

CONSUMER PROTECTIONS

North Carolina law requires that health insurance and health maintenance organization (HMO) products sold in the state provide certain consumer protections. These consumer protections are generally applicable to:

- ◆ Non-group policies
- ◆ Most small group policies
- ◆ Large groups that purchase health insurance through an HMO, a commercial carrier, or Blue Cross and Blue Shield of North Carolina

There are special consumer protections built into the laws governing small-group and large-group insurance. Those protections are listed in Part III.

Most of the consumer protections listed in this chapter are not applicable to groups that self-fund or are otherwise exempt from state law (unless otherwise stated). For information on self-funded (ERISA) plans, please see Chapter 11.

Throughout this chapter, insurance companies and HMOs are referred to collectively as “insurers” or “health plans.” Sometimes, the chapter refers to managed care organizations—which typically includes HMOs, Preferred Provider Organizations (PPOs), or Point-of-Service (POS) plans. When a law or provision refers specifically to an HMO, this term is used. Individuals who are insured by or covered under a health plan are referred to as “enrollees.” Other documents may refer to enrollees as insureds, members, patients, or beneficiaries.

This chapter concerns general consumer protections in the following areas:

Access to Providers

Continuing Care Retirement Communities

Maintaining Relationships with Existing Providers (Continuity of Care)

Network Adequacy

No Penalty for Going Outside a Network if Insufficient Providers

Obstetricians and Gynecologists

Optometrists, Podiatrists, Certified Clinical Social Workers, Certified Substance Abuse Professionals, Licensed Professional Counselors, Dentists, Chiropractors, Psychologists, Pharmacists, Certified Fee-Based Practicing Pastoral Counselors, Advanced Practice Nurses, Nurse Practitioners

Pediatricians

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Specialists

Using Specialists and Primary Care Providers

Standing Referrals to Specialists

Appeals and Grievances, External Review, and Right to Sue

- Internal Appeal and Grievance Procedures
- Appeals of Noncertification Decisions
- First-Level Grievance Reviews
- Second-Level Grievance Hearings
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- False and Misleading Advertisements
- Information About Treatment of Certain Health Conditions
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- Materials Must Be Understandable
- Provider Directories

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- Patient Advocacy Office

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Mental or Physical Conditions
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- Prescription Drugs
- Prescription Drugs for Cancer Treatment
- Prostate-Specific Antigen Test
- Public Health Measures
- Reconstructive Breast Surgery
- Tax-Supported Institutions
- Temporomandibular Joint Treatment

¹ Note: Insurers and HMOs are not always required to provide all the mandated benefits listed in this section. Some of the mandated benefits are limited to group plans. Other laws require insurers to cover certain services if the insurer or HMO already is providing a similar benefit. The extent of the mandate is described in more detail in the section below on Mandated Benefits.

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Nondiscrimination Against Certain Health Professionals

Prohibition on Certain Managed Care Provider Incentives

Prompt Payment

Providers Protected From Retaliation When Filing Appeals on Behalf of Enrollees

Quality Assurance

Internal Quality Assurance Systems

Provider Credentialing Procedures

Provider Discipline Systems

Regulatory Oversight by the NC Department of Insurance

Accountability and Enforcement Mechanisms

Consumer Services Division

Financial Solvency

Adequate Financial Resources

Insolvency Protections
Obtaining Other Coverage Upon Insolvency
Premium Rate Oversight
Premium Rates Established
Premium Rates Periodic Adjustments

Utilization Review

Assessing Utilization of Health Services
Conducting Utilization Reviews
Medical Necessity Standards
Notice to Enrollees About Utilization Review Procedures
Time Limits for Review

Each section below provides a reference to the laws codified in the North Carolina Statutes [N.C.G.S.], or to the North Carolina Administrative Code—the regulations that govern insurance companies and HMOs [N.C.A.C.]. There is also a glossary at the end of this book.

ACCESS TO PROVIDERS

Continuing-Care Retirement Communities

Insurers must allow residents of continuing-care retirement communities who need nursing home care to obtain the care from a facility within the continuing-care retirement community. However, the facility must be a Medicare-certified skilled nursing home and must agree to be reimbursed at the same rate negotiated with similar providers. The nursing home must meet the health plan's billing, quality assurance, utilization review, confidentiality, nondiscrimination, grievance, and appeal procedures [N.C.G.S. § 58-3-200(f)].

Maintaining Relationships with Existing Providers (Continuity of Care)

HMOs must allow certain enrollees with special health conditions to continue to see their providers, even if the provider is not part of the HMO's network. The intent of this law is to give people with special health conditions a reasonable amount of time to transition to a network provider. During the transition period, the enrollee can continue the relationship with the existing provider, if the provider agrees to accept the HMO's prevailing rates, and meet other usual HMO requirements. The law applies to individuals who have just joined an HMO (if a physician is not part of the HMO network) as well as to existing HMO enrollees if the provider leaves the network. To qualify for this protection, you must have a special health condition such as a terminal condition, a chronic illness or condition that is life threatening, degenerative, or disabling. An enrollee with an acute illness or condition that is serious enough to require treatment to avoid death or permanent harm can also receive this transitional coverage. Pregnant women are also entitled to this protection beginning with the second trimester of pregnancy. As a general rule, enrollees are given 90 days to transfer to a new provider, but this period may be

extended for some people. For example, enrollees with a terminal illness can continue to see their existing providers for the remainder of their lives, and pregnant women can continue their relationships with their providers until the child is born (and for 60 days post partum) [N.C.G.S. §§ 58-67-88, 135-39.4A(g)].

Network Adequacy

Insurers that operate network-based plans (like HMOs or PPOs) must have systems to ensure the adequacy of the network. Insurers must set their own access standards and monitor how well the network meets these internal standards. The health plan's access standards should include information about how long enrollees must travel to obtain primary care, specialty care, hospital-based services and other facilities. Insurers must also monitor waiting times to find out how long it takes to get an appointment with network providers [N.C.G.S. §§ 58-3-191(a)(4)(c); 135-39.4A(g)].

Insurers may not charge enrollees more money or otherwise penalize enrollees for using out-of-network providers, if the health plan lacks sufficient network providers to meet the health care needs of the patients without unreasonable delay [N.C.G.S. § 58-3-200(d)].

Insurers may not restrict enrollees from selecting a pharmacy if the pharmacy has agreed to participate in the health benefit plan according to the terms offered by the insurer. Insurers may *not* charge higher cost sharing that would affect the enrollees' choice of a pharmacy [N.C.G.S. § 58-51-37].

Obstetricians and Gynecologists (OB/GYNs)

Insurers that use network providers must allow female enrollees 13 years or older to obtain the services of a contracting obstetrician-gynecologist without prior referral for obstetrical or gynecological related services [N.C.G.S. § 58-51-38].

Optometrists, Podiatrists, Certified Clinical Social Workers, Certified Substance Abuse Professionals, Licensed Professional Counselors, Dentists, Chiropractors, Psychologists, Pharmacists, Certified Fee-Based Practicing Pastoral Counselors, Advanced Practice Nurses, and Physician Assistants

Insurance plans may not deny payment or reimbursement for any service which is within the scope of practice of a licensed optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse (such as a nurse practitioner or nurse midwife) or physician assistant. This section does not require insurers to cover services that would not otherwise be covered. But if the service is normally covered, the insurer may not deny payment to any of these licensed or certified practitioners, if they are providing the covered services within their scope of practice. The goal is to give the enrollee a choice of providers [N.C.G.S. §§ 58-50-26, 58-50-30, 58-65-1; 58-65-36, 135-39.4A(g), 135-40.6(11), 135-40.7B (c)(10)].

