treatment of the covered person; or with the manufacturer or developer of the principal drug, device, procedure, or other therapy proposed for the covered person. A provider participating in the insurer's network may serve on the review panel, if the provider is otherwise qualified to do so under this section. If an insurer contracts with an independent organization to assemble a review panel and conduct second-level review, that organization shall not be affiliated with the insurer. Once convened, the panel shall operate independently in accordance with this section. The insurer shall provide the review panel with administrative assistance related to the review meeting."

Section 8.2. G.S. 58-50-62(g) reads as rewritten:

"(g) Second-Level Grievance Review Procedures. – ~~An insurer's procedures for conducting a second-level grievance review shall include:~~

(1) ~~The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.~~ The review panel shall select one panel member to act as chairperson. The chairperson shall schedule and hold the review meeting within 45 days after receiving a request for a second-level review.

(2) ~~The covered person shall be notified in writing at least 15 days before the review meeting date.~~ At least 20 days before the review meeting date, the review panel shall notify the insurer of the meeting time. The insurer shall provide appropriate facilities for the review meeting.

(3) ~~The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.~~ At least 15 days before the review meeting date, the insurer shall provide written notice to the covered person and the review panel of the date, time and location of the review meeting. The panel chairperson shall have authority to conduct the review meeting, including determining the order and length of presentations, approving witnesses, and questioning participants. The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting. The review panel shall issue its written recommendation, including the panel's determination in the matter and the applicable information required under G.S. 58-60-62(h), to the insurer within three business days after the review meeting."

Section 8.3. G.S. 58-50-62(h) reads as rewritten:

"(h) Second-Level Grievance Review Decisions. – An insurer shall issue ~~a~~ its written decision to the covered person and, if applicable, to the covered person's provider, within ~~seven~~ three business days after ~~completing the review meeting.~~ receipt of the review panel's recommendation. The insurer's decision shall follow the recommendation of the review panel if the recommendation is in favor of the covered person, but the insurer may issue a decision in favor of the covered person if the recommendation of the review panel is in favor of the insurer if the insurer chooses to do so. The decision shall include:

(1) The professional qualifications and licensure of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.

(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.

(7) A statement that the decision is the insurer's final determination in the matter and that the covered person's options at the plan-level have been exhausted.

(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office."

Section 8.4. G.S. 58-50-62(i) reads as rewritten:

"(i) Expedited Second-Level Procedures. – An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the ~~insurer shall conduct the review proceeding and communicate its decision~~ review proceeding shall be conducted and the panel's recommendation communicated within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information."

PART IX. CLAIM PAYMENTS TO HEALTH CARE PROVIDERS.

Section 9. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes a health care provider or facility that is responsible for directly making the claim with an insurer."

PART X. HEALTH BENEFIT PLAN PROVIDER TERMINATIONS.

Section 10. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-250. Provider terminations.**

(a) This section applies to each insurer that contracts with health care providers to provide services to persons covered under its health benefit plans.

(b) Every contract between an insurer offering a health benefit plan and a health care provider shall include a provision that states that the insurer shall not terminate or refuse to renew a provider's contract or reduce its total payment or compensation to the provider, including withhold amounts, because the provider has:

(1) Filed complaints about the insurer with the Department or any other State or federal agency.

(2) Advocated within the plan in the interest of a patient for medically necessary and appropriate care.
(3) Served a disproportionate share of enrollees who, because of medical conditions, are high-cost or high-utilization patients.
(4) Reported to State or federal authorities any act or practice that jeopardizes the health or welfare of a patient."

PART XI. IMPROVE USEFULNESS AND INTEGRITY OF HEALTH PLAN REPORTING.

Section 11.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-192. Managed care reporting and disclosure requirements.**

(a) The Commissioner may impose a fine on any company that does not submit a complete and accurate report to the Commissioner as required in G.S. 58-3-191. The Commissioner may grant one extension of up to 30 days to an insurer that demonstrates a reasonable need for the extension. The applicable fine shall be five hundred dollars ($500.00) per day until a proper report is received by the Commissioner. The imposition of a fine under this section does not preclude the Commissioner from taking action on the license of the insurer as allowed under G.S. 58-3-100.

(b) The Commissioner shall publish a report based on the data received from health benefit plans for this section.

(c) The information required by G.S. 58-3-191(a) shall be made in a format prescribed by the Commissioner."

Section 11.2. G.S. 58-67-50(e) reads as rewritten:

"(e) ~~Effective January 1, 1989, 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 Date 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. In addition, beginning~~ Beginning with data for the calendar year ~~1998,~~ 1999, every HMO, for group contracts of 1,000 or more members, shall provide, upon request of the group, ~~cost, use of service, prevention, outcomes, and other~~ group-specific data as collected and reported in accordance with the latest edition of the Health Plan Employer Data and Information Set (HEDIS) guidelines, as published by the National Committee for Quality Assurance(NCQA). Beginning with data for the calendar year ~~1998,~~ 1999, every HMO shall file with the Commissioner and make available to all employer groups, not later than the deadline listed in the latest edition of the HEDIS guidelines, ~~July 1 of the following calendar year,~~ a HEDIS report, completed in accordance with the latest edition of the HEDIS guidelines, and accompanied by an audit report from an auditor who has been certified by NCQA to conduct HEDIS audits. ~~of health benefit plan-wide experience on its costs, use of services, and other aspects of performance, in the HEDIS format.~~ In addition, every health maintenance organization

shall provide at least general inpatient and ambulatory care utilization data for the group on group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information for groups of 100 or more shall be compiled and reported in accordance with the Use of Services section of the latest edition of the HEDIS guidelines. Beginning with data for calendar year 1999, the Commissioner may impose a fine on any HMO that does not submit a complete and accurate report to the Commissioner as required in this section. The Commissioner may grant one extension of up to 30 days to an HMO that demonstrates a reasonable need for such extension. The applicable fine shall be five hundred dollars ($500.00) per day until a proper report is received by the Commissioner. The imposition of fine does not preclude the Commissioner from taking action on the license of the HMO under G.S. 58-3-100. The Commissioner shall publish a report using selected measures from the HEDIS data set."

PART XII. EFFECT OF HEADINGS.

Section 12. The headings to the parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART XIII. EFFECTIVE DATES.

Section 13. Sections 1, 2, 3, 4, 5, 6, and 7 of this act apply to all health benefit plans that are delivered, issued for delivery, or renewed on and after July 1, 2000. Sections 8.1, 8.2, 8.3, 8.4, 9, and 10 of this act apply to all health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. The remainder of this act is effective when it becomes law. 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.