**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 1999**

**H** **3**

HOUSE BILL 736
Committee Substitute Reported Without Prejudice 4/20/99
Committee Substitute #2 Favorable 4/27/99

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

Sponsors:

Referred to:

March 30, 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 sections to read:

"**§ 58-3-220. Patient access to quality managed health care.**

(a) Definitions. – As used in this section and in G.S. 58-3-225, 58-3-230, and 58-3-235:

(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.

(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. – Each plan shall provide reasonable access to health services offered by the insurer. As long as a qualified provider is available and agrees to the terms of the contract, the 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. The insurer shall not shift the burden of ensuring access to quality health care as prescribed in this subsection to individual providers.

The Commissioner shall determine what constitutes reasonable access to health services offered by an insurer within a network of providers. When determining what shall constitute reasonable access to health services, the Commissioner shall consider the following factors:

(1) The standard of individual care and access to health care in the community;
(2) The type of condition and severity of health condition of the insured;
(3) The insured's 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 against the insurers for failure to provide reasonable access to health 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 civil penalties pursuant to G.S. 58-2-70.

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

(1) The health plan does not require hospital privileges of providers unless such privileges are 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 or indemnification as to any provider acting within the scope of the provider's license or certification solely on the basis of the providers' licenses or classifications.

(3) Not less than 30 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.

(4) The terms and conditions of the plan affecting insureds and providers are not modified without 60 days' 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.

(5) 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, fraud, patient satisfaction, 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. This does not require the insurer to accept the provider; and

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

(6) 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.

(e) Insurer Responsibility for Intermediaries. – For purposes of this section, G.S. 58-3-100, 58-3-191, 58-3-200, 58-3-225, 58-3-230, 58-3-235, 58-67-88, 58-50-62, and 58-67-50, 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.

"**§ 58-3-225. Provider directories.**

(a) As used in this section, 'updated directory information' means the current participation status of a provider, information known to the insurer indicating that a provider is not currently accepting new patients, and other information included in a printed provider directory.

(b) An insurer that uses a network of contracting health care providers for its health benefit plans shall provide a copy of its current provider directory, including any specialty directory, to all insureds on or before the effective date of initial coverage and shall make these directories available to current and prospective insureds upon request. Updated directory information reflecting the most current information available to the insurer shall be available to insureds by telephone and may also be made available by other media.

(c) Each directory shall include, in addition to the name, address, telephone number, and area of specialty for each health care provider and facility in its provider network, an indication of whether the provider:

(1) May be selected as a primary care provider.
(2) Is or is not currently accepting new patients.
(3) Has any other restrictions that would limit an insured's access to coverage from that provider.
(4) A brief explanation, including costs to the insured, of how an insured may access providers outside of the network.
(5) An explanation of the insured's right to transition coverage.
(6) The consumer complaint telephone number at the Department of Insurance.

The directory shall also include the date of its publication and instructions on how a current or prospective insured can obtain information about changes in the provider network or a provider's ability to accept new patients that may have occurred since the most recent printing of the directory.

(d) The directory shall include all of the types of licensed or certified health care providers with which the insurer contracts directly or with whom the insurer has access through a contract with an intermediary organization. If a contracting provider requests,

the names of any allied health care providers who practice and deliver primary care services under the supervision of the contracting provider and whose services are covered by virtue of the carrier's contract with the supervising provider shall be listed as part of the directory listing for the contracting provider.

(e) An insurer may maintain separate directories for specialty services, such as mental health, substance abuse, or centers of excellence, but shall make each of its directories available to current and prospective insureds in accordance with this section.

"**§ 58-3-230. Health plan disclosure requirements.**

At the time of application for and delivery of a health benefit plan, the insurer shall deliver to the applicant and insured a clear and concise description of the coverage provided by the plan. The description shall be printed on a form prescribed by the Commissioner. The description shall include:

(1) Definitions of terms used in the health benefit plan.

(2) A brief description of the principal benefits or coverage provided, including any coverage exclusions or limitations.

(3) A brief description of how coverage determinations are made, including whether factors other than medical necessity and coverage exclusions and limitations are considered.

(4) A brief explanation of insurer and insured payment responsibilities, including how plan allowances, such as 'usual and customary charges,' are developed.

(5) A brief explanation of provider network limitations and requirements, including requirements for the use of subnetworks, when prior authorization or precertification is required, and how tertiary and quaternary care are arranged.