Insurers who operate network-based plans may not exclude these providers from their provider network solely on the basis of their license or certification. In other words, the insurer cannot exclude whole categories of providers if the providers can provide covered services within the scope of their license or certification. However, providers that are included in the network must agree to the insurer's regular rules of participation (such as quality assurance and utilization review requirements). Persons who are enrolled in an HMO will need to choose a network provider in order to obtain coverage. Those who are enrolled in either a Point-of-Service (POS) or Preferred Provider Organization (PPO) will need to choose a network provider in order to obtain the higher level of coverage [N.C.G.S. §§ 58-50-30(g), 135-39.4A(g)].

Pediatricians

Insurers that use a provider network must allow children under the age of 18 to choose a contracting pediatrician in the network as their primary care provider [N.C.G.S. §§ 58-3-240, 135-39.4A(g)].

Provider Hold-Harmless Provisions

Providers are prohibited from charging HMO enrollees for covered services other than the allowable coinsurance, co-payments or deductibles. The providers may not charge patients for these services, even if the HMO fails to pay the provider [11 N.C.A.C. § 20.0202]. The patient can, however, agree to pay for *non-covered* services out-of-pocket. This protection applies only to enrollees in HMOs.

Specialists

North Carolina laws have provisions that allow certain enrollees to use specialists as their primary care providers, and other laws that enable certain enrollees to obtain standing or extended referrals to specialists.

Using a Specialist as a Primary Care Provider

Insurers must have procedures to allow enrollees with a serious or chronic degenerative, disabling, or life-threatening disease or condition to select a specialist with expertise in treating this condition as their primary care provider. To serve as a primary care provider, the specialist must coordinate the enrollee's ongoing care and must follow all of the insurer's other rules for primary care providers [N.C.G.S. §§ 58-3-235, 135-39.4A(g)].

Standing Referrals to Specialists

All insurers that require patients to obtain referrals before they can see a specialist must have new procedures to allow certain patients to obtain standing or extended referrals. Insurers must have a process to allow patients with chronic, degenerative, disabling, or life-threatening diseases or conditions to obtain extended or standing referrals to in-network specialists. The standing referrals will not exceed 12 months,

and shall be part of a treatment plan coordinated with the primary care physician, specialist, and the health plan [N.C.G.S. §§ 58-3-223, 135-39.4A(g)].

APPEALS AND GRIEVANCES, EXTERNAL REVIEW, AND RIGHT TO SUE

Persons who are covered by most insurance plans have multiple ways to appeal denials of care or treatment, or to otherwise complain about the care or coverage under the plan. In general, they must first exhaust internal insurance appeal and grievance mechanisms (called “internal review”), then must appeal to an independent external review organization (called the “external review”). If the enrollee goes through the internal and external appeals route and is still not satisfied with an insurer’s decision to deny or limit health care services, then that person can sue the insurer in court.

Internal Appeals and Grievance Procedures

Enrollees have two separate internal appeal routes. One takes place when the enrollee contests a decision to deny or limit health care services (noncertification decision). This is called an “appeal.”² The other appeal route occurs when a member is unhappy with other aspects of the plan’s operations. A complaint about other operations of the plan is called a “grievance.”

Enrollees have the right to two levels of review, for both appeals and grievances. The first level of review has a different name and a slightly different process depending on whether it is a first-level appeal or first-level grievance review. However, the second-level review is the same regardless of whether the dispute is a denial of services or another problem with the plan’s operation. This is referred to as a second-level grievance hearing.

Enrollees who contest noncertification decisions (denials of services or procedures) have the right to ask for expedited review if the normal time limits could hurt the enrollee’s health. Otherwise the normal time limits apply. There is not an expedited process for first-level grievance decisions, because first-level grievance hearings do not deal with noncertification decisions (these are handled at the first level appeals).

Under state law, state employees are also entitled to have internal appeals that are substantially similar to those set out below [N.C.G.S. § 135-39.7].

Appeals of Noncertification Decisions

Denial Notices: When insurers deny care, they must send the enrollee a noncertification letter explaining why the requested service or procedure was denied. The notice must include the clinical reasons for the noncertification as well as instructions on how to appeal the plan’s decision [N.C.G.S. § 58-50-61(h)]. Enrollees

² The appeals procedures do not apply to any noncertification given solely on the basis that a health benefit plan does not provide coverage for the health care services being requested if the exclusion of the specific service requested is clearly stated in the certificate of coverage [N.C.G.S. § 58-50-61(a)(13)].

should always ask for a copy of the clinical review criteria used in making the decision. This provides a more complete explanation for why the requested treatment, procedure, or admission was denied.

First-Level Appeals: Enrollees can file appeals on their own behalves. In addition, a physician or other person acting on the enrollee's behalf can file an appeal [N.C.G.S. 58-50-61(j)]. All plans must offer at least two levels of appeals. A physician who was not involved in the original decision must hear the first appeal. Normally the physician has 30 days to decide the appeal [N.C.G.S. § 58-50-61(k)].

Expedited Review: Enrollees can request expedited appeals if their health would be harmed by the 30-day delay. In an expedited appeal, the physician has up to four days to make a decision. However, enrollees can request the decision be made immediately if there is a more immediate health care need [N.C.G.S. § 58-50-61(k), (l)]. Enrollees will have their health services covered until notified of the expedited review decision, if the appeal involves concurrent review such as continued stay in a hospital. Enrollees are not entitled to expedited review if the health care services have already been provided and the issue is whether the care was appropriate (retrospective review).

Notice of Decision: Each health plan or utilization review organization must provide a written decision to the enrollee and the enrollee's provider. The decision should contain the qualifications of the person reviewing the appeal, the reviewer's decision including the medical rationale and evidence used as the basis for the decision, instructions on how to file a second-level grievance hearing, and information about the right to seek an independent, external review [N.C.G.S. §§ 58-50-61(k), 58-50-77].

First-Level Grievance Reviews

Reasons to File a Grievance: Enrollees have the right to file a grievance any time they are dissatisfied with any of a plan's policies, decisions, or actions. For example, enrollees can file grievances if they are unhappy with the quality of care or the availability of health care services. Similarly, they can file grievances if the health plan fails to reimburse them for certain out-of-pocket payments that should have been covered by the plan [N.C.G.S. §§ 58-50-62(b), 58-50-61(a)(6)].

First-Level Grievance Reviews: The enrollee, his representative, or the provider may submit a first-level grievance. Within three business days after receiving notice of the grievance, the health plan must provide the enrollee with information on how to submit written materials. The person reviewing the grievance cannot be the same person who initially handled the grievance. If the issue is a clinical one, at least one of the reviewers must be a medical physician with appropriate expertise. The health plan must make a grievance decision within 30 days after receiving the complaint. The notice of the decision must include the same information as provided in first-level appeal decisions [N.C.G.S. §§ 58-50-62(e), 58-50-77].

