GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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HOUSE BILL 541*

Short Title: Improve HMO Services. (Public)

Sponsors: Representatives Dockham; and Brawley.

Referred to: Insurance.

March 19, 1997

A BILL TO BE ENTITLED

AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE FOR EMERGENCY CARE, PROVIDING PEER REVIEW PROTECTION, AND ALLOWING THE USE OF RATES UPON FILING; AND TO CONFORM STATE LAW TO FEDERAL REQUIREMENTS REGARDING RENEWABILITY OF HEALTH INSURANCE POLICIES.

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 available to the enrollee, 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 trade secrets by contracted parties.

(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. G.S. 58-67-180 reads as rewritten:

"**§ 58-67-180. Confidentiality of medical ~~information.~~ information; peer review committees.**

(a) As used in this section, 'peer review committee' means a committee, composed of duly licensed health care providers of an HMO licensed under this Article, that is formed for the purpose of evaluating the quality of health care, including provider credentialing.

(b) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from ~~such person~~ the enrollee or applicant or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except as follows:

(1) ~~to~~ To the extent that it may be necessary to carry out the purposes of this Article; or

(2) ~~upon~~ Upon the express consent of the enrollee or applicant; or

(3) ~~pursuant~~ Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) ~~in~~ In the event of claim or litigation between ~~such person~~ the enrollee or applicant and the health maintenance organization wherein ~~such~~ the 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~~ the information to the health maintenance organization is entitled to claim.

(c) A member, agent, or employee of a duly appointed peer review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(d) (1) The information considered by a peer review committee and the records of its actions and proceedings are confidential and not subject to subpoena or order except in proceedings before the appropriate State licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member, officer, director, or other member of an HMO or its staff engaged in assisting or furnishing information to the peer review committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities.

(2) Information considered by a peer review committee and the records of its actions and proceedings which are used pursuant to subdivision

(d)(1) of this subsection by a State licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of the committee.

(e) The proceedings of a peer review committee, the records and materials it produces, and the materials it considers shall, if obtained by the Commissioner, be maintained by the Commissioner on a confidential basis in accordance with this Article and shall not become part of the public record."

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

"**§ 58-3-170.2. Coverage required for emergency care.**

(a) A health benefit plan shall provide coverage for emergency-room screening and stabilization for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms. Emergency conditions are those that arise suddenly, or become acute if the patient has a chronic condition, and require immediate treatment to avoid jeopardy to a patient's life or health.

(b) To promote continuity of care and optimal care by the treating physician, the emergency department shall contact the patient's primary care physician as soon as possible.

(c) As used in this section, '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."

Section 4. G.S. 58-67-50(b)(1) reads as rewritten:

"(b) (1) No schedule of premiums for enrollee group coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until ~~a copy of such schedule, or amendment thereto, has been filed with and approved by the Commissioner.~~ it has been filed with the Commissioner. Nothing herein shall prohibit a health benefit plan from issuing premium quotes to groups before filing the schedule of premiums with the Commissioner."

Section 5. 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.~~ 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~~ filing, ~~for forms~~

~~and within 60 days after the filing for premiums, they~~ the form shall be deemed to be approved."

Section 6. G.S. 58-65-45 reads as rewritten:

"**§ 58-65-45. Public hearings on revision of existing schedule or establishment of new schedule; publication of notice.**

Whenever any hospital service corporation licensed under this Article and Article 66 of this Chapter makes a rate filing or any proposal to revise an existing rate schedule or contract form, the effect of which is to increase or decrease the charge for its contracts, or to set up a new rate schedule, ~~and such rate schedule is subject to the approval of the Commissioner, such~~ the hospital service corporation shall file its proposed rate change or contract form and supporting data with the ~~commissioner,~~ Commissioner, who shall review the filing in accordance with the standards in G.S. 58-65-40. ~~Such~~ The rate revision or new rate schedule with respect to individual subscriber contracts shall be guaranteed by the insurer, as to the contract and certificate holders ~~thereby~~ affected, for a period of not less than 12 months; or with respect to individual subscriber contracts as an alternative to giving ~~such~~ the guarantee, ~~such~~ the rate revision or new rate schedule may be made applicable to all individual contracts at one time if the corporation chooses to apply for ~~such~~ the relief with respect to ~~such~~ the contracts no more frequently than once in any 12-month period. ~~Such~~ The rate revision or new rate schedule shall be applicable to all contracts of the same type; provided that no rate revision or new rate schedule may become effective for any contract holder unless the corporation has given written notice of the rate revision or new rate schedule not less than 30 days prior to the effective date of ~~such~~ the revision or new rate schedule. The contract holder ~~thereafter~~ must pay the revised rate or new rate schedule in order to continue the contract in force. The Commissioner may ~~promulgate~~ adopt reasonable rules, after notice and hearing, to require the submission of supporting data and ~~such~~ the information as is deemed necessary to determine whether ~~such~~ the rate revisions meet these standards. At any time within 60 days after the date of any filing under this section or G.S. 58-65-40, the Commissioner may give written notice to the corporation of a fixed time and place for a hearing on the filing, which time shall be no less than 20 days after notice is given. ~~In the event no notice of hearing is issued within 60 days from the date of any filing, the filing shall be deemed to be approved, subject to modification by the Commissioner as authorized by G.S. 58-65-40.~~ In the event the Commissioner gives notice of a hearing, the corporation making the filing shall, not less than 10 days before the time of the hearing, cause to be published in a daily newspaper or newspapers published in North Carolina, and in accordance with the rules ~~and regulations~~ of the Commissioner of Insurance, a notice, in the form and content approved by the Commissioner, setting forth the nature and effect of ~~such~~ the proposal and the time and place of the public hearing to be held. If the Commissioner does not issue an order within 45 days after the day on which the hearing began, the filing shall be deemed to be approved, subject to modification by the Commissioner as authorized by G.S. 58-65-40."

