

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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SENATE BILL 973
Commerce Committee Substitute Adopted 4/30/97
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Short Title: Health Plan Information.

(Public)

Sponsors:

Referred to:

April 21, 1997

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO PROVIDE CERTAIN
3 INFORMATION.

4 The General Assembly of North Carolina enacts:

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

7 "**§ 58-3-190. Managed care reporting and disclosure requirements.**

8 (a) Each health benefit plan shall annually, on or before the first day of March of
9 each year, file in the office of the Commissioner the following information, to the extent
10 applicable:

11 (1) The number of and reasons for complaints by plan participants
12 regarding medical treatment received by the plan;

13 (2) The number of participants who terminated coverage under the plan for
14 any reason;

15 (3) The number of provider contracts that were terminated in the preceding
16 year and the reasons for termination. This information shall include the
17 number of providers leaving the plan and the number of new providers.
18 This paragraph does not require the disclosure of any identifying

1 information about a provider, and no civil liability shall arise from
2 compliance with this paragraph;

3 (4) Utilization data that includes statistics relating to the utilization, quality,
4 availability, and accessibility of services, as defined by the
5 Commissioner; and

6 (5) Aggregate financial compensation data, including the percentage of
7 providers paid under a capitation arrangement, discounted fee-for-
8 service or salary, the services included in the capitation payment, and
9 the range of compensation paid by withhold or incentive payments.
10 This information shall be submitted on a form prescribed by the
11 Commissioner.

12 (b) Disclosure requirements. – Each health benefit plan shall provide the following
13 applicable information to plan participants and prospective participants upon request:

14 (1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-
15 65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125,
16 58-50-55), or the contract and benefit summary of any other type of
17 health benefit plan.

18 (2) The plan's utilization review criteria or treatment protocol used to
19 determine the medical necessity of a specific procedure or treatment;

20 (3) The plan's restrictive formularies or prior approval requirements for
21 obtaining prescription drugs, whether a particular drug or therapeutic
22 class of drugs is excluded from its formulary, and the circumstances
23 under which a nonformulary drug may be covered; and

24 (4) The plan's procedures and medically based criteria for determining
25 whether a specified procedure, test, or treatment is experimental.

26 (c) For purposes of this section, 'health benefit plan' or 'plan' means accident and
27 health insurance policies or certificates; hospital, medical, or dental service corporation
28 contracts; health maintenance organization (HMO) subscriber contracts; and plans
29 provided by a MEWA or plans provided by other benefit arrangements, to the extent
30 permitted by ERISA."

31 Section 2. This act becomes effective October 1, 1997.