GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H **1**

HOUSE BILL 1282

Short Title: Managed Care/Patient Access. (Public)

Sponsors: Representatives Nye; Brown, Cansler, Carpenter, Clary, Cole, Crawford, Gulley, Hiatt, Hill, Hunter, Jeffus, Justus, Kiser, McAllister, Morris, Sherrill, Smith, Starnes, Tallent, Wainwright, Warner, and Warwick.

Referred to: Health.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE PATIENT ACCESS TO QUALITY MANAGED HEALTH CARE.

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:

"**§ 58-3-205. Patient access to quality managed health care.**

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

(1) 'Health benefit plan' or 'plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or

its representatives, or a managed care plan provided under the Teachers' and State Employees' Comprehensive Major Medical Plan. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term care or nursing home care.
e. Medicare supplement.
f. Coverage issued as a supplement to liability insurance.
g. Workers' compensation.
h. Medical payments under automobile or homeowners' insurance.
i. Hospital income or indemnity.
j. 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.
k. Any insurance that federal law or regulations exempts from the regulation of this section.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(b) Scope. – The requirements of this section are in addition to others applicable under this Chapter. If any of the provisions of this section are in conflict with other provisions of this Chapter this section controls to the extent of the conflict.

(c) Access to Quality Health Care Providers. – Every health benefit plan shall be designed and administered to ensure that it has the number and classes of providers adequate to treat appropriately the number of the plan's insureds in the geographic area or areas covered by the plan and that the plan's insureds have an appropriate choice of primary care providers and other providers. Every health benefit plan shall ensure that at least two primary care providers are within 20 miles or 30 minutes' average driving time or public transportation, if available, whichever is less, within the geographic area of ninety percent (90%) of the enrolled population.

The provisions of any contract between an insurer and a provider that set out the requirements of subdivisions (1) through (5) of this subsection shall not be any more stringent than the specifics of these subdivisions. The insurer shall not shift the burden of ensuring access to quality health care as prescribed in this subsection to individual providers.

In addition to reviewing the plans of insurers to determine whether they conform to the specific requirements of this subsection, the Commissioner shall determine what constitutes reasonable access to medical services offered by an insurer within a network of providers. When determining what shall constitute reasonable access to medical services the Commissioner shall consider the following factors:

(1) The standard of individual care and access to medical care in the community;
(2) The type of condition and severity of medical condition of the insured;
(3) The costs and expenses associated with obtaining services in the network as compared to the costs to the insured if the same services could be obtained from any provider;
(4) Waiting times for appointments and number of hours providers are available;
(5) Complaints of the insurers for failure to provide reasonable access to medical care.

If the Commissioner determines that a network is not sufficient to provide reasonable access to quality health care, whether in required specifics or in overall effect, the Commissioner shall notify the insurer and, if the Commissioner determines that the insufficiency is part of a pattern of denial of reasonable access, may impose the same penalties that may be imposed for retaliation and discrimination prescribed by G.S. 58-3-216.

(d) Compensation for Out-of-Network Providers. – The fee paid by an insurer to a provider outside the plan's network shall be at least as much as the fee paid to a provider within the plan's network for the same service.

(e) Access Ensured by Plan Fairness and Due Process. – Every health benefit plan shall ensure that:

(1) There are no criteria for hospital privileges required of providers that are not reasonably related to the services being provided or that are not necessary for the provider's provision of the full scope of services to the insured.
(2) The plan does not discriminate with respect to participation, reimbursement, or indemnification as to any provider acting within the scope of the provider's license or certification and does not differentiate in reimbursement rates among providers providing the same service solely on the basis of the providers' licenses or classifications.
(3) Providers are terminated only for cause affecting quality of care.
(4) Not less than 10 days before terminating a provider for cause, the plan shall provide to the provider written notice of the proposed termination, together with specific reasons for the termination.
(5) The terms and conditions of the plan affecting insureds and providers are not modified without adequate notification to the insureds and the providers and there is adequate opportunity for providers to amend these modified terms and conditions, appeal the modified terms and conditions, or terminate the provider's participation.
(6) In addition to meeting the specific requirements prescribed in subsection (c) of this section in developing its network of providers, the insurer shall establish relevant objective criteria solely related to quality of care and scope of practice for initial and subsequent consideration of

providers. These criteria shall be reasonably related to services provided.