Section 7. G.S. 58-65-40 reads as rewritten:

"**§ 58-65-40. Supervision of Commissioner of Insurance; form of contract with subscribers; schedule of rates.**

No hospital service corporation shall enter into any contract with subscribers unless and until it ~~shall have~~ has filed with the Commissioner of Insurance a specimen copy of the contract or certificate and of all applications, riders, and endorsements for use in connection with the issuance or renewal thereof to be formally approved by ~~him~~ the Commissioner as conforming to the section of this Article entitled 'Subscribers' contracts,' and conforms to all rules ~~and regulations promulgated~~ adopted by the Commissioner of Insurance under ~~the provisions of~~ this Article and Article 66 of this Chapter. The Commissioner of Insurance shall, within a reasonable time after the filing of ~~any such~~ the form, notify the corporation filing the ~~same~~ form either of ~~his~~ approval or of ~~his~~ disapproval of ~~such~~ the form.

No corporation subject to ~~the provisions of~~ this Article and Article 66 of this Chapter shall enter into any contract with a subscriber after the enactment hereof unless and until it ~~shall have~~ has filed with the Commissioner of Insurance a full schedule of rates to be paid by the subscribers to ~~such contracts~~ the contracts. ~~and shall have obtained the Commissioner's approval thereof.~~ The Commissioner may ~~refuse approval~~ schedule a hearing after filing ~~if he finds~~ upon finding that ~~such~~ the rates are excessive, inadequate, or unfairly discriminatory; or do not exhibit a reasonable relationship to the benefits provided by ~~such~~ the contracts. At all times ~~such rates and~~ the form of subscribers' contracts shall be subject to modification and approval of the Commissioner of Insurance under rules ~~and regulations~~ adopted by the Commissioner, in conformity to this Article and Article 66 of this Chapter."

Section 8. G.S. 58-67-85(a) reads as rewritten:

"(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~~ The 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~~ the contract shall at all times be furnished upon request of enrollees ~~thereto.~~ to the contract."

Section 9. The catch line of G.S. 58-51-1 reads as rewritten:

"**§ 58-51-1. ~~Form,~~ Form and classification ~~and rates~~ to be approved by ~~Commissioner.~~ Commissioner; rates filed.**"

Section 10. G.S. 58-3-173(c) reads as rewritten:

"(c) ~~Renewal of the health benefit plans shall be guaranteed by the insurer except:~~

~~(1) For nonpayment of the required premium by the policyholder or contract holder.~~

~~(2) For fraud or material misrepresentation by the policyholder or contract holder.~~

~~(3) When the insurer ceases providing health benefit plans, provided notice of the decision to cease providing health benefit plans is given to the Commissioner and to the policyholder or contract holder six months before the renewal of the health benefit plan would have taken effect.~~

Except as provided in this subsection, a health benefit plan shall renew or continue the coverage at the option of the contract holder.

(1) General exceptions. – A health benefit plan may nonrenew or discontinue health insurance coverage based only on one or more of the following:

a. Nonpayment of premiums. – The contract holder has failed to pay premiums in accordance with the health insurance coverage, or the health benefit plan has not received timely premium payments.

b. Fraud. – The contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

c. Violation of participation or contribution rules. – The contract holder has failed to comply with a material plan provision related to employer contribution or group participation rules.

d. Termination of coverage. – The health benefit plan is ceasing to offer coverage in the market in accordance with subdivision (2) of this subsection.

e. Movement outside service area. – In the case of a health benefit plan that offers coverage through a network plan, there is no longer any enrollee with the plan who lives, resides, or works in the service area.

f. Association membership ceases. – The membership of an employer in an association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(2) Requirements for uniform termination. –

a. Particular coverage not offered. – In any case where a health benefit plan decides to discontinue offering a particular coverage, that coverage may be discontinued only if all of the following are met:

1. The health benefit plan provides notice to each contract holder and policyholder of the discontinuance at least 90 days prior to the date of discontinuance.

2. The health benefit plan offers to the contract holder the option to purchase any other health insurance coverage currently being offered by the plan.
3. The health benefit plan acts uniformly without regard to the claims experience of the contract holder or any health status-related factor relating to any covered policyholder or new participants who may become eligible for the coverage.

b. Discontinuance of all coverage. –
1. In general. – In the case in which a health benefit plan elects to discontinue offering all health insurance coverage in a market, that coverage may only be discontinued if both of the following are met:
a. The plan provides notice to the Commissioner, the contract holder, and the policyholders of the discontinuation at least 180 days prior to the date of discontinuance.
b. All health insurance issued or delivered for issuance in that market is discontinued and not renewed.
2. Prohibition of market reentry. – In the case of a discontinuation in a market, the plan shall not provide for the issuance of any health insurance coverage in the market and State during the five-year period beginning on the date of the discontinuance.

(3) Exception for uniform modification of coverage. – At the time of coverage renewal, a health benefit plan in the large group market may modify the health insurance coverage for a product offered to a group health plan. At the time of coverage renewal and for coverage in the market other than through an association, a plan in the small group market may modify the health insurance coverage for a product if the modification is effective on a uniform basis among group health plans with that product and it is in compliance with the provisions of G.S. 58-50-125."

Section 11. This act is effective when it becomes law.