

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 455\*

Pensions & Retirement and Insurance Committee Substitute Adopted 4/29/97

Short Title: Improve HMO Services.

(Public)

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Sponsors:

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Referred to:

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March 24, 1997

A BILL TO BE ENTITLED

1 AN ACT TO IMPROVE HMO SERVICES BY PROTECTING PHYSICIAN  
2 COMMUNICATIONS REGARDING TREATMENT, REQUIRING COVERAGE  
3 FOR EMERGENCY CARE, AND REDUCING THE APPROVAL PERIOD FOR  
4 RATE FILINGS.  
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6 The General Assembly of North Carolina enacts:

7 Section 1. Article 3 of Chapter 58 of the General Statutes is amended by  
8 adding the following new section to read:

9 **"§ 58-3-170.1. Treatment discussions not limited.**

10 (a) A health benefit plan shall not limit either of the following:

11 (1) The participating plan provider's ability to discuss with an enrollee the  
12 clinical treatment options medically available, the risks associated with  
13 the treatments, or a recommended course of treatment.

14 (2) The participating plan provider's professional obligations to patients as  
15 specified under the provider's professional license.

16 (b) Nothing in this section shall be construed to:

17 (1) Prevent a health benefit plan from prohibiting disclosure of financial  
18 trade secrets by contracted parties.

19 (2) Expand or revise the scope of benefits covered by a health benefit plan.

1 (c) As used in this section, 'health benefit plan' means accident and health  
2 insurance policies or certificates; nonprofit hospital or medical service corporation plan  
3 contracts; health, hospital, or medical service corporation plan contracts; health  
4 maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA  
5 or plans provided by other benefit arrangements, to the extent permitted by ERISA."

6 Section 2. Chapter 58 of the General Statutes is amended by adding the  
7 following new section to read:

8 **"§ 58-3-190. Coverage required for emergency care.**

9 (a) Every entity providing a health benefit plan shall provide coverage for  
10 emergency services at least to the extent necessary to screen and to stabilize the person  
11 covered under the plan and shall not require prior authorization of the services if a  
12 prudent layperson acting reasonably would have believed that an emergency medical  
13 condition existed. Payment of claims for emergency services shall be based on the  
14 retrospective review of the presenting symptoms.

15 (b) With respect to emergency services provided by a health care provider who is  
16 not under contract with the plan, the services shall be covered if:

- 17 (1) A prudent layperson acting reasonably would have believed that a delay  
18 would worsen the emergency, or  
19 (2) The covered person did not seek services from a provider under contract  
20 with the plan because of circumstances beyond the control of the  
21 covered person.

22 (c) If a health benefit plan has given prior authorization for emergency services,  
23 then the plan shall cover the services and shall not retract the authorization after the  
24 services have been provided unless the authorization was based on a material  
25 misrepresentation about the covered person's health condition made by the provider of  
26 the emergency services or the covered person.

27 (d) Coverage of emergency services shall be subject to coinsurance, co-payments,  
28 and deductibles applicable under the health benefit plan. A health benefit plan shall not  
29 impose cost-sharing for emergency services provided under this section that differs from  
30 the cost-sharing that would have been imposed if the physician or provider furnishing the  
31 services were a provider contracting with the health benefit plan.

32 (e) Both the emergency department and the health benefit plan shall make a good  
33 faith effort to communicate with each other in a timely fashion to expedite post-  
34 evaluation or post-stabilization services in order to avoid material deterioration of the  
35 covered person's condition within a reasonable clinical confidence, or, with respect to a  
36 pregnant woman, to avoid material deterioration of the condition of the unborn child  
37 within a reasonable clinical confidence.

38 (f) Health benefit plans shall provide information to their covered persons on all  
39 of the following:

- 40 (1) Coverage of emergency medical services.  
41 (2) The appropriate use of emergency services, including the use of the  
42 '911' system and other telephone access systems utilized to access  
43 prehospital emergency services.

- 1           (3) Any cost-sharing provisions for emergency medical services.
- 2           (4) The process and procedures for obtaining emergency services, so that
- 3           covered persons are familiar with the location of in-plan emergency
- 4           departments and with the location and availability of other in-plan
- 5           settings at which covered persons may receive medical care.
- 6       (g) As used in this section, the term:
- 7           (1) 'Emergency medical condition' means a medical condition manifesting
- 8           itself by acute symptoms of sufficient severity, including but not limited
- 9           to severe pain, or by acute symptoms developing from a chronic
- 10           medical condition that would lead prudent layperson, possessing an
- 11           average knowledge of health and medicine, to reasonably expect the
- 12           absence of immediate medical attention to result in any of the following:
- 13           a. Placing the health of an individual, or, with respect to a pregnant
- 14           woman, the health of the woman or her unborn child, in serious
- 15           jeopardy.
- 16           b. Serious impairment to bodily functions.
- 17           c. Serious dysfunction of any bodily organ or part.
- 18           (2) 'Emergency services' means health care items and services furnished or
- 19           required to screen for and treat an emergency medical condition until
- 20           the condition is stabilized, including prehospital care and ancillary
- 21           services routinely available to the emergency department.
- 22           (3) 'Health benefit plan' means accident and health insurance policies or
- 23           certificates; nonprofit hospital or medical service corporation contracts;
- 24           health, hospital, or medical service corporation plan contracts; health
- 25           maintenance organization (HMO) subscriber contracts; and plans
- 26           provided by a MEWA or plans provided by other benefit arrangements,
- 27           to the extent permitted by ERISA.
- 28           (4) 'To stabilize' means to provide medical care that is appropriate to
- 29           prevent a material deterioration of the person's condition, within
- 30           reasonable medical probability, in accordance with the HCFA (Health
- 31           Care Financing Administration) interpretative guidelines, policies and
- 32           regulations pertaining to responsibilities of hospitals in emergency cases
- 33           [reference Section 1867 (EMTALA-Emergency Medical Treatment and
- 34           Labor Act)]."

35           Section 3. G.S. 58-67-50(c) reads as rewritten:

36           "(c) The Commissioner shall, within a reasonable period, approve any form if the

37 requirements of subsection (a) of this section are met and any schedule of premiums if

38 the requirements of subsection (b) of this section are met. It shall be unlawful to issue the

39 form or to use the schedule of premiums until approved. If the Commissioner disapproves

40 the filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall

41 specify the reasons for disapproval. A hearing will be granted within 30 days after a

42 request in writing by the person filing. If the Commissioner does not approve or

43 disapprove any form or schedule of premiums within 90 days after the filing for forms

1 and within ~~60~~45 days after the filing for premiums, they shall be deemed to be  
2 approved."

3           Section 4. Section 2 of this act becomes effective January 1, 1998, and applies  
4 to health benefit plans issued, renewed, or amended on or after that date. The remainder  
5 of this act becomes effective July 1, 1997.