Each insurer shall establish mechanisms for soliciting and acting upon applications for provider participation in the plan in a fair and systematic manner. These mechanisms shall, at a minimum, include:

a. Allowing all providers who desire to apply for participation in the plan an opportunity to apply at any time during the enrollment period or, when an insurer does not conduct open continuous provider enrollment, conducting a provider enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least 30 days in advance of the enrollment period; and

b. Making criteria for provider participation in the plan available to all applicants.

(7) A utilization review or grievance procedure pursuant to G.S. 58-50-61 and G.S. 58-50-62 shall include on the review or grievance panel at least one provider with the same type of license as the provider who is a party to the review or grievance, or, if the provider is a medical doctor, at least one clinical peer of the provider who is a party to the review or grievance.

(f) Investigation of Complaints About External Review Process. – Within five days of receiving a complaint about a plan's external review process under G.S. 58-50-62, the Commissioner shall conduct an investigation to determine if the process complies with State law and rules. The Commissioner shall make a determination within 15 days of receipt of the complaint and, if the Commissioner finds that the process does not comply with State law and rules, the Commissioner may require corrective action and may impose the same sanctions or penalties as authorized under G.S. 58-2-70.

(g) Insurer Responsibility for Intermediaries. – For purposes of (i) this section, (ii) G.S. 58-3-100, 58-3-191, 58-3-200, 58-3-216, 58-3-217, 58-3-218, 58-3-219, and (iii) G.S. 58-3-225, 58-3-230, 58-3-235, 58-3-240, 58-3-245, 58-67-88, 58-50-62, 58-3-250, 58-3-192, and 58-67-50, as enacted in House Bill 285 of the 1999 General Assembly, the duties placed on an insurer include a duty to ensure that any intermediary the insurer contracts with to provide health care under the insurer's health benefit plan complies with the requirements of this section to ensure patient access to quality managed health care. As used in this subsection, the term ‘intermediary' means an entity that employs or contracts with health care providers for the provision of health care services, and that also contracts with an insurer covering the health care services under a health benefit plan."

Section 2. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-3-216. Protection for patient advocacy; prohibition against retaliation and discrimination; penalties.**

(a) A health benefit plan or insurer shall not retaliate against a covered person or health care provider based on the covered person's or provider's use of or participation in a health benefit plan's utilization review process or grievance process.

(b) Except as otherwise provided in this section, a health benefit plan or insurer shall not retaliate or discriminate against a health care provider because the provider in good faith:

(1) Discloses information relating to the care, services, or conditions affecting one or more covered persons of the plan to an appropriate State or federal regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the insurer;

(2) Acts as an advocate, advisor, or representative of a covered person at any level of a plan's review process;

(3) Initiates, cooperates, or otherwise participates in an investigation or proceeding by a State or federal regulatory agency with respect to the care, services, or conditions affecting one or more covered persons; or

(4) Participates in an external appeals process of the health benefit plan.

For purposes of this section, the term ‘insurer' includes an institutional health care provider that is a participating provider with a health benefit plan or that receives payments for benefits provided by the health benefit plan. The prohibitions of this section apply to the institutional health care provider to the same extent as to the insurer.

(c) For purposes of this section, a health care provider is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action:

(1) The disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care providers with the same licensure or certification and the same experience;

(2) The provider reasonably believes the information to be true;

(3) The information evidences either a violation of a law, rule, or regulation of an applicable accreditation standard or of a generally recognized professional or clinical standard, or that a patient is in imminent hazard of loss of life or serious injury; and

(4) Subject to subdivisions (2) and (3) of this subsection, the provider has followed reasonable internal procedures of the health benefit plan established for the purpose of addressing quality of care concerns before making the disclosure. This subdivision applies only if the internal procedures involved are reasonably expected to be known to the health care provider. For purposes of this subsection, a health care provider is reasonably expected to know of internal procedures if those procedures have been made available to the provider through distribution or posting.

(d) Subsection (b) of this section does not protect disclosures that would violate State or federal law or that would diminish or impair the rights of any person to the

continued protection of confidentiality of communications provided by State or federal law.

