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Short Title:	Managed Care/Patient Access.	(Public)
Sponsors:	Representatives Nye; and Wainwright.	
Referred to:	Insurance.	

April 11, 2001

A BILL TO BE ENTITLED

AN ACT TO IMPROVE NORTH CAROLINA'S LAWS PERTAINING TO ACCESS TO EYE CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-245. Requirements for access to eye care providers.**

(a) A health benefit plan offered by an insurer that provides eye or vision care benefits and any provider network established by or on behalf of the insurer to provide those benefits shall:

(1) Allow every insured direct access, without prior referral, to the services of eye care providers within the provider network for all primary eye or vision care benefits provided by the plan.

(2) Permit any licensed eye care provider who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as an eye care provider of primary eye or vision care benefits to any person covered by the plan. The plan shall allow every contracting eye care provider pursuant to this subdivision to provide covered primary eye or vision care services to covered persons within the full scope of the contracting provider's licensure in accordance with North Carolina State law.

(3) Permit every insured under the health benefit plan to choose any eye care provider licensed in this State to provide primary eye or vision care benefits covered under the health benefit plan, whether the provider is a contracting provider within the health benefit plan or a noncontracting provider. The insurer shall reimburse the noncontracting eye care provider for services covered under the health benefit plan in the same manner, to the same extent, at the same rate,

and on the same payment schedule as the insurer reimburses eye care providers within the insurer's provider network.

(b) The following contracting requirements shall apply to agreements entered into pursuant to subdivision (a)(2) of this section:

(1) An insurer, or the utilization review organization or intermediary acting on the insurer's behalf to establish a network of eye care providers, shall not exclude an eye care provider from contracting under subdivision (a)(2) of this section solely because the eye care provider lacks hospital privileges or a particular license or certification if the privileges, license, or certification are not reasonably necessary to provide primary eye or vision care benefits. State, federal, or private accrediting organization credentialing requirements that apply to the insurer are deemed, as a matter of law, reasonably necessary.

(2) In addition to meeting the specific requirements prescribed in subdivision (1) of this subsection, the insurer, or the utilization review organization or intermediary acting on the insurer's behalf to establish a network of eye care providers, shall:

a. Establish relevant objective written criteria for contracting with and credentialing eye care providers.

b. Establish reasonable time frames for eye care provider enrollment, which may be continuous, or, at a minimum, at least twice a year.

c. Complete the credentialing process for contracting eye care providers within 60 days of receipt of all information necessary to review the provider's request for participation in the plan.

d. Make criteria for provider participation in the plan available to all eye care providers who request a copy of the criteria.

(3) No contract provision with respect to reimbursement for services to an eye care provider contracting under subdivision (a)(2) of this section shall discriminate solely on the basis of licensure.

(4) An insurer, or a utilization review organization or intermediary acting on the insurer's behalf to establish a network of eye care providers, may terminate or refuse to renew the contract of an eye care provider with whom it has contracted for primary eye or vision care services, only for cause.

(c) Nothing in this section shall be deemed to require an insurer to (i) offer or provide any eye or vision care benefits beyond those specified in the health benefit plan or (ii) contract directly with an eye care provider if the insurer uses a utilization review organization or intermediary to establish a network of eye care providers.

(d) Definitions. – As used in this section:

(1) 'Eye care provider' means a licensed ophthalmologist or licensed optometrist who provides eye or vision care services to any individual

requesting services who is eligible for Medicaid or Medicare coverage as well as other individuals requesting services.

(2) 'Health benefit plan' has the meaning applied under G.S. 58-3-167.

(3) 'Insurer' has the meaning applied under G.S. 58-3-167.

(4) 'Primary eye or vision care benefits' means those routine services and materials that are necessary to evaluate the function of the eyes, diagnose, treat, or manage ocular disease or injury, or fit corrective lenses, but does not include investigational or surgical correction of eye or vision problems.

(5) 'Private accrediting organization' means either of the following independent accrediting organizations: the National Committee for Quality Assurance or the American Accreditation HealthCare Commission."

SECTION 2. G.S. 58-50-62(f) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision.

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical

peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(3) In addition to meeting the specified requirements of subdivision (2) of this subsection, in all cases where the matter giving rise to the second-level review involves a noncertification or clinical issue involving an eye care provider's rendering of eye or vision care services, the insurer shall include on the second-level review grievance panel at least one provider with the same type of license as that eye care provider."

SECTION 2.1. A patient shall have the same right to receive a copy from the provider of a contact lens prescription as that person has under law for a copy of a prescription for lenses for eyeglasses.

SECTION 3. This act becomes effective October 1, 2001, and applies to all health benefit plans that are issued or renewed on or after that date. The renewal of a health benefit plan is presumed to occur on each anniversary date on which the coverage was first effective on the persons covered by the health benefit plan.