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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House Committee Substitute Favorable 8/13/97

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 by plan participants regarding medical treatment received by the plan;

(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.

This paragraph does not require the disclosure of any identifying information about a provider, and no civil liability shall arise from compliance with this paragraph;

(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.

(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and 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) The plan's utilization review criteria or treatment protocol used to determine the medical necessity of a specific procedure or treatment;

(3) 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

(4) 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) 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.