Second-Level Grievance Hearings

Hearing Procedures: Health plans must also have second-level grievance reviews for enrollees who are dissatisfied with the decision of the noncertification appeal or first-level grievance review. The health plan must notify the enrollee of the name and telephone number of the grievance coordinator, and must provide information about the second-level grievance process within 10 days of receiving a request for a second-level grievance. Enrollees have more extensive due-process rights at the second-level grievance review. Specifically, an enrollee can attend the second-level grievance hearing and request and receive all information relevant to the case in order to prepare for the hearing. Enrollees may present their cases to the review panel, submit supporting materials before and at the review meeting, ask questions of any member of the review panel and bring other persons to help in the review hearing. These could include a family member, employer representative, or attorney. If the enrollee chooses to bring an attorney, then an attorney may also represent the health plan [N.C.G.S. § 58-60-62(f)(1)b].

The health plan will convene a hearing panel to hear second-level grievances. The panel will usually consist of people who are not employees of the health plan or utilization review organization, who were not previously involved in the decision, and who do not have a financial interest in the outcome of the review. All people reviewing a second-level grievance involving a noncertification or clinical decision should be providers who have appropriate expertise³ in the health issue in dispute. The review panel has up to 45 days to hold the hearing, and up to 15 days thereafter to make a decision. This decision is a recommended decision to the health plan.

Expedited Hearings: Enrollees can request an expedited second-level review if their health could be harmed because of any time delays [N.C.G.S. § 58-60-62(i)]. Enrollees may request an expedited second-level review even if the first-level appeal or grievance review was not expedited. If necessary, the health plan may conduct the hearing over the phone or through submission of written information.

Second-level Hearing Decisions: Each health plan must provide a written decision to the enrollee and the enrollee's provider (if appropriate). The decision should contain the qualifications of the people reviewing the grievance, the reviewer's decision, the medical rationale for the decision, and the evidence used as the basis for the decision. The decision must also notify the enrollee of the right to seek an independent, external review [N.C.G.S. §§ 58-60-62(h), 58-50-77].

Independent External Review

Enrollees who are not satisfied with the outcomes of the internal appeals and grievances can appeal further to an independent, external review organization. There are no fees to appeal to an independent, external review organization. The right to

³ If the HMO used a clinical peer in the noncertification appeal or a first-level grievance review panel, then the HMO may use one of its employees on the second-level grievance review panel (if the second-level panel consists of three or more people). [N.C.G.S. §§ 58-50-62(f)(2)].

seek an outside, independent review applies only to cases involving noncertification decisions (i.e., the decision by the insurer to deny covered medical care). State employees also have a right to external review after exhausting the internal review process [N.C.G.S. § 135-39.7].

Enrollees should contact the NC Department of Health and Human Service's Healthcare Review (HCR) Program directly if they want to request a review or obtain forms. A request for external review is not considered received until it is in the HCR offices. The HCR Program can be reached at (919) 715-1163 or (877) 885-0231, by e-mailing hcr@ncdoi.net, or by going on-line to the consumer sections of www.NCDOI.com.

Requesting an external review. Ordinarily, the enrollee must exhaust the internal appeals and grievance process. The enrollee will be considered to have exhausted the internal process if the enrollee obtained a decision in a second-level grievance hearing, or if he or she filed a second-level grievance and has not received a written decision within 60 days of filing the grievance. In certain instances, the enrollee can file a request for an independent, external review without having first exhausted the internal appeals and grievance procedures. First, the enrollee can seek an expedited external review if he or she has a medical condition where the time for completing an expedited internal appeals or second-level grievance would reasonably be expected to jeopardize his or her life or health, or jeopardize the ability to regain maximum function. In addition, the enrollee need not exhaust the internal appeal and grievance process if the insurer agrees to waive the exhaustion requirement [N.C.G.S. § 58-50-79].

Standard external review. The enrollee has 60 days from the date of the appeals or second-level grievance decision to request an external review. The request must be made to the Commissioner of the Department of Insurance. The Commissioner will then obtain information from the insurer to determine whether the case is appropriate for external review. To be considered appropriate, the individual requesting the review must have been covered under the plan at the time the health care services were requested, the requested services must be covered under the plan, and the enrollee must have exhausted the internal appeals and grievance procedures (or satisfied one of the exceptions to the exhaustion requirement). The Commissioner can request additional information from either the insurer or the enrollee in making his decision about whether the case is appropriate for external review. Both the enrollee who requested the review and the insurer will be notified of the Commissioner's decision.

If the case is accepted for external review, it will be assigned to an independent external review organization (assignment is made on a rotating basis to review organizations). The insurer has seven days to provide to the external review organization any information considered in making the noncertification appeals or second-level grievance decision. The Commissioner will forward any new information provided by the enrollee to the insurer. The insurer can reconsider its internal review decision at any time prior to the completion of the external review. If the insurer reverses its original noncertification decision, then the external review process will end [N.C.G.S. § 58-50-80(a)-(h)].

Expedited external review. An enrollee may request an expedited external review at various times in the review process. The enrollee may request an expedited external review after the initial noncertification decision, the notice of the first-level appeals, or the second-level grievance. To qualify for an expedited external review, the enrollee must show that the completion of the normal expedited internal appeals and

grievance procedures would reasonably be expected to seriously jeopardize the life or health of the enrollee, or jeopardize the ability to regain maximum function. Enrollees can also request an expedited external review if they received emergency services but have not yet been discharged from the facility, and if the disputed issue is a noncertification of an admission, continued stay in a facility, or health care service needed in the facility. The Commissioner must decide within three days after the request if the case is appropriate for expedited external review. In making this determination, the Commissioner shall consult with a medical professional who has not been involved in the internal appeals and grievance procedures, and who will not be involved in the external review [N.C.G.S. § 58-50-82].

Review organization. The external review organization must be independent—that is, it cannot have any ties to the insurer, enrollee, or any health care provider involved in the underlying dispute. The organization must ensure timely decisions and confidentiality of the medical records. In addition, the external review organization must have qualified and impartial health professionals who can review the underlying dispute. These health professionals must be experts in the treatment of the injury, illness, or medical condition that is being contested. In addition, the health professionals must have current clinical experience treating patients with the same or similar condition, injury, or illness, and be knowledgeable about the recommended care or treatment. If the enrollee’s treating provider is a doctor, then the health care professional who reviews the underlying dispute must also be a doctor holding a similar specialty certification. If the enrollee’s treating provider is not a medical doctor, then the provider who reviews the dispute should hold a license, registration, or certification similar to that of the treating provider [N.C.G.S. § 58-50-87].

Standards of review. The external review organization must base its decision on the enrollee’s medical condition at the time of the initial noncertification decision. In addition, it must consider the following factors in making its decision:

- ◆ The enrollee’s medical records
- ◆ The attending health care provider’s recommendation
- ◆ Consulting reports from appropriate health care providers and other documents submitted by the insurer, the enrollee, or the enrollee’s treating physician
- ◆ The most appropriate practice guidelines based on sound clinical evidence and periodically updated
- ◆ Any applicable clinical review criteria developed and used by the insurer
- ◆ Medical necessity, as defined under the North Carolina statutes [N.C.G.S. §58-3-200(b)]
- ◆ Any documentation supporting the medical necessity and appropriateness of the provider’s recommendation

The external review organization’s decision may not be contrary to the terms of coverage under the enrollee’s health benefit plan. Thus, for example, the external review organization may not require the insurer to cover a particular treatment or

procedure if it is specifically excluded under the applicable health plan [N.C.G.S. § 58-50-80(i)].

