February 22, 2001

S 199. MANAGED CARE PATIENTS' BILL OF RIGHTS (=H 194). *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*. Identical to H 194, introduced 2/21/01.

Intro. by Wellons, Purcell, Forrester.

Ref. to Insurance	GS 1A, 58, 90

April 25, 2001

S 199. MANAGED CARE PATIENTS' BILL OF RIGHTS. Intro. 2/22/1. Senate committee substitute makes the following changes to 1st edition. Changes bill's title to AN *ACT 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 PATIENTS' ASSISTANCE 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 INSURED OR ENROLLEES BY THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING TREATMENT DECISIONS*. (1) With respect to continuation of services upon the termination of an HMO agreement, limits the obligation of the HMO with respect to pregnancy to 60 days postpartum and adds a specification that an HMO is not obligated to continue services that would constitute a danger to the enrollee. (2) With respect to access to specialist care, amends GS 58-3-200(d) to limit ability of HMO to subject enrollee to out-of-network provisions for such access. (3) With respect to selection of a specialist as the primary care provider, adds to new GS 58-3-230 a statement that if the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider. (4) With respect to access to drugs outside an insurer's closed formulary, amends GS 58-3-221 to provide that the complete list of the formulary must be available to enrollees and must permit access to non-formulary drugs upon certain representations by the treating physician. (5) Renames bill's provisions for a Managed Care Ombudsman Program as the Managed Care Patients' Assistance Program. (6) With respect to provider directories, adds detail to new GS 58-3-245 as to what the directory is to contain. (7) With respect to access to clinical trials, removes requirement in new GS 58-3-255 that the trials must be approved by the applicable qualified institutional review boards, and adds a provision specifying that the insurer may deny a claim for payment with respect to clinical trials if costs that need not be covered are intertwined with costs that must in a way that cannot be separated out. (8) With respect to external reviews of decisions to deny certification of coverage, provides that the Comm'r is to make assignment to external reviewer on a systematic rotating basis. Also adds a provision that the reviewer is not bound by any decisions or conclusions reached during the insurer's utilization review process or in the internal grievance process. Adds requirements with respect to external review organizations. (9) With respect to liability for coverage violations, adds to new GS 90-21.54 a provision that no action may be commenced until the plaintiff has exhausted all administrative remedies and appeals, including internal ones. (10) With respect to medical records, adds a provision amending GS 58-2-105 concerning disclosure of medical records to external review organizations.