(6) Tax and health plan accreditation status of the insurer.

(7) A statement that the outline is a summary of the health benefit plan and that the health benefit plan should be examined to determine health benefit plan provisions.

(8) A brief explanation, including costs to the insured, of how an insured may access providers outside of the network.

(9) An explanation of the insured's right to transition coverage.

"**§ 58-3-235. Access to eye care providers.**

(a) A health benefit plan offered by an insurer that includes primary eye care benefits and any provider network established by or on behalf of an insurer to provide such benefits shall allow every insured direct access without prior referral to the services of eye care providers for all primary eye benefits provided by the plan and permit any licensed eye care provider who agrees to abide by the terms, conditions, and reimbursement rates, and standards of quality of the health benefit plan to serve as an eye care provider to any person covered by that plan.

(b) Nothing in this section shall be deemed to mandate that an insurer provide any eye care benefits beyond those specified in the health benefit plan.

(c) For purposes of this section:

(1) 'Eye care provider' means a licensed ophthalmologist or licensed optometrist who provides primary eye or vision care services.

(2) 'Primary eye care benefits' means those routine services and materials that are necessary to evaluate the function of the eyes, diagnose, treat, or manage ocular disease or injury, or to fit corrective lenses. This benefit does not include investigational or surgical correction of eye or vision problems."

Section 2. 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, fees, or copayments for health care services covered under the health benefit plan that are obtained outside the insurer's health benefit plan provider network, except that the insurer may charge the insured a fifteen percent (15%) administrative fee per service. ~~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.~~ 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 minus the amount of the administrative fee."

Section 3. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-88. Access to transition care.**

(a) Each health benefit plan shall provide transition coverage for a minimum of 90 days or until the insured's reenrollment, whichever is later, to each insured of a participating health care provider who is no longer in the plan network. If an insured's health care provider leaves or is terminated from an insurer's provider network, the insurer shall reimburse for the insured's treatment by that provider for a minimum of 90 days or until the insured's reenrollment, whichever is later or, for an insured who is beyond the first trimester of a pregnancy, until the conclusion of postpartum care. Except in the case of a pregnancy that is beyond the first trimester, this section is complied with if there is a contractual obligation for the insurer and the provider to provide a minimum notice of cancellation or nonrenewal that will allow an insured to receive care for 90 days before the termination of the contract. The period of transition coverage is deemed to commence on the date that the insurer notifies the insured that the insured's provider will no longer participate in the network.

(b) Each insurer shall provide transition coverage to insureds who are newly covered under a new or existing group contract because of an involuntary change in health plans, during which time they may continue to receive reimbursement for care from a provider authorized to treat them under the previous insurer's plan and have access to prescription drugs covered under the formulary of the previous insurer's plan. Persons eligible for transition coverage are those who are in the second or third trimester of pregnancy or undergoing treatment for a condition or disease that is chronic, degenerative and disabling, or life-threatening. In the case of a member who is beyond the first trimester of a pregnancy at the time of the involuntary plan change, the insurer shall

provide for transition coverage until the conclusion of postpartum care. For all other persons eligible, the transition coverage shall be provided for a minimum period of 180 days. Eligibility and the commencement of the transition period shall be determined by the date on which the insured signed the application or enrollment form for the new insurer. Coverage during the transition period is the responsibility of the new insurer.

(c) Coverage of continued services during a transition coverage period may be made contingent upon the provider's agreement to:

(1) Continue to accept reimbursement for services under the same terms that were provided for in the provider's contract that has been or will be terminated.

(2) Comply with the insurer's requirements for quality assurance.

(3) Refer within the insurer's provider network.

(4) Comply with the insurer's established requirements for participating providers and other policies and procedures, such as data submission and obtaining precertification for certain services.

In the case of an insured's involuntary change of health plans, coverage of services from a provider who contracts with the insured's previous insurer shall be based on the new insurer's provider contracts for comparable services. Except as provided in subsection (b) of this section, nothing in this section requires an insurer to cover services that would not be covered if a member had not been in a transition coverage period. An insurer does not have to offer transition coverage if the insurer terminated the provider's contract for reasons relating to quality of care.

(d) Each insurer shall include a clear description of an insured's rights to transition coverage in its evidence of coverage and summary plan description."

Section 4. Nothing in this act requires the appropriation of State funds.

Section 5. This act is effective when it becomes law and applies to health benefit plans delivered, issued for delivery, renewed, extended, or modified on or after January 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.