**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 1997**

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SENATE BILL 933

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

Sponsors: Senator Perdue.

Referred to: Commerce.

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 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 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.
(2) Necessary for and appropriate to the symptoms, diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
(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, if conditions of coverage state that services and supplies must also be cost-effective.

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 covered person's health condition which was knowingly made by the provider of the service, supply, or other item.

(c) Emergency Services. – When conducting utilization review or making a determination for coverage of emergency services:

(1) An insurer shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of

those services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a health care provider that does not have a contract with the insurer, the insurer shall cover emergency services necessary to screen and stabilize an insured and shall not require prior authorization of those services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed and use of a provider contracting with the insurer would result in a delay that would worsen the emergency.

(2) An insurer shall cover emergency services if a contracting health care provider or an authorized representative of the carrier recommended that the covered person obtain the emergency services.

(3) If an insurer authorizes emergency services, it shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on the authorization, unless the authorization was based on a material misrepresentation about the insured's health condition that was made by the emergency services provider, the insured, or the insured's representative.

(4) Nothing in this subsection precludes coverage of emergency services being made subject to applicable coinsurance, copayments, and deductibles as specified in the health benefit plan.

(5) Nothing in this subsection precludes an insurer from establishing authorization procedures for the coverage of services after an emergency medical condition either has been found not to exist or has been stabilized.

(6) To facilitate review and treatment authorization for postevaluation and poststabilization services, an insurer shall provide access to an authorized representative 24 hours per day, seven days per week.

As used in this subsection: 'Emergency services' means health care items and services, furnished or required to evaluate and treat an emergency medical condition until such condition is stabilized, including ambulance services and ancillary services routinely available to the emergency department. 'Emergency medical condition' means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. 'Stabilized' means, with respect to an emergency medical condition, that the emergency medical condition has resolved or that no material deterioration of the condition is likely, within reasonable medical probability, to result from the omission of immediate further care or result from or occur during the transfer from one facility to another.

(d) Provider Network Access Plans. – This subsection and subsections (e) through (g) of this section apply to insurers that write health benefit plans that require or encourage members to use selected health care providers in return for additional benefits or higher levels of coverage. Beginning with the 1998 calendar year, insurers shall annually file a provider network access plan with the Commissioner no later than February 1 of the same calendar year. The access plan shall be in a format prescribed by the Commissioner and shall include:

(1) The provider network for the health benefit plan.

(2) The procedures used for making or denying referrals within and outside the network, including the procedures used when no appropriate provider is reasonably available, as determined under subsection (e) of this section.

(3) The process used for monitoring and assuring on an ongoing basis the ability of the network to deliver covered services to insureds, including a discussion of at least the following factors: provider-covered person ratios by specialty, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the accessibility of technological and specialty services available to meet appropriately the special needs of covered persons requiring technologically advanced or specialty care.

(4) The efforts to address the needs of insureds with limited English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

(5) The method used for assessing the health care needs of insureds and their satisfaction with services.

(6) The method used for informing insureds of the plan's services and features, including the plan's appeal and grievance procedures, process for choosing and changing providers, and procedures for providing and approving emergency and specialty care.

(7) The method used for ensuring the coordination and continuity of care for insureds referred to specialty physicians, for insureds using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

(8) The method used for allowing insureds to change primary care providers.

(9) The proposed plan for providing continuity of care in the event of contract termination between the insurer and any of its participating providers, or in the event of the insurer's insolvency or other inability to continue operations of the health benefit plan.

(10) Any other information required by the Commissioner.

Effective January 1, 1998, every insurer shall file an access plan with the Commissioner before offering a new health benefit plan and shall file an update to an existing access plan with the Commissioner whenever there are material changes in the

access plan. Effective January 1, 1998, insurers shall make the access plans available on their business premises and shall provide them to any insured upon request. Effective January 1, 1999, every insurer shall annually file with the Commissioner a performance report related to the targets specified in its network access plan for the previous year, with the report due by February 1 each year.

(e) Services Outside Provider Networks. – No insurer shall penalize or subject an insured to less favorable benefits or coverage unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay. No insurer shall reduce payment for a service provided by a provider outside of the insurer's provider network more than twenty percent (20%) of the payment that would be made to a provider in the insurer's network for the same service.

(f) 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 who fails to meet other legitimate selection criteria.

(g) Continuing Care Retirement Community Residents. – If an insured is a resident of a continuing care retirement community regulated under Article 64 of this Chapter, the insurer shall provide the insured the option to receive approved service in the continuing care retirement community that serves as the insured's primary residence. This option is available only if the continuing care retirement community has available or can make arrangements to provide the needed service, and the continuing care retirement community is willing to accept the contract rate that has been negotiated with similar service providers for the same services and supplies. Those services include skilled nursing care, rehabilitative and other therapy services, and postacute care as needed.

(h) Information For Prospective Insureds. – At the request of a prospective insured, an insurer shall provide that person with a sample copy of its health benefit plan.

(i) No insurer shall deny payment for covered services when those services are provided without any required preauthorization, precertification, or concurrent or prospective review if the provider reasonably believed that the patient's health condition could be further harmed by any delay in the provision of those services."

Section 2. This act applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after October 1, 1997. 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 3. This act becomes effective October 1, 1997.