GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 881

Short Title: Coverage for Emergency Services. (Public)

Sponsors: Senators Winner; Forrester, Gulley, Lee, Miller, and Perdue.

Referred to: Pensions & Retirement and Insurance.

April 15, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO PROVIDE COVERAGE FOR CERTAIN EMERGENCY MEDICAL CARE SERVICES.

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 section to read:

"**§ 58-3-190. Requirements for emergency medical care services.**

(a) Every entity providing a health benefit plan shall provide coverage for emergency services at least to the extent necessary to screen and stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

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

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the plan because of circumstances beyond the control of the covered person.

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

(d) Coverage of emergency services shall be subject to coinsurance, copayments, and deductibles applicable under the health benefit plan. A health benefit plan shall not impose cost sharing for emergency services provided under the circumstances described in subsections (b) and (c) of this section that differs from the cost sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the health benefit plan.

(e) To promote continuity of care and optimal care by the health benefit plan physician, when post-evaluation or post-stabilization services are immediately required, the treating physician or a designated representative shall make a good faith effort to contact the appropriate health benefit plan physician as soon as possible after the covered person has been screened and stabilized. Both the emergency department and the health benefit plan shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or, with respect to a pregnant woman, to avoid material deterioration of the condition of her unborn child within a reasonable clinical confidence. If the treating physician and the health benefit plan physician are unable to agree on the provision of post-evaluation or post-stabilization services, then the health benefit plan shall pay for the services unless:

(1) A health benefit plan physician with appropriate expertise to evaluate the suspected clinical problem arrives at the hospital emergency department immediately to assume responsibility for the treatment of the covered person, or

(2) The treating physician and the health benefit plan physician agree to transfer the covered person to another facility using medical resources consistent with the condition of the covered person, and the treating physician determines that the covered person is stabilized for purposes of transfer to another facility.

(f) Health benefit plans shall provide information to their covered persons on:

(1) Coverage of emergency medical services;

(2) The appropriate use of emergency services, including the use of the '911' system and other telephone access systems utilized to access prehospital emergency services;

(3) Any cost sharing provisions for emergency medical services; and

(4) The process and procedures for obtaining emergency medical services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of an individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy,

b. Serious impairment to bodily functions, or

c. Serious dysfunction of any bodily organ or part.

(2) 'Emergency services' means health care items and services furnished or required to screen for and treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(3) 'Health benefit plan' means accident and health insurance policies or certificates, nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements to the extent permitted by ERISA.

(4) 'Stabilize' means:

a. For purposes of obtaining post-stabilization authorization for further testing or care, no material deterioration of the covered person's condition is considered likely within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of her unborn child within a reasonable clinical confidence.

b. For purposes of transferring a covered person from one facility to a second facility, the covered person is expected to leave the hospital and be received at a second facility with no material deterioration in the person's condition; and, the treating physician attending the covered person in the emergency department reasonably expects that the medical care available at the receiving facility is no less than the medical care that would be provided at the transferring facility; or

c. For purposes of discharging a covered person, other than for the purpose of transfer to another facility, that further medical care including diagnostic workup or treatment could be reasonably performed on anything other than an immediate inpatient basis, provided the covered person is given a reasonable plan for appropriate follow up care and discharge instructions."

Section 2. For purposes of this act, renewal of a health benefit plan, policy, or contract 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, policy, or contract.

Section 3. This act becomes effective July 1, 1997, and applies to health benefit plans issued, renewed, or amended on and after that date.