(e) A health care provider or covered person allegedly aggrieved by a violation of this section may file a written complaint with the Commissioner alleging the violation. Within 10 days following receipt of the complaint the Commissioner shall mail a copy of the complaint to the insurer and shall initiate an investigation. If after investigation the Commissioner finds there is not reasonable cause to believe the allegations are true, the Commissioner shall dismiss the complaint and shall so inform the person who filed the complaint and the insurer. If the Commissioner finds reasonable cause to believe the allegations are true, the Commissioner shall serve notice on the insurer of a hearing to be held at a time and place fixed in the notice. The hearing shall be held within 10 days of service on the insurer. The Commissioner shall also notify the person who filed the complaint of the date and time of the hearing. At the hearing the person who filed the complaint shall have an opportunity to present evidence and the insurer shall have an opportunity to answer the charges and present evidence. If the hearing results in a finding by the Commissioner of a violation of this section, the Commissioner may suspend or revoke the insurer's license, and shall order the payment of a monetary penalty as provided in subsection (f) of this section. Each day during which a violation occurs shall constitute a separate offense.

(f) Upon a finding by the Commissioner of a violation as specified in subsection (e) of this section, the Commissioner shall order the payment of a penalty of not less than one thousand dollars ($1,000) per day. In determining the amount of the penalty, the Commissioner shall consider the degree and extent of harm caused by the violation, the amount of money that inured to the benefit of the violator as a result of the violation, whether the violation was committed willfully, and the prior record of the violator in complying or failing to comply with laws, rules, or orders applicable to the violator. The penalty shall be payable to the Commissioner, who shall then forward the clear proceeds of which to the State Treasurer for deposit in accordance with State law. An order of the Commissioner under this subsection is subject to review by the Superior Court of Wake County as provided in G.S. 58-2-75.

(g) The decision of the Commissioner under this section shall not impair the right of a health care provider or covered person to pursue any other action or remedy available under law.

(h) Nothing in this section shall prevent the Commissioner from negotiating a mutually acceptable agreement between any person as to any civil penalty.

(i) As used in this section, the term:

(1) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.

(2) 'Health benefit plan' has the same meaning as applies to the term under G.S. 58-3-205.

(3) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes and who provides health care services to a covered person under a health benefit plan.

(4) 'Insurer' has the same meaning as applies to the term under G.S. 58-3-205.

"**§ 58-3-217. Civil action.**

(a) A health care provider or covered person under a health benefit plan allegedly aggrieved by a violation of G.S. 58-3-216 may commence a civil action in the superior court in the county where the violation occurred, where the complainant resides, or where the respondent has its principal place of business in this State. Upon a finding by the court of a violation of G.S. 58-3-216, the court shall order the insurer who committed the violation to pay damages to the complainant in an amount that would make the harmed complainant whole. If the court finds that the complainant was injured by a willful violation of G.S. 58-3-216, then the court shall treble the amount of damages awarded.

(b) As used in this section, the term:

(1) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.

(2) 'Health benefit plan' has the same meaning as applies to the term under G.S. 58-3-205.

(3) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes and who provides health care services to a covered person under a health benefit plan.

(4) 'Insurer' has the same meaning as applies to the term under G.S. 58-3-205.

"**§ 58-3-218. Prohibition against transfer of indemnification by health benefit plans.**

(a) No contract or agreement between a health benefit plan or insurer, or any agent acting on behalf of a health benefit plan or insurer, and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the health benefit plan, insurer, or agent, as opposed to the health care provider.

(b) Any provision in a contract or agreement prohibited by subsection (a) of this section is void ab initio and is not enforceable. The existence of the prohibited provision does not invalidate any other provision of the contract.

"**§ 58-3-219. Health claims settlement.**

(a) Proper Reimbursement Required. – All insurers shall properly reimburse claimants for all clean health insurance claims within 30 days of claim submission, whether the claim is filed electronically or submitted on paper.

(b) Claims Editing Process. – Insurers shall have a good faith basis for any claims editing process or program utilized by the insurer including validity edits, consistency edits, and claims rule edits. Descriptions of such editing programs, rules, and procedures

shall be available for review by the Department of Insurance and to contracting providers and their representatives.

(c) Penalties for Failure to Properly Reimburse. – Any insurer that does not comply with subsection (a) of this section shall pay:

(1) One and one-half percent (1.5%) monthly interest to the claimant, accruing from the day after payment is due, on that amount of the claim that remains unpaid; and

(2) After notice and hearing, fines not to exceed one thousand dollars ($1,000) per day that the claim remains unpaid, accruing from the day after payment is due. Fines shall be payable to the Commissioner, who shall then forward the clear proceeds of which to the State Treasurer for deposit in accordance with State law.

