GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 934

Short Title: Preferred Provider Amendments. (Public)

Sponsors: Senator Perdue.

Referred to: Commerce.

April 17, 1997

A BILL TO BE ENTITLED

AN ACT TO REWRITE AND MODERNIZE THE LAWS ON PREFERRED HEALTH CARE PROVIDERS, PREFERRED PROVIDER ORGANIZATIONS, AND PREFERRED 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 a new section to read:

"**§ 58-50-56. Preferred provider organizations and benefit plans.**

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

(1) 'Insurer' means an insurer or service corporation subject to this Chapter.

(2) 'Preferred provider' means health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services on a fee-for-service basis. A 'preferred provider' is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives.

(3) 'Preferred provider benefit plan' means a health benefit plan offered by an insurer in which both of the following features are present:

a. Utilization review or quality management programs are used to manage the provision of covered health care services; and

b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers; and health care services are provided by preferred providers under a contract pursuant to G.S. 58-50-55.

(4) 'Preferred provider organization' or 'PPO' means an insurer holding contracts with preferred providers to be used by or offered to insurers offering preferred provider benefit plans.

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice.

(c) At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. The second and third paragraphs of G.S. 58-50-30(a) apply to preferred provider benefit plans.

(d) Any provision of a contract between an insurer offering a preferred provider benefit plan and a health care provider that restricts the provider's right to enter into preferred 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.

(e) Except where specifically prohibited either by this section or by rules adopted by the Commissioner, the contractual terms and conditions for special reimbursements shall be those that the parties find mutually agreeable.

(f) Every PPO shall provide all of the preferred providers with whom it holds contracts information about all of the insurers with whom the PPO does business and the insurers' preferred provider benefit plans. This information shall include for each insurer and preferred provider benefit plan the benefit designs and incentives that are used to encourage insureds to use preferred providers.

(g) The Commissioner may adopt rules applicable to insurers offering preferred provider benefit plans under this section. These rules shall provide for:

(1) Accessibility of preferred provider services to individuals within the insured group.

(2) The adequacy of the number and locations of health care providers.

(3) The availability of services at reasonable times.

(4) Financial solvency.

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

(1) The name by which the preferred provider benefit plan is known and its business address.

(2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.

(3) The names and addresses of all health care providers designated by the PPO as preferred providers; and the terms of the agreements entered into with those providers.

(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.

(i) A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan. The preferred provider benefit plan may limit the coverage for health care services obtained from a provider who does not participate in the plan, except that payments for services rendered by a nonparticipating provider may not be reduced by more than twenty percent (20%) of the payment that would be made to a participating provider for the same service. This percentage limitation shall not require any waiver of copayments or waiver of deductibles in determining payments for services rendered by nonparticipating providers. Preferred provider benefit plans shall provide for payment for services rendered by nonparticipating providers. Except as provided in this subsection, this payment may differ from that provided to participating providers in the discretion of the person or insurer offering the preferred provider health benefit plan.

(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties.

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers."

Section 2. Article 63 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-63-70. Health care service discount practices by insurers and service corporations.**

(a) It is an unfair trade practice for any insurer or service corporation subject to this Chapter to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged for medical services, procedures, or supplies provided by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees.

(b) It is an unfair trade practice for any person with knowledge that an insurer or service corporation intends to make the type of misrepresentation prohibited in subsection (a) of this section to provide substantial assistance to that insurer or service corporation in accomplishing that misrepresentation."

Section 3. G.S. 58-51-57(a) reads as rewritten:

"(a) Every policy or contract of accident or health insurance, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for pap smears and low-dose screening mammography."

Section 4. G.S. 58-51-58(a) reads as rewritten:

"(a) Every policy or contract of accident and health insurance, and every preferred ~~provider contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer."

Section 5. G.S. 58-51-59(a) reads as rewritten:

"(a) No policy or contract of accident or health insurance, and no preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;

(2) The American Hospital Formulary Service Drug Information; or

(3) The United States Pharmacopeia Drug Information."

Section 6. G.S. 58-65-92(a) reads as rewritten:

"(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as

apply to similar services covered under the certificate or contract shall apply to coverage for pap smears and low-dose screening mammography."

Section 7. G.S. 58-65-93(a) reads as rewritten:

"(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer."

Section 8. G.S. 58-65-94(a) reads as rewritten:

"(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;

(2) The American Hospital Formulary Service Drug Information; or

(3) The United States Pharmacopeia Drug Information."

Section 9. G.S. 58-50-65(a) reads as rewritten:

"(a) ~~Nothing in Articles 50 through 55 of this Chapter shall apply to or affect any policy of liability or workers' compensation insurance, except that the provisions of G.S. 58-50-50 and subsections (b) and (c) of G.S. 58-50-55 shall apply to policies of workers' compensation insurance.~~ Except for G.S. 58-50-56, nothing in Articles 50 through 55 of this Chapter applies to liability or workers' compensation insurance policies."

Section 10. G.S. 90-14.13 reads as rewritten:

"**§ 90-14.13. Reports of disciplinary action by health care institutions; immunity from liability.**

The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in ~~G.S. 58-50-50,~~ G.S. 58-50-56, and all other provider organizations that issue credentials to physicians who practice medicine in the State, shall, after consultation with the chief of staff of such institution, report to the Board any revocation, suspension, or limitation of a physician's privileges to practice in that

institution. Each such institution shall also report to the Board resignations from practice in that institution by persons licensed under this Article. The Board shall report all violations of this subsection known to it to the licensing agency for the institution involved.

Any licensed physician who does not possess professional liability insurance shall report to the Board any award of damages or any settlement of any malpractice complaint affecting his or her practice within 30 days of the award or settlement.

The chief administrative officer of each insurance company providing professional liability insurance for physicians who practice medicine in North Carolina, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund operated by a hospital authority, group, or provider shall report to the Board within 30 days:

(1) Any award of damages or settlement affecting or involving a physician it insures, or

(2) Any cancellation or nonrenewal of its professional liability coverage of a physician, if the cancellation or nonrenewal was for cause.

The Board may request details about any action and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public. The Board shall report all violations of this paragraph to the Commissioner of Insurance.

Any person making a report required by this section shall be immune from any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in reckless disregard of whether the report was false."

Section 11. G.S. 135-39.5(12) reads as rewritten:

"(12) Determining basis of payments to health care providers, including payments in accordance with ~~G.S. 58-50-55.~~ G.S. 58-50-56."

Section 12. G.S. 58-65-140 is repealed.

Section 13. G.S. 58-50-50 and G.S. 58-50-55 are repealed.

Section 14. Any administrative rules that were adopted by the Commissioner under the authority of G.S. 58-50-50 or G.S. 58-50-55 and that were effective before October 1, 1997, are not affected by the repeals in Section 13 of this act.

Section 15. This act becomes effective October 1, 1997.