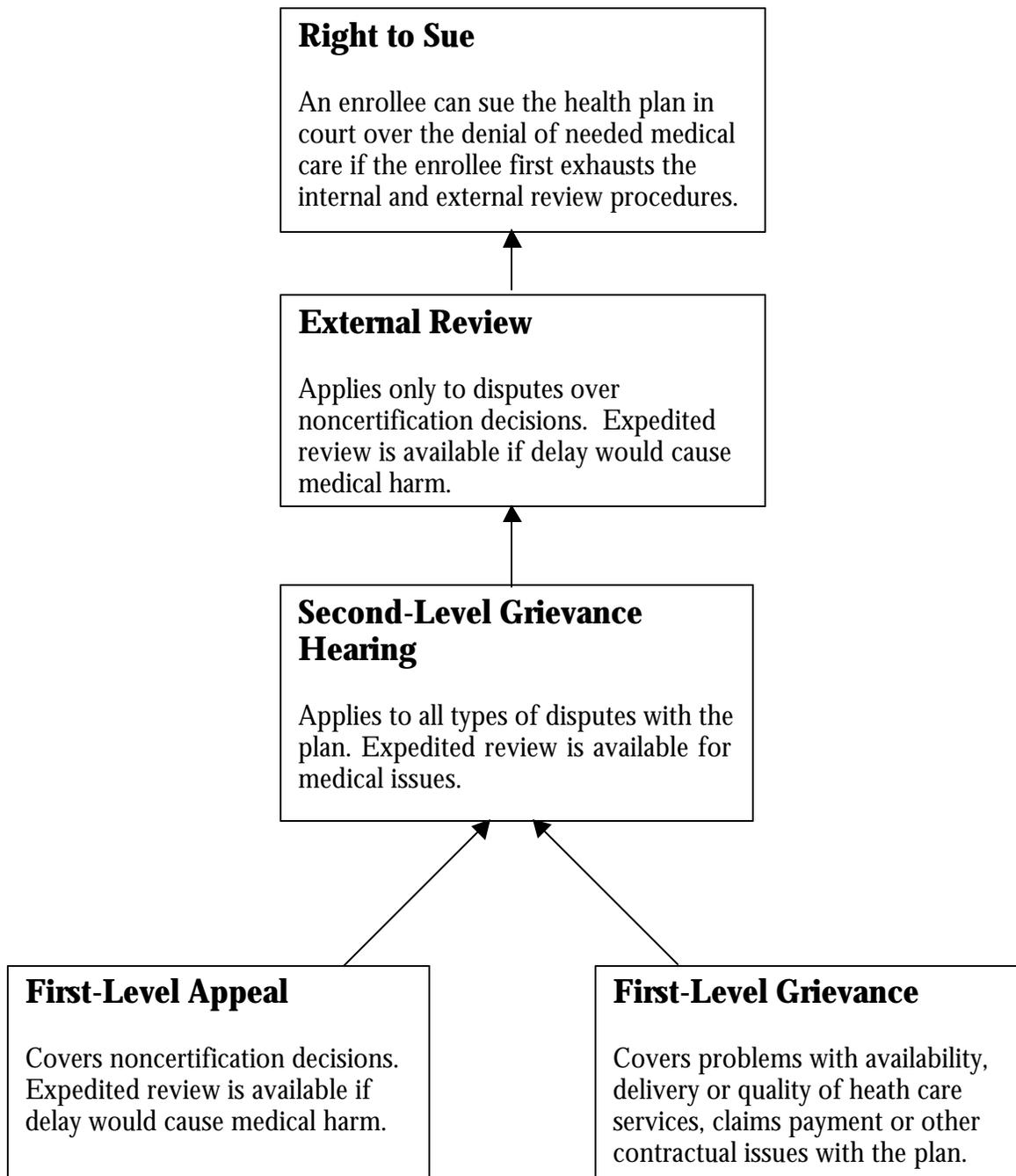
Notice of decision: The external review organization must generally make its decision within 45 days of when the enrollee initially requested an external review. However, in the case of an expedited external review, the organization must make its decision as expeditiously as the medical condition requires, but in no event more than four days after the initial request for a review. The notice of decision must include information about the underlying reason for the request, the date the organization received information from the enrollee and insurer, the date the review was conducted and the date of the decision, the principal reason(s) for the decision (including the clinical rationale), reference to any evidence or guidelines considered in making the decision, and the professional qualifications of the clinical peer reviewers. An insurer has three business days to reverse its original noncertification decision if the external review organization decides in favor of the enrollee for regular reviews, and one day in the case of an expedited review. [N.C.G.S. §§ 58-50-80(j)-(l); 58-50-82].

Right to Sue Insurers

In the past, it has been difficult for enrollees to sue their insurance company for damages caused by a wrongful denial of care. However, in 2001, the NC General Assembly enacted legislation making it somewhat easier to sue insurers if an enrollee was harmed by an insurer's decision to deny coverage for health services (noncertification decision). In order to be able to sue the insurer, the enrollee must first exhaust both the internal and external appeals process [N.C.G.S. § 90-21.54]. State employees also have a similar right to bring suit for wrongful denials of care [N.C.G.S. § 143-291]. Either side can introduce the decision of the independent review organization as evidence during the trial.

Enrollees who win their lawsuits may be able to recover actual damages (for example, for the cost of care, lost wages, or reimbursement for pain and suffering). In addition, the enrollee may be able to recover punitive damages, if the action by the insurer was particularly egregious. However, as a practical matter it will be very difficult to prevail in a lawsuit against an insurer. Insurers are required to exercise only "ordinary care." Ordinary care has been defined in the statutes as "that degree of care that, under the same or similar circumstances, a[n insurer] of ordinary prudence would have used at the time the [insurer] made the health care decision." -21.50(8); 90-21.51]. If the insurer prevails in the independent, external review, it may be difficult to show that the insurer was not exercising ordinary care.

Procedures for Appeals, Grievances, and Reviews



CONFIDENTIALITY

Confidentiality of Medical Records

In general, insurers may not disclose any medical information of an enrollee or applicant without his or her prior written consent. Sometimes a person may be asked to authorize the release of medical information in order to obtain health insurance coverage. In addition, there are some limited circumstances when the consent of the patient is not needed. Insurers can release medical information by court order. Insurers can also release medical information in the event of litigation between the insurer and enrollee if the information is relevant to the case. Medical information can be shared within the insurer so that the insurer can assess the appropriateness of the care provided or monitor quality. Any organization that the insurer contracts with to help in these activities is subject to these confidentiality provisions [N.C.G.S. §§ 58-39-75, 58-67-180, 11 N.C.A.C. §§ 20.0408, 20.0509].

All insurers (including HMOs) are also subject to the Insurance Information and Privacy Act [N.C.G.S. §58-39-1 et. seq.]. This statute sets rules for the collection, use, and disclosure of medical information involving insurance transactions. For example, insurers may seek information about your medical history before offering you certain types of non-group health insurance. Applicants and enrollees have the right to examine this information for accuracy. Also, you can find out the reason why a health plan decides not to offer you insurance coverage [N.C.G.S. § 58-39-5].

