GENERAL ASSEMBLY OF NORTH CAROLINA

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SENATE BILL 973
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Short Title: Health Plan Information. (Public)

Sponsors:

Referred to:

April 21, 1997

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS TO PROVIDE CERTAIN INFORMATION.

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. Managed care reporting and disclosure requirements.**

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

(1) The number of and reasons for complaints received from plan participants regarding medical treatment;

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

(3) The number of provider contracts that were terminated in the preceding year and the reasons for termination. This information shall include the number of providers leaving the plan and the number of new providers;

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

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

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

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

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

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

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

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

(c) For purposes of this section, 'health benefit plan' or 'plan' means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans in which utilization review or quality management programs are used to manage the provision of covered health care services, and enrollees are given incentives through benefit

differentials to limit the receipt of covered health care services to those provided by participating providers."

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