

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021**

**SENATE BILL 228
RATIFIED BILL**

AN ACT TO LOWER HEALTH CARE COSTS AND EXPAND ACCESS BY ALLOWING
SMALL BUSINESSES TO OFFER EXCLUSIVE PROVIDER BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding two new sections to read:

"§ 58-50-56.1. Exclusive provider organizations, exclusive provider benefit plans.

(a) Definitions. – The following definitions apply in this section:

- (1) Exclusive provider benefit plan. – A health benefit plan offered by an insurer in which insureds must receive covered services from health care providers who are under a contract with the insurer and under which there is no requirement of coverage for care received from a health care provider who is not under contract with the insurer, except for emergency services as required by G.S. 58-3-190 and medically necessary covered services as required by G.S. 58-3-200(d).
- (2) Exclusive provider organization or EPO. – An insurer holding contracts with providers to be used by or offered to insurers offering exclusive provider benefit plans.
- (3) Insurer. – An insurer or service corporation subject to this Chapter.
- (4) Participating provider. – A health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services; however, a participating provider is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives.

(b) Insurers may enter into contracts for an exclusive provider organization with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice. A contract for an exclusive provider organization that is not disapproved by the Commissioner within 90 days of its filing by the insurer shall be deemed to be approved.

(c) Any provision of a contract between an insurer offering an exclusive provider benefit plan and a health care provider that restricts the provider's right to enter into provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(d) Every insurer offering an exclusive provider benefit plan and contracting with an EPO shall require by contract that the EPO provide all of the participating providers with whom it holds contracts information about the insurer and the insurer's exclusive provider benefit plans. This information shall include for each insurer and participating provider benefit plan the benefit designs and incentives that are used to encourage insureds to use participating providers.

(e) The Commissioner's rules adopted and applicable for preferred provider organizations related to provider accessibility for the insured group, adequacy of providers,



availability of services at reasonable times, and financial solvency shall apply for exclusive provider organizations.

(f) Each insurer offering an exclusive provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall annually disclose the following information:

- (1) The name by which the exclusive provider benefit plan is known and its business address.
- (2) The name, address, and nature of any separate organization that administers any preferred provider benefit plan for the insurer.
- (3) The terms of the agreements entered into by the insurer with providers in an exclusive provider organization.
- (4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(g) Each insurer shall include a clear statement in any application and any benefit booklets for exclusive provider benefit plans that out-of-network coverage for insureds in the exclusive provider benefit plan only applies for (i) emergency services and (ii) medically necessary covered services when an in-network provider is not reasonably available.

(h) Any provisions of this Chapter that apply to preferred provider benefit plans or preferred provider organizations as of July 1, 2021, shall also apply to exclusive provider benefit plans or exclusive provider organizations.

"§ 58-50-56.2. Exclusive provider organization continuity of care.

(a) Definitions. – The following definitions apply in this section:

- (1) Ongoing special condition. – One of the following conditions:
 - a. An acute illness that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
 - b. A chronic illness, disease, or condition that is life-threatening, degenerative, or disabling and that requires medical care or treatment over a prolonged period of time.
 - c. Pregnancy from the start of the second trimester.
 - d. A terminal illness for which an individual has a medical prognosis of a life expectancy of six months or less.
- (2) Terminated or termination. – The expiration or nonrenewal of a contract. The term does not include an ending of the contract by an insurer for failure to meet applicable quality standards or for fraud.

(b) Termination of a Provider. – If (i) a contract between an insurer and a health care provider offering an exclusive provider benefit plan is terminated by the provider or by the insurer, or benefits or coverage provided by the insurer are terminated because of a change in the terms of provider participation in an insurer's exclusive provider benefit plan and (ii) an insured is undergoing treatment from the provider for an ongoing special condition on the date of termination, then the following shall apply:

- (1) Upon termination of the contract by the insurer or upon receipt by the insurer of written notification of termination by the provider, the insurer shall notify the insured on a timely basis of the termination and of the insured's right to elect continuation of coverage of treatment by the provider. This subdivision shall apply only if the insured has a claim with the insurer for services provided by the terminated provider or the insured is otherwise known by the insurer to be a patient of the terminated provider.
- (2) Subject to subsection (h) of this section, the insurer shall permit an insured to elect to continue to be covered with respect to the treatment by the terminated

provider for the ongoing special condition during a transitional period, as provided under this section.

(c) Newly Covered Insured. – Each exclusive provider benefit plan offered by an insurer shall provide transition coverage to individuals who (i) are newly covered under an exclusive provider benefit plan because the individual's employer has changed benefit plans and (ii) are undergoing treatment from a provider for an ongoing special condition. On the date of enrollment, an insurer shall notify the newly covered insured of (i) the right to elect continuation of coverage of treatment by a provider that is not contracted with the exclusive provider benefit plan and (ii) the method and time line by which the insured should contact the insurer. Subject to subsection (h) of this section, the insurer shall permit the newly covered insured to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period, as provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in this section, the length of a transitional period provided under this subsection shall be determined by the treating health care provider, so long as it does not exceed 90 days after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual, or if the individual was on an established waiting list for surgery, organ transplantation, or other inpatient care, before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment described in subsection (c) of this section, then the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through post discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an individual has entered the second trimester of pregnancy on or before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section, and the provider was treating the pregnancy before the date of the notice or the date of enrollment in the plan, then the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an individual was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section or at the time of enrollment in the plan under subsection (c) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the plan, then the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An insurer may condition coverage of continued treatment by a provider under subsection (b) or subsection (c) of this section upon the following terms and conditions:

- (1) When care is provided pursuant to subsection (b) of this section, the provider agrees to accept reimbursement from the insurer and, with respect to cost-sharing, from the insured involved at the rates applicable before the start of the transitional period as payment in full.
- (2) When care is provided pursuant to subsection (c) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area or the PPO or other rate agreed to by the provider and insurer, if applicable, plus the applicable copayment from the newly covered insured, as reimbursement in full from the insurer and the insured for all covered services.

- (3) The provider agrees to comply with the quality assurance programs of the insurer responsible for payment under this subsection and to provide to the insurer necessary medical information related to the care provided. The insurer's quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the insured.
- (4) The provider agrees to adhere to the insurer's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan approved by the insurer, and member hold harmless provisions.
- (5) The receipt of notification from the insured within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subsection (c) of this section that the insured elects to continue receiving treatment by the provider.
- (6) The provider agrees to discontinue providing services at the end of the transition period and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.
- (i) Construction. – Nothing in this section shall be construed to do any of the following:
 - (1) Require the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, require the coverage of benefits not provided under the policy in which the newly covered insured is enrolled.
 - (2) Require an insurer to offer a transitional period when the insurer terminates a provider's contract for reasons relating to quality of care or fraud. Refusal by an insurer to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.
 - (3) Prohibit an insurer from extending any transitional period beyond that specified in this section.
 - (4) Prohibit an insurer from terminating the continuing services of a provider when the insurer has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. A termination for these reasons shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.
- (j) Disclosure of Right to Transitional Period. – Each insurer shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

SECTION 2. The Department of Insurance may adopt temporary rules to implement this act.

SECTION 3. This act becomes effective October 1, 2021, and applies to insurance contracts issued, renewed, or amended on or after that date.

In the General Assembly read three times and ratified this the 30th day of August, 2021.

s/ Ralph Hise
Presiding Officer of the Senate

s/ Harry Warren
Presiding Officer of the House of Representatives

Roy Cooper
Governor

Approved _____m. this _____ day of _____, 2021