GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 932
Commerce Committee Substitute Adopted 6/18/97

Short Title: HMO Operations. (Public)

Sponsors:

Referred to:

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH HEALTH BENEFIT PLAN REPORTING AND DISCLOSURE REQUIREMENTS AND MAKE IMPROVEMENTS IN THE OPERATIONS OF HEALTH MAINTENANCE ORGANIZATIONS IN NORTH CAROLINA.

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:

"**§ 58-3-210. Health plan reporting and disclosure requirements.**

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

(1) 'Health benefit plan' means any of the following if offered 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
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) Each insurer shall annually, on or before April 1 of each year, file in the office of the Commissioner the following information and reports relating to its activities in the previous calendar year, to the extent applicable. All information and reports shall be in a format prescribed by or acceptable to the Commissioner:

(1) A report on the availability and accessibility of each of its provider networks offered, which shall include:

a. Information on the insurer's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the insurer's methodology for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in plan membership will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the insurer's provider network; and an evaluation of actual plan performance against performance targets.

b. The insurer's method for arranging or providing health care services from nonnetwork providers, both within and outside of

its service area, when network providers are not available to provide covered services.

c. Information on the insurer's program to determine the level of provider network accessibility necessary to serve its membership. This information shall include the insurer's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the insurer's methods and standards for determining whether in-network services are reasonably available and accessible to a covered person, for the purpose of determining whether a covered person should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the insurer's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, plan performance, and network provider performance.

(2) A report of grievances for the previous calendar year, as defined in G.S. 58-50-61 and processed in accordance with G.S. 58-50-62. The report shall include number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every insurer shall file with the Commissioner, as part of its annual grievance report, a certificate of compliance stating that the carrier has established and follows, for each

of its lines of business, grievance procedures that comply with G.S. 58-50-62.

(3) A report summarizing its utilization review program activities for the previous calendar year. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of covered persons. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 58-50-61.

(4) A report showing the number of participants and groups who terminated coverage under the plan in the previous calendar year, which includes the number of participants who terminated coverage because the group contract under which they were covered was terminated, the number of participants who terminated coverage for reasons other than the termination of the group under which they were enrolled, and the number of group contracts terminated.

(5) A report showing the number of changes in provider network. The report shall detail the number of provider contracts that were terminated during the previous calendar year, showing voluntary and involuntary terminations separately, and the number of provider contracts that were added to the network. This subdivision does not require the disclosure of any identifying information about a provider, and no civil liability shall arise from compliance with this subdivision.

(6) A report listing the types of methods of provider compensation utilized in its provider contracts, such as: capitation arrangements; discounted fee-for-service; salary; and withhold or incentive arrangements.

(c) Each health benefit plan shall provide its prospective insureds upon request its evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, G.S. 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan written by the insurer.

(d) Effective April 1, 1998, insurers shall make the reports that are required under subsection (b) of this section and that have been filed with the Commissioner available on their business premises and shall provide any insured access to them upon request."

Section 2. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 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."

Section 3. 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 with data for the calendar year 1998, every HMO, for group contracts of 1,000 or more members, shall provide cost, use of service, prevention, outcomes, and other group-specific data as collected 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. Beginning with data for the calendar year 1998, every HMO shall file with the Commissioner and make available to all employer groups, not later than July 1 of the following calendar year, a report of health benefit plan-wide experience on its costs, use of services, and other aspects of performance, in the HEDIS format."

Section 4. G.S. 58-67-100 reads as rewritten:

"**§ 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 ~~he~~ the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under G.S. 58-2-131, 58-2-132, and 58-2-133.

~~(b) Every health maintenance organization shall submit its books and records relating to the health care plan to such examinations and in every way facilitate them. For the purpose of examinations, the Commissioner may administer oaths to, and examine the officers and agents of the health maintenance organization concerning their business.~~

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

(d) ~~In lieu of such~~ Instead of conducting an examination, the Commissioner may accept the report of an examination made by the ~~Commissioner of Insurance or Commissioner of Public Health~~ HMO regulator of another state."

Section 5. G.S. 58-67-140 reads as rewritten:

"**§ 58-67-140. Suspension or revocation of ~~certificate of authority.~~ license.**

(a) The Commissioner may ~~suspend or revoke any certificate of authority issued to a health maintenance organization under this Article if he finds that any of the following conditions exist: suspend, revoke, or refuse to renew~~ suspend or revoke any HMO license if the Commissioner finds that the HMO:

(1) ~~The health maintenance organization is~~ 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) ~~The health maintenance organization issues evidence~~ Issues evidences of coverage or uses a schedule of premiums for health care services ~~which~~ that do not comply with ~~the requirements of~~ G.S. 58-67-50.

(3) ~~The health maintenance organization no~~ No longer maintains the financial reserve specified in G.S. 58-67-40 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(4) ~~The health maintenance organization, or any person on its behalf, has~~ Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.

(5) ~~The continued operation of the health maintenance organization~~ Is operating in a manner that would be hazardous to its enrollees.

(6) ~~The health maintenance organization has otherwise failed to substantially comply with this Article.~~ 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) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210.

(b) A ~~certificate of authority~~ license shall be suspended or revoked only after compliance with ~~the requirements of~~ G.S. 58-67-155.

(c) When ~~the certificate of authority of a health maintenance organization~~ an HMO license is suspended, the ~~health maintenance organization~~ HMO shall not, during the ~~period of such~~ 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 whatsoever.~~ solicitation.

(d) When ~~the certificate of authority of a health maintenance organization~~ an HMO license is revoked, ~~such organization~~ 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 ~~such organization.~~ the HMO. ~~It~~ The HMO shall engage in no advertising or ~~solicitation whatsoever.~~ solicitation. The Commissioner may, by written order, permit such further

operation of the ~~organization as he~~ 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."

Section 6. This act becomes effective January 1, 1998.