The US Department of Health and Human Services recently issued regulations to further protect patient privacy. The regulations were implemented as part of the Health Insurance Portability and Accountability Act (often referred to as the HIPAA requirements). These privacy regulations spell out in detail when and how health plans and providers can use and disclose patient health information. The regulations also establish several new important patient protections. For example:

- ◆ You have a right to know how your medical information will be used and when it will be shared with others.
- ◆ You have a right to inspect and obtain a copy of your health information (with certain limited exceptions, such as when providing access may cause harm). In addition, you have a right to correct the medical information if you think it is inaccurate, or to submit a “statement of disagreement” if the health care provider disagrees with your proposed correction.
- ◆ You have a right to find out when your information has been disclosed to other organizations over the past six years. (Note: this does not include when your information is disclosed in order to obtain insurance reimbursement or to other providers for treatment purposes).
- ◆ You have a right to request that your providers make special arrangements for communicating with you—for example, if you don’t want medical information sent to your home, you can arrange to have it sent to another location.

- ◆ You also have a right to request that your provider not release your medical information for specific purposes—such as for research purposes.

These new privacy protections are scheduled to become effective on April 14, 2003. [45 C.F.R. §§ 160.101 *et. seq.*, 160.102 *et. seq.*, 160.500 *et. seq.*]

CONSUMER INFORMATION

Evidence of Coverage

Insurers must provide enrollees with an explanation of the services or benefits covered under the insurance plan. Many plans refer to this document as the Evidence of Coverage (EOC), while other insurance companies refer to similar documents as member handbooks, subscriber contracts, or insurance policies. [N.C.G.S. §§ 58-65-60, 58-67-50(a)].

Insurers have specific requirements for what information must be included in the evidence of coverage or insurance policy. These documents must include a description of:

- ◆ The health services or other benefits covered under the plan
- ◆ Any limitations on the services or benefits covered
- ◆ Any required cost sharing
- ◆ The total amount that the enrollee must pay for health services
- ◆ A description of the insurer's method to resolve enrollee complaints
- ◆ A detailed explanation of appeal and grievance procedures
- ◆ Explanation of information that is available to enrollees and prospective enrollees upon request and instructions on how to obtain this information
- ◆ Definition of medical necessity
- ◆ Coverage that is available for out-of-network services
- ◆ Information about the utilization review process
- ◆ A description of the reasons, if any, that a health plan can terminate a member's enrollment

[N.C.G.S. §§ 58-3-191(b), 58-50-61, 58-50-62, 58-65-60, 58-67-50(a)(3)(b), 135-39.4A(g)]. Insurers must give enrollees or prospective enrollees a copy of these documents, upon their request [N.C.G.S. § 58-3-191(b)]. Similar requirements also apply to self-funded or ERISA plans (see Chapter 11).

False and Misleading Advertisements

Consumers have certain protections to ensure that they receive accurate information. For example, insurers are prohibited from using false and misleading advertisements, or misleading incentives to encourage people to purchase a health insurance policy. False and misleading advertisements and inducements are prohibited as unfair competition. Insurers are required to include information about major coverage limitations prominently in all of their advertisements. Consumers who think they have been harmed by false and misleading advertisements should contact the Consumer Services Division of the NC Department of Insurance for more information about their rights at: (800) 662-7777 or (800) 546-5664 [N.C.G.S. §§ 58-63-1 *et. seq.*, 58-67-65, 11 N.C.A.C. § 12.0518-0536].

Information About Treatment of Certain Health Conditions

Insurers that offer managed care plans (HMOs, PPOs or POS plans) must provide enrollees and prospective enrollees certain information upon their request. A current or prospective enrollee has the right to request information about:

- ◆ How his or her health condition would be treated under the plan (called the insurers' review criteria or treatment protocol)
- ◆ A list of the health plan's drug formulary, and how to request drugs outside the formulary
- ◆ The procedures the health plan uses in determining whether a specific procedure, test, or treatment is considered experimental or investigational

This information is especially important for people with pre-existing health problems or special health needs [N.C.G.S. § 58-3-191(b), 135-39.4A(g)].

Information To Compare Insurers

Insurers that offer managed care plans (HMOs, PPOs or POS plans) are required to report certain information to the NC Department of Insurance. Some of this information may be useful in comparing insurers. These data include:

- ◆ *Grievances:* Managed care plans must report information about member grievances. Grievances can result from problems with accessibility or quality of services, claims payments, questions about covered benefits, or other complaints. Insurers must provide information on the number of and reasons for the grievances, and the number of grievances resolved in the members' favor.
- ◆ *Participants and groups that withdraw from the health plan:* Managed care plans are required to report the number of groups (generally employer-based plans) and individual enrollees that left the health plan. In addition, the insurers must report data on the numbers of providers who left a plan voluntarily and involuntarily. [N.C.G.S. §§ 58-3-191(a)(2)(3), 135-39.4A(g)].

- ◆ *Provider Network Adequacy Information:* The managed care plans are required to report information on the number of specific types of providers who are in their network, by county. This includes primary care providers, specialists, facilities, and mental health and chemical dependency providers. [N.C.G.S. §§ 58-3-191(a)(4), 135-39.4A(g)]. In addition, plans are required to develop internal standards to ensure network adequacy (for example, that each enrollee has access to in-network providers within reasonable distances and time frames). Each managed care plan establishes its own standards, and then must measure its actual performance against its internal standard.
- ◆ *Utilization review and appeal data:* Managed care plans are required to report information on the types and number of utilization reviews performed and how many of these reviews resulted in a denial of services (noncertifications). In addition, managed care plans must also provide information on the number of appeals, and the outcome of these appeals. [N.C.G.S. § 58-3-191(a)(4)(f), 135-39.4A(g)].
- ◆ *Provider compensation data:* HMOs are required to submit information on the percentage of providers paid according to different payment arrangements, including capitation, discounted fee-for-service, or salary. In addition, the HMOs must also report about the range of compensation paid under a withhold or incentive system [N.C.G.S. § 58-3-191(a)(5), 135-39.4A(g)]. (Note: this section does not apply to PPOs.)
- ◆ *Health Plan Employer Data and Information Set (HEDIS®):* HMOs are required to report HEDIS® data to the state. HEDIS® is a standardized set of performance measures that consumers and other purchasers can use to compare insurers. [N.C.G.S. § 58-67-50(e)]. PPOs are not required to collect or report HEDIS® data.

Some but not all of the information noted above is available in a publication called *The 2001 Managed Care Consumer Guide: A Comparison of HMOs and PPO plans in North Carolina*. The Consumer Guide includes selected HEDIS® data, as well as information on grievances, appeals, member and physician turnover, and plan contact information. It is updated annually. You can access the Guide on the Internet at: <http://www.ncdoi.com/Consumer/Publications.asp>. (Note: Once you get to this page, click on the Health Insurance and Managed Care publications under type of publications. You should then see this publication listed.) Alternatively, if you want a copy of the publication or need additional information, you can call the NC Department of Insurance Consumer Services Section at: (800) 546-5664.

