NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: HB 736 Proposed Committee Substitute

SHORT TITLE: Managed Care/Patient Access

SPONSOR(S): Rep. Rogers

FISCAL IMPACT

Yes ( ) **No (X)** **No Estimate Available ( )**

	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04
REVENUES					
EXPENDITURES					
POSITIONS:					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Insurance

EFFECTIVE DATE: Sections 1, 2, 3, 4, 5, 6, and 7 apply to all health benefit plans that are delivered, issued for delivery, or renewed on and after July 1, 2000. Sections 8.1, 8.2, 8.3, 8.4, 9, and 10 apply to all health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. The rest of the act is effective when it becomes law. For the purposes of the 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.

BILL SUMMARY: (Taken from bill analysis prepared by Committee Counsel for House Health Committee)

Section 1. Adds a new section to Article 3 of Chapter 58:

Applicability: Defines *"Health benefit plan" and "Insurer":* These terms are broadly defined to include traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans would be exempt from these requirements. Many employers, particularly larger employers, self-fund health benefit plans for their employees. These self-funded plans are exempt from State regulation because of a federal law, the Employee Retirement Income Security Act (ERISA), governing employee pension and benefit plans.

Provider networks: Requires insurers to design their networks to meet specific access and sufficiency requirements in terms of numbers and classes of contracted providers within a

specified geographic area or areas covered by the health plan, *subject to the availability and willingness of providers to contract with the insurer.*

Commissioner's duty to determine "reasonable access to health services": Provides specific factors the Commissioner must use to determine whether an insurer's network provides reasonable access to health care for its insured.

Provider protections:

- *Hospital privileges*: insurers would not be able to require providers to obtain hospital privileges in order to contract with the insurer if hospital privileges are not necessary for that provider to perform the covered services to the insured.
- *Discrimination:* insurers would not be able to discriminate between different classes of providers acting within their scope of practice.
- *Notice of termination:* insurers would be required to provide at least 30 days notice and the basis (in writing) for termination to providers.
- *Notice of contract modifications:* insurers would be required to provide at least 60 days notice of any proposed change in the terms and conditions of the health plan to insured and providers.
- *Objective selection criteria:* insurers would be required to base provider selection criteria on relevant objective criteria solely related to quality of care and scope of practice.
- *Clinical peers:* insurers would be required to include a provider of the same type of license or a clinical peer if the provider is a medical doctor on utilization or grievance panels.

Insurer responsibility of intermediaries: Intermediaries are entities that contracts with the insurer to provide health care services by employing or sub-contracting with health care providers. This section would require insurers to make sure that the intermediaries they contract with comply with the same laws and regulations regarding access to health care.

Provider directories: This section adds a new G.S. 58-3-225 to regulate the content and availability of an insurer's directory of contracting health care providers.

Health plan disclosure requirements: Adds a new G.S. 58-3-230 that provides for specific disclosure requirements by health benefit plans to applicants and insured, including:

- Definitions of terms used in the health benefit plan,
- Principal benefits of coverage provided and any coverage exclusions or limitations,
- How coverage determinations are made,
- Insurer and insured payment responsibilities,
- Provider network limitations and requirements,
- Tax and health benefit plan accreditation status of the insurer,
- A description of the insured's rights to transition coverage,
- An explanation of how an insured can access out-of-network providers and any additional costs associated with doing so.
- A statement that these descriptions are summaries and that the health benefit plan itself should be examined to determine health benefit plan benefits.

Direct access to eye care specialists: With the exception of OB/GYN services, current North Carolina law does not provide individuals enrolled in health benefit plans with direct access to providers who are not traditionally considered primary care providers. This section adds a new G.S. 58-3-235 requiring health benefit plans that include primary eye care benefits to allow every insured direct access *without prior referral* for primary eye care services to any optometrists and ophthalmologists willing to accept the terms and conditions of the insurer.

Section 2. Amends G.S. 58-3-200(d) to provide for out-of network coverage:

Insured protections: Under current law, insurers are prohibited from penalizing a insured when they seek treatment from a provider outside the insurer's network of contracted physicians *when they can not reasonably obtain the same services from someone within the insurer's network.* This section would amend this provision to provide that insurers may not penalize insured when they go out of the network for any reason. They would, however be subject to an administrative surcharge of 5.5% or $40.00 (whichever is less) for each service provided by an out-of –network provider.