(d) Disputed Claims. – Where there is a good faith dispute regarding the legitimacy of a claim or the appropriate amount of reimbursement, notice that a dispute exists shall be furnished by the insurer to the claimant upon receipt of the claim, and in no event later than 14 days after receipt of an electronic claim or 30 days after receipt of a paper claim. Disputes shall be subject to prompt and efficient third-party resolution, either through mandatory arbitration or otherwise as established in rules adopted by the Commissioner. It is a violation of this section for an insurer to fail to properly reimburse a provider for a clean health insurance claim properly submitted without a good faith basis for its failure to properly reimburse.

(e) Claims Processing. – If an insurer requires additional information to process a claim, the insurer must notify the claimant of all deficiencies within 14 days of receipt of an electronic claim or within 30 days of receipt of a paper claim. Resubmission of a claim by a claimant containing all information requested in the notice of deficiency shall be paid by the insurer within 14 days of the insurer's receipt of an electronic claim or within 30 days of the insurer's receipt of a paper claim.

(f) Process for Reporting Delinquent Payments. – The Commissioner shall adopt rules establishing a means by which covered persons, health care providers, and health care facilities may notify the Department of delinquent payments. The Commissioner shall investigate all complaints and shall issue a written response to the complaining party.

(g) Penalty for Retaliation for Reporting Delinquent Payments. – Any insurer that retaliates against a claimant or health care provider for notifying the Commissioner of delinquent payment of claims, by terminating its relationship or otherwise, shall be subject to a fine which may be imposed by the Commissioner in an amount not to exceed five thousand dollars ($5,000). The fine shall be payable to the Commissioner, who shall then forward the clear proceeds of which to the State Treasurer for deposit in accordance with State law.

(h) Definitions. – As used in this section, the term:

(1) ‘Clean health insurance claim' means, but is not limited to, a claim that is submitted on an insurer's standard claim form, which has been completed with all material information requested by the form, and does

not contain attachments or does not require additional information for processing.

(2) 'Health benefit plan' has the same meaning as applicable to the term under G.S. 58-3-205.

(3) 'Insurer' has the same meaning as applicable to the term under G.S. 58-3-205.

(4) 'Proper reimbursement' means the full payment of a clean health insurance claim in accordance with an insurer's reimbursement schedule of reasonable specificity applicable to the claimant and provided to the claimant prior to the claim, such that a claimant would have the ability to understand beforehand the amounts due and conditions of reimbursement."

Section 3. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 upon a determination of a violation by an insurer of G.S. 58-3-219. ~~if an insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim.~~"

Section 4. G.S. 58-3-200(d) reads as rewritten:

"(d) Services Outside Provider Networks. – No insurer shall penalize an insured or subject an insured to additional deductibles for health care services obtained outside the insurer's health benefit plan provider network. ~~the out-of-network benefit levels offered under the insured's approved health benefit plan unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.~~ Health plans shall report, at least monthly, to the Commissioner all complaints by insureds regarding medical care and reasonable access to medical care through the plan. The Commissioner shall investigate and compile complaints regarding reasonable access to and availability of contracting health care providers, provide written responses to each, and report annually to the Joint Legislative Health Care Oversight Commission the total number of complaints, the nature and subject of the complaints, the findings of the Commission, and any other relevant information."

Section 5. G.S. 58-3-191 is amended by adding the following new subdivision to read:

"(1a) The number of claims denied, the reasons for the denials, and the number of times over the year that any particular reason was used as a basis for denying coverage."

Section 6. G.S. 58-3-191 is amended by adding the following new subsection to read:

"(a1) Each health benefit plan shall report, at least monthly, to the Commissioner all complaints by insureds regarding medical care and reasonable access to medical care

through the health benefit plan. The Commissioner shall investigate and compile complaints regarding reasonable access to and availability of contracting health care providers, provide written responses to each complaint, and shall report annually to the Joint Legislative Health Care Oversight Commission the total number of complaints, the nature and subject of the complaints, the findings of the Commissioner, and any other information requested by the Commission or that the Commissioner considers relevant. If the Commissioner finds that a network is not sufficient to provide reasonable access, the Commissioner shall order the insurer to refund all out of network penalties charged to all insureds receiving services from the network, and may impose other penalty the Commissioner deems appropriate pursuant to G.S. 58-2-70."

Section 7. Nothing in this act requires the appropriation of State funds.

Section 8. This act is effective when it becomes law. Section 1 of this act applies to health benefit plans delivered, issued for delivery, renewed, extended, or modified on or after July 1, 2000. For 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.