Materials Must Be Understandable

State law requires that all materials given to consumers be understandable at a ninth grade reading level. This means that the member handbooks (Evidence of Coverage or insurance policies) should be understandable to those with a high school reading level [N.C.G.S. §§ 58-38-1 *et. seq.*, 58-66-1 *et. seq.*]. However, the state allows each health plan to assess the readability of its consumer materials. Insurers can exclude

medical terminology in their assessment of the readability level. In effect, insurance materials are often difficult for the average person to understand.

Provider Directories

Every insurer that has a network of providers must maintain a provider directory. The directory shall include information about the provider's name, address, phone number, and, if applicable, the provider's specialty. The directory must also state whether the provider can be selected as a primary care provider. In addition, the directory should note whether or not the provider is accepting new patients (if that is known by the insurance company). The directory must list all the different types of participating providers. If the provider requests, the directory must also include the names of any allied health professionals who provide primary care services under the supervision of the participating provider. The directory shall be updated no less frequently than once a year. The insurer must also maintain a telephone system or on-line system so that enrollees can obtain up-to-date network information [N.C.G.S. §§ 58-3-245, 135-39.4A(g)].

MANAGED CARE PATIENT ASSISTANCE PROGRAM

An Office of Managed Care Patient Assistance has been created in the Consumer Protection Division of the NC Department of Justice. The Managed Care Patient Assistance Program was created to help managed-care enrollees. The Office will help answer consumer questions, advise managed-care enrollees about the utilization review process, and help enrollees with their grievance, appeal, and external review procedures. The Office will also develop and distribute consumer education materials, and make recommendations to the General Assembly about efforts that could be implemented to help managed care enrollees [N.C.G.S. § 143-730].

The Managed Care Patient Assistance Program can be reached at:
Managed Care Patient Assistance Program
Consumer Protection Division
N.C. Department of Justice
P.O. Box 629
Raleigh, NC 27602-0629
(866) 867-6272 (toll-free outside of Raleigh)
(919) 733-6272 (in Raleigh)
mcpap@mail.jus.state.nc.us

MANDATED BENEFITS

Bone Mass Measurements

Insurers must provide coverage of bone mass measurements for enrollees who are at risk of developing osteoporosis or low bone mass. Coverage must include bone mass measurements at least every 23 months and more frequently if follow-up measurements are medically necessary. Coverage for the bone mass measurements

shall be the same as for other similar services. Persons who qualify for coverage of bone mass measurements include those with:

- ◆ Estrogen deficiency and risk of osteoporosis or low bone mass
- ◆ Radiographic osteopenia anywhere in the skeleton
- ◆ Long-term steroid therapy
- ◆ Primary hyperparathyroidism
- ◆ Monitoring to assess their response to osteoporosis drug therapies
- ◆ Histories of low-trauma fractures
- ◆ Other known conditions or medical therapies known to cause osteoporosis or low-bone mass. [N.C.G.S. §§ 58-3-174, 58-50-155]

Chemical Dependency Treatment

Insurers must offer groups coverage for the treatment of chemical dependency. If the health plan provides the group total annual benefits for all services in excess of \$8,000, then that plan must provide a minimum of \$8,000 for the necessary care and treatment of chemical dependency. The plan must provide a lifetime maximum of no less than \$16,000. While insurers are required to offer this coverage, groups may reject it [N.C.G.S. §§ 58-51-50; 58-65-75, 58-67-70].

Clinical Trials

Insurers must cover the health care costs for certain enrollees who are enrolled in phase II, phase III, or phase IV clinical trials. Only trials that are funded by the National Institutes for Health, Centers for Disease Control, Veterans Administration, Department of Defense, Food and Drug Administration, or Agency for Health Care Research and Quality, and that are designed to evaluate new treatments for life-threatening medical conditions, have to be covered. To be eligible for coverage, the enrollee must show that the treatment offered by the trial is medically preferable to other non-investigational treatments. The insurer is only responsible for the costs of medically necessary health care services associated with participation in the clinical trial—not the costs of the health care services or treatment provided and paid for as part of the clinical trial. For example, if a clinical trial is evaluating a new drug, the cost of the medication will be covered by the trial. However, the insurer must cover the doctor's costs in monitoring the enrollee's condition and any diagnosis or treatment of complications [N.C.G.S. §§ 58-3-255].

Colorectal Cancer Screening

Insurers must cover colorectal cancer examinations and laboratory tests for cancer. Screenings must be covered for persons who are at least 50 years old, or who are younger than 50 but at high risk for colorectal cancer. The screenings must be covered in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on

Cancer Coordination and Control. Insurers may not impose higher deductibles, co-payments, or coinsurance on colorectal cancer screenings than they do on other similar screening tests. [N.C.G.S. §§ 58-3-179, 58-50-155].

Contraceptives

Insurers that cover prescription drugs and devices must also cover prescription contraceptives or devices. Coverage must include the insertion and removal of contraceptive devices as well as contraceptive examinations. With one exception, insurers may not impose higher deductibles, co-payments, or coinsurance on contraceptive drugs and devices than they do on other prescription drugs or devices. Special payment rules apply to drugs or devices that are inserted and do not need to be refilled on a periodic basis (such as IUDs). For these drugs or devices, the insurer may require advance payment of the total coinsurance amount, based on the useful life of the drug or device. Religious employers (such as churches) can request that insurers not provide contraceptive coverage if it is contrary to the employer's religious tenets. [N.C.G.S. §§ 58-3-178, 58-50-155].

Dental Procedures for Young Children and Persons with Serious Mental or Physical Conditions

Insurers must pay for the costs of anesthesia and hospital or facility charges associated with dental procedures provided to children under age nine, to persons with serious mental or physical conditions, or persons with significant behavioral problems, if the provider certifies that hospitalization or general anesthesia is needed in order to safely perform the procedures. The same deductibles, coinsurance, network requirements, and medical necessity provisions as apply generally to coverage of physical illness will apply to coverage of these services [N.C.G.S. § 58-3-122].

Diabetes Self-Care

Insurers must cover diabetes outpatient self-management training, equipment, supplies, medications, and laboratory procedures used to treat diabetes. The insurer may decide who shall provide and be reimbursed for the outpatient self-management training and educational services [N.C.G.S. §§ 58-51-61, 58-65-91, 58-67-74].

Emergency Services

Insurers must provide coverage for emergency medical services needed to screen and to stabilize an enrollee. Prior authorization cannot be required if an ordinary person (prudent layperson) acting reasonably would have believed that an emergency medical condition existed. The enrollee may obtain emergency-related services from a non-network provider if the person reasonably believes that the delay in seeking care from a network provider would worsen the emergency. The health plan may charge its regular coinsurance, co-payments, or deductibles but may not charge

additional cost-sharing amounts for using a non-network provider [N.C.G.S. § 58-3-190].

Mammograms and Pap Smears

Insurers must provide coverage for periodic pap smears and mammograms. Coverage of pap smears will be provided once a year or more often if recommended by a physician. Mammograms must be covered according to the following schedule:

- ◆ One or more mammograms a year, as recommended by a physician, for any woman who is at risk of breast cancer
- ◆ One baseline mammogram for any woman 35-39 years of age
- ◆ A mammogram every other year for any woman 40-49 years of age or more frequently upon a physician's recommendation
- ◆ A mammogram every year for any woman 50 years of age or older

Insurers may not impose higher co-payments on pap smears or mammograms than they do on other similar screening tests [N.C.G.S. §§ 58-50-155, 58-51-57, 58-65-92, 58-67-76].