Provider protections: This section also provides that insurers would not be able to pay the out-of-network provider less than what contracted providers receive for the same service.

Section 3. Transition Coverage: This section adds a new G.S. 58-67-88 to establish a mechanism for transition coverage for health benefit plans offered by HMOs only that are not point-of-service plans. (A point-of-service POS option is a type of plan offered by managed care organizations, including health maintenance organizations that allow people who are willing to pay higher out-of-pocket costs to see out-of-plan providers).

This section requires a minimum of 90 days or until reenrollment (whichever is longer) to each insured for services provided by a health care provider shown as a currently participating provider at the time of enrollment, who will no longer participate in the plan network. If a person becomes newly covered by an HMO because of an involuntary change in health benefit plans, the section requires the new plan to provide 180 days transition coverage.

Section 4. This act does not require an appropriation of State funds.

PART XII: EFFECT OF HEADINGS.

Section 12. Provides that the headings to the parts of the act are a convenience to the reader and are for reference only.

ASSUMPTIONS AND METHODOLOGY:

This bill expands the current North Carolina law regulating managed care organizations. Expanding the regulations with which entities must comply may in some instances impact the entities' cost of operations. However, expanding the regulations may also have a fiscal impact on the governmental entity responsible for ensuring compliance with the regulatory requirements. In North Carolina, the Managed Care and Health Benefits Division within the Department of Insurance is responsible for monitoring and regulating the activities of managed care entities. These entities include health maintenance organizations, preferred provider organizations, managed care indemnity health insurers, and multiple employer welfare arrangements. The Division monitors and regulates the activities of the managed care entities through market practice examinations of companies, review of document filings required of companies, and data collection and analysis.

The Division currently conducts examinations, lasting from two to eight weeks, which entail comprehensive reviews of the policies, procedures and practices in major operational areas of the company. The Division also reviews filings for an HMO certificate of authority and form health care provider contracts used by HMO and managed care indemnity health insurers and annual filings from PPOs. The review of the filings permit evaluation of the companies'

practices and compliance with written policies and procedures and compliance with regulations pertaining to carriers' responsibilities for arranging the provider networks.

This bill requires the managed care entities to provide additional consumer and provider protections which include the following: sufficiency of provider networks, provider termination protections, provider discrimination protections, health plan reporting requirements, provider participation on utilization and grievance review panels, direct access to eye care providers, health benefit plan disclosure requirements, health plan transition coverage, and provider directories. The Department of Insurance believes that the additional protections provided by the bill require an increase in their current level of review and enforcement activity. Specifically they believe that ensuring compliance with the health benefit plan disclosure requirements and determining whether the insurer has provided reasonable access to health services within the network of providers will increase their level of forms review and enforcement. Further, the Division also believes that the list of specific factors for determining reasonable access to health services will provide a basis for more consumer complaints than are currently filed.

The Department estimates that the increased level of review and enforcement activity will require the time and effort equivalent to one Regulatory Analyst II at an annual salary, including benefits, of $42,000. Additional nonrecurring funds totaling $10,000 would be needed for office furniture and desktop PC ($3,000) and for restructuring existing facilities ($7,000) to create office space for the position. The Fiscal Research Division believes, however, that the Department can perform the review and enforcement activity required to ensure compliance with the requirements of the bill with its existing staff. The Department currently has staff who perform comprehensive reviews of managed care organizations on a periodic basis as well as reviews of form provider contracts and annual filings. To accommodate any increased effort required by the bill, we recommend that the Department review the scope and, if appropriate, the frequency of the current level of review and enforcement activity to identify areas where less review and enforcement are needed. We note, however, that a year of experience may reveal a substantial increase in the number of complaints and instances of noncompliance that warrant an increase in the level of review and enforcement activity and additional resources to maintain an adequate level of effectiveness.

FISCAL RESEARCH DIVISION 733-4910
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DATE: Wednesday, April 28, 1999

Signed Copy Located in the NCGA Principal Clerk's Offices