February 21, 2001

H 194. MANAGED CARE PATIENTS' BILL OF RIGHTS. *TO IMPROVE ACCESS TO HEALTH CARE ADVICE, INFORMATION, AND SERVICES TO COVERED PERSONS UNDER HEALTH BENEFIT PLANS; ESTABLISH STANDARDS FOR HEALTH PLAN DISCLOSURES TO CONSUMERS; ESTABLISH A MANAGED CARE OMBUDSMAN PROGRAM; REQUIRE COVERAGE FOR CLINICAL TRIALS AND NEWBORN HEARING SCREENING; PROVIDE STANDARDS FOR INDEPENDENT REVIEW OF NONCERTIFICATIONS BY AN INSURER OR MANAGED CARE PLAN, AND TO HOLD MANAGED CARE ENTITIES LIABLE FOR HARM CAUSED TO INSUREDS OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING TREATMENT DECISIONS*.

Part I. Patient Access to Medical Advice and Care

Continuity of Care in HMOs. Adds new GS 58-67-88, requiring HMOs to provide continuity of care for patients who are terminally ill or are receiving care for an ongoing special condition (defined as an acute illness serious enough to require medical care to avoid death or permanent harm; a chronic illness or condition that is life-threatening, degenerative, or disabling and requires care over a prolonged period; or pregnancy). When an HMO terminates its contract with the patient's health care provider, or the benefits or coverage provided by the patient's health care provider are terminated because of a change in the terms of the provider's participation in the HMO, the HMO must (1) notify patients with terminal illness or ongoing special conditions, and (2) permit the patients to elect to continue to be covered for care by the health care provider during a transitional period. Provides for a standard transitional period of up to 90 days, as determined by the health care provider. Other transitional periods are provided for special conditions: (1) an extended transitional period is available for scheduled surgery, organ transplantation, or institutional care; (2) the transitional period for pregnancy extends through the provision of post-partum care; and (3) the transitional period for terminal illness extends to the end of the patient's life with respect to care directly related to the terminal illness. Permits HMOs to condition the continuing care upon the provider's willingness to accept reimbursement at rates applicable before the transitional period, and to adhere to the HMO's quality assurance standards and to other policies and procedures for participating providers. Requires HMOs to notify enrollees of the right to continuity of care.

Extending or Standing Referral to Specialist. GS 58-3-223 requires insurers that do not allow direct access to specialists to have policies and procedures permitting insureds to receive extended or standing referrals to in-plan specialists for serious or chronic degenerative, disabling, or life-threatening conditions requiring on-going specialty care. Bill amends the statute to require insurers to permit standing referrals to specialists with subspecialty training in pediatrics for children under the age of 18 with such conditions, and to permit extended or standing referrals to out-of-network specialists when in-plan specialists are not available without unreasonable delay.

Selection of Specialist as Primary Care Physician. Adds new GS 58-3-230, requiring insurers to have policies and procedures permitting an insured with a serious or chronic degenerative, disabling, or life-threatening disease or condition to select a specialist as the insured's primary care physician, if the insurer determines that the insured's care would most appropriately be coordinated by the specialist. Requires insurer to permit the use of a specialist that does not participate in the insurer's plan if a participating specialist is not available without unreasonable delay.

Direct Access to Pediatrician. Adds new GS 58-3-240, requiring insurers that use networks of contracting health care providers to permit insureds to choose a contracting pediatrician as the primary care provider for the insured's children under the age of 18.

Access to Prescription Drugs. Amends GS 58-3-221 to require insurers that restrict access to covered prescription drugs or devices to meet all the requirements of that section (currently applies only to insurers that maintain closed formularies). Defines "restricted access drug or device" as a covered prescription drug or device for which reimbursement is conditioned in one of two ways: (1) the insurer approves the prescription in advance, or (2) the health care provider prescribes one or more alternative drugs or devices before prescribing the drug or device in question.

Managed Care Ombudsman Program. Establishes Office of Managed Care Ombudsman and provides that an ombudsman will be appointed by the Governor. Sets forth duties and

responsibilities for the ombudsman that are substantially similar to those in H 36, introduced 2/1/01. H 36 placed the office in the Dep't of Insurance and provided an appropriation for it. This bill does not specify the administrative location of the office or provide an appropriation; rather, it provides that administrative and financial support for the office shall be provided from fees collected by the Insurance Comm'r.

Part II. Health Plan Disclosures

Managed Care Reporting and Disclosure Requirements. Amends GS 58-3-191(b) to require health benefit plans to disclose to plan participants and prospective participants the plan's closed formularies and restricted access drugs or devices.

Provider Directory Information. Adds new GS 58-3-245, requiring health benefit plans that use provider networks to make available to insureds a listing of all network providers and to update the listing at least once a year. Also requires plans to provide an electronic, on-line, or telephonic system providing up-to-date information.

Disclosure of Payment Obligations. Adds new GS 58-3-250, requiring insurers that calculate benefit amounts for covered services through a method other than a fixed dollar amount co-payment to disclose to insureds how they determine payment obligations.

Part III. Mandated Benefits

Clinical Trials. Adds new GS 58-3-255, requiring health benefit plans to pay for the medically necessary costs of insureds' participation in covered clinical trials. Defines "covered clinical trials" as patient research studies designed to evaluate new treatments, including prescription drugs, that (1) involve the treatment of life-threatening medical conditions, (2) are clearly superior to available noninvestigational treatment alternatives, and (3) have clinical and preclinical data demonstrating that the trial will be at least as effective as noninvestigational alternatives. Sets forth additional requirements for a study to qualify as a covered clinical trial.

Newborn Hearing Screening. Adds new GS 58-3-260, requiring health benefit plans to pay for newborn hearing screening ordered by the attending physician pursuant to GS 130A-125.

Part IV. External Review and Managed Care Entity Liability

Independent, External Review Process. Identical to the external review provisions of S 21, introduced 1/30/01.

Health Plan Liability. Substantially identical to the liability provisions of S 21, introduced 1/30/01.

The provisions of Part IV are effective Dec. 1, 2002. Remainder effective when it becomes law, and applies to health benefit plans that are delivered, issued for delivery, or renewed on or after Jan. 1, 2002.

Intro. by Baddour, Nye, Hackney, Justus.

Ref. to Rules	GS 1A, 58, 90