Maternity Care

Insurers are not required to provide maternity coverage. When the company does provide coverage, benefits must be the same as for other services [N.C.G.S. § 58-3-170]. In other words, an insurer may not impose higher co-payments on maternity care than it does on other similar care. Regardless of whether the policy provides maternity coverage, a complication of pregnancy must be treated similarly to other illnesses or sicknesses covered under the health plan's contract. A nonelective cesarean section is considered a complication of pregnancy [11 N.C.A.C. § 12.0323]. Insurers may not deny maternity coverage to an unmarried woman if the coverage is available to married women.

Also, any health benefit plan that provides maternity coverage must pay for inpatient care for a mother and her newborn child for at least 48 hours after vaginal delivery or 96 hours after a cesarean section [N.C.G.S. §§ 58-3-169, 58-3-170].

Newborn Hearing Screening

Insurers must cover the costs of newborn hearing screening, and may not charge higher deductibles, coinsurance, or other cost sharing than required for other similar services [N.C.G.S. §§ 58-3-260, 130A-125].

Prescription Drugs

Insurers that use a closed or restricted formulary for prescription drugs must have a process to allow exceptions to the formulary. To obtain coverage of a restricted or nonformulary drug, a participating provider must notify the health plan that:

- ◆ The drugs on the formulary have been ineffective in treating the patient's condition
- ◆ The drugs on the formulary are reasonably expected to cause a harmful reaction in the patient

In addition, the drug must be prescribed in accordance with the health plan's clinical protocol. Insurers may not charge patients any additional deductible, cost-sharing, or a higher co-payment for using nonformulary medications as an exception to the formulary [N.C.G.S. § 58-3-221, 135-39.4A(g)].

Prescription Drugs for Cancer Treatment

Insurers that cover the medication cost for the treatment of one type of cancer must, under certain circumstances, also cover the costs of that medication for the treatment of another type of cancer. For this protection to apply, the following standards must be met:

- ◆ The drug must be approved by the US Food and Drug Administration (FDA)
- ◆ It must have been proven effective
- ◆ It must be accepted for the additional use by the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Drug Information

Coverage may be denied if the medication is experimental or investigational (unless it meets the requirements for coverage of clinical trials) or if the FDA finds that the drug should not be used to treat the other type of cancer [N.C.G.S. §§ 58-50-156, 58-51-59, 58-65-94, 58-67-78].

Prostate-Specific Antigen Test (PSA)

Insurers must cover prostate-specific antigen (PSA) tests or other tests for the presence of prostate cancer. A physician must order a PSA test in order for it to be covered. PSAs must be covered at the same level as other similar services [N.C.G.S. §§ 58-50-155, 58-51-58, 58-65-93, 58-67-77]. In other words, plans may not impose higher co-payments or cost sharing on PSA tests than they do on other similar screening tests.

Public Health Measures

HMOs and local health departments are required to collaborate and cooperate to protect the public health. For example, HMOs and local health departments could jointly sponsor a local health promotion or disease prevention activity [N.C.G.S. § 58-67-66].

Reconstructive Breast Surgery

Insurers that cover mastectomies must also cover reconstructive breast surgery following a mastectomy [N.C.G.S. §§ 58-50-155, 58-51-62, 58-67-79]. The decision to discharge a patient following a mastectomy must be made in consultation by the attending physician and the patient [N.C.G.S. § 58-3-168].

Tax-Supported Institutions

Insurance companies must provide the same coverage for services provided in a tax-supported institution, such as a state psychiatric institution, as the company provides for services in other public or private health care facilities. This provision *only* applies to *group* coverage, and does *not* apply to HMOs [N.C.G.S. §§ 58-51-40, 58-65-65].

Temporomandibular Joint (TMJ) Treatment

Insurers must provide coverage for diagnostic, therapeutic, or surgical procedures involving bones or joints of the jaw, face, or head, including the temporomandibular joint, if the procedure is medically necessary. These insurers must provide coverage if the condition is caused by congenital deformity, disease, or traumatic injury [N.C.G.S. § 58-3-121].

NONDISCRIMINATION

Acquired Immune Deficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV)

HIV infection and AIDS must be covered as any other illness or sickness in health insurance policies. Insurers may *not* write plans excluding coverage of AIDS or HIV [11 N.C.A.C. § 2.0324].

Children

There are a number of antidiscrimination provisions that apply to children. Some laws are intended to protect children born out of wedlock; others are for newborn, adoptive, or foster children; and other laws protect children born with disabilities. In addition to the nondiscrimination provisions, non-custodial parents may be required to provide insurance coverage for their children in certain instances.

Children Born Out of Wedlock

No child may be denied coverage because the child was born out of wedlock, was not claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the health plan's service area. In addition, the plan must allow a parent to enroll a child when required to do so by court or administrative order. This is true even if it is outside the normal enrollment period [N.C.G.S. § 58-51-120].

Newborns, Adoptive Children, and Foster Care Children

Insurers must provide coverage for newborn infants and foster children from the moment of the child's birth or on the day that the foster child is placed in a foster home. The plan shall provide the same coverage for congenital defects or anomalies that is provided for most sicknesses or illnesses [N.C.G.S. § 58-51-30]. The plan must also cover adopted children upon placement with a person who has insurance coverage, and may not impose pre-existing-condition exclusions [N.C.G.S. § 58-51-125].

Children with Developmental Disabilities or Other Disabilities

Insurers cannot refuse to enroll a child in an insurance plan that covers physical illness or injury because of that child's physical disability or mental retardation [N.C.G.S. § 58-51-35]. Insurance companies must continue coverage for dependent children who are mentally retarded or have physical disabilities after the child reaches the age at which coverage would normally terminate. This applies if the child is incapable of self-supporting employment and is chiefly dependent upon the policyholder for support and maintenance [N.C.G.S. §§ 58-51-25, 58-65-2, 58-67-171].

Medical Support Orders

Noncustodial parents may be ordered to cover their children under their health insurance coverage as part of a child support order. If ordered by the court, employers and health insurers are required to provide health insurance for the child, if dependent coverage is normally available. Employers are not required to pay for dependent coverage if they do not otherwise contribute to the costs of dependent or family coverage [N.C.G.S. §§ 50-13.11, 110-136.11 *et. seq.*].

Gender or Marital Status

No health plan can limit, refuse to issue, or refuse to continue coverage because of a person's sex or marital status. However, the plan may charge different premiums and may take marital status into account when determining a person's eligibility for dependent coverage. For example, a plan could not deny health insurance coverage to a woman working part-time if men working similar part-time jobs could obtain coverage. A plan also may not deny dependent coverage to husbands of female

employees when dependent coverage is available to the wives of male employees. Similarly, plans may not restrict, reduce, or modify benefits payable for disorders of the genital organs of only one sex [N.C.G.S. §§ 58-63-1, 58-2-40, 58-3-120, 58-63-1, 58-63-60].

Genetic Information

Insurers may not discriminate against enrollees on the basis of genetic information [N.C.G.S. §58-3-215(c)]. Specifically, insurers may not raise either the group premium rates or the premium rates for any specific individual in the group, and may not refuse to issue a policy because of genetic information obtained about one of the prospective enrollees.

Health Status

Insurers have certain rules that prevent them from discriminating against people because of their health status. There are different rules for people enrolled in group plans (typically employer-sponsored plans), and those who are seeking coverage in the individual market (non-group plans).

Group plans: Insurers may not exclude individuals from coverage or refuse to renew coverage because of their health status, medical condition, claims experience, genetic information, disability, use of health care services, or being a victim of domestic violence. In addition, the health plan may not charge any individual covered under a group plan a higher premium on the basis of that person's health (or any of the other factors listed above). However, insurers may exclude coverage for certain pre-existing conditions (see below). Insurers may charge the group as a whole higher premiums based on that group's use of health services [N.C.G.S. § 58-68-35]. Generally, insurers must renew coverage to groups at the option of the employer. In other words, the insurer cannot refuse to renew coverage to a group based on the group's use of health services, although the insurer can refuse to renew for certain limited reasons. For example, an insurer need not renew the policy if the employer failed to pay premiums or committed fraud, or if the insurer stops writing health insurance in the area [N.C.G.S. § 58-68-45].

Non-group plans: Insurers cannot refuse to enroll *eligible* individuals in the non-group market because of their health status. Eligible individuals are people who:

- ◆ Had 18 or more months of prior health insurance coverage from an employer group, governmental or church health plan
- ◆ Do not have access to another group or government-sponsored health plan
- ◆ Did not lose prior health insurance coverage because of nonpayment of premiums or fraud
- ◆ Elected continuation coverage if it was offered and, if so, continued the coverage until the guaranteed time period ran out

Insurers are not required to offer individuals coverage under all the health insurance policies they sell in the non-group market. At a minimum, plans must offer the two most popular non-group plans, such as the policies with the largest premium volume. While insurers have to offer coverage to certain individuals in the non-group market, there is no limit on the premiums that can be charged [N.C.G.S. § 58-68-60 et seq.].

Pre-Existing Conditions. Some people may have more limited coverage when they first apply for health insurance coverage. These are people who received medical advice, diagnosis, or treatment for a physical or mental condition within six months of enrolling in the health insurance plan (called a “pre-existing condition”). Some persons with pre-existing conditions may be subject to a pre-existing condition exclusion period. In these instances, the insurer will provide health insurance—but need not cover the health condition that existed prior to coverage. For example, if a person had a heart attack within the six months prior to coverage, then the insurance can exclude coverage for any heart-related health condition for a “pre-existing exclusionary period.” However, an insurer cannot impose a pre-existing exclusionary period if you were previously insured, had health insurance coverage for at least twelve months, and did not experience a gap in coverage for more than 63 days [N.C.G.S. § 58-68-30].

The length of the exclusionary period depends on two factors: 1) when you enroll in your health insurance plan; and 2) if you previously had health insurance coverage and met part of the pre-existing condition exclusionary time period.

Enrolling During an Open-Enrollment Period. The maximum pre-existing exclusionary period is 12 months if you enroll during your employer’s open-enrollment period (i.e., generally within 30-31 days of when you become eligible for enrollment). Note: an employer need not impose any pre-existing exclusionary time period. Often very large employers do not impose pre-existing condition exclusionary periods regardless of whether you sought care within the six month prior to enrolling in health insurance.

Late Enrollment. People who do not enroll during the “open-enrollment” period can generally be subject to an 18-month exclusionary time period. However, certain enrollees are not considered “late enrollees.” For example, newborns are not considered late enrollees if they enroll within 30 days after birth. Similarly, children who are adopted are not late enrollees if enrolled within 30 days after being placed for adoption. Individuals who lose other coverage (for example, because their spouse or parent who was providing health insurance coverage loses that coverage) are also not considered late enrollees.

Creditable Prior Coverage. People who were previously covered with health insurance will get credit for any coverage (as long as there was not a gap in coverage for more than 63 days). Thus, if a person had a pre-existing condition and was previously covered by a health plan for four months, he or she will be credited with four months’ coverage in meeting their new 12-month or 18-month pre-existing condition exclusionary period.

Medicaid Coverage

Insurers are prohibited from taking into account the fact that an enrollee is receiving Medicaid coverage in insuring the person or making payments under the health benefit plan [N.C.G.S. § 58-51-115]. In other words, insurers may not exclude individuals or services because they are already covered by Medicaid.

People with Mental Illness or Chemical Dependency

Persons with mental illness or chemical dependence enrolled in group contracts covering 20 or more employees are given limited protections. Insurers may not refuse to enroll someone in a health plan that covers physical illness or injury because that person has a mental illness or chemical dependence. Similarly, insurers may not charge these enrollees a higher premium or reduce the coverage for physical illness or injury [N.C.G.S. §§ 58-51-55, 58-65-90, 58-67-75].

People with Sickle Cell Trait or Hemoglobin C Trait

Insurers cannot refuse to enroll someone in an insurance plan that covers physical illness or injury because of that person's sickle cell or hemoglobin C trait [N.C.G.S. §§ 58-51-45, 58-65-70, 58-67-171]. In addition, insurers are prohibited from charging higher premiums because of these health conditions.

People with Visual or Hearing Impairments

Insurers cannot refuse to enroll a person, limit coverage, or charge higher premiums because that person is fully or partially blind or deaf [N.C.G.S. §§ 58-3-25(b), (c), 58-51-15(7), 58-67-65(b)].

Race, Color or National Origin

Insurers are prohibited under state law from limiting coverage, refusing to insure, refusing to continue coverage, and from charging different premium rates because of a person's race, color, or national or ethnic origin [N.C.G.S. §§ 58-3-25(c), 58-65-85, 58-67-65(f)].

POINT-OF SERVICE (POS) AND PREFERRED PROVIDER ORGANIZATION (PPO) PROTECTIONS

Cost Sharing (Point of Service Plans)

In POS plans enrollees have the option of seeking care outside of the network. Usually enrollees have to pay deductibles, higher co-payments, and/or more coinsurance than they would if they received care inside the network. North Carolina laws limit the amount that HMOs can charge for using out-of-network providers. For example, coinsurance for out-of-plan covered services may not be more than 30 percent more than coinsurance for in-plan coverage. The deductible may not be

more than five times the amount of the annual deductible for in-plan coverage. The deductible may not be more than \$2,000/\$6,000 for individual/family coverage if the in-plan does not have a deductible. The co-payments may not exceed the co-payments for in-plan covered services by more than \$50 or 100%, whichever is greater. The annual and lifetime maximum, if any, may not be less than one-half of the amounts of any annual or lifetime maximums for in-plan covered services [11 N.C.A.C. § 12.1403].

Cost-Sharing (Preferred Provider Organizations)

Enrollees in PPOs also have the option of seeking care outside the network. Often, enrollees will have to pay higher deductibles or coinsurance than if they received care inside the network. North Carolina limits the amounts that insurers can charge for using out-of-network providers. Coinsurance for out-of-plan covered services may not be more than 30 percent more than coinsurance for in-plan coverage. The deductible may not be more than two times the amount of the annual deductible for in-plan coverage. If the insurer does not have a deductible for in-plan coverage, then the deductible for out-of-plan coverage cannot exceed \$250 per person or \$750 per family. The co-payments may not exceed the co-payments for in-plan covered services by more than \$20 or 100%, whichever is greater. The annual and lifetime maximum, if any, may not be less than one-half of the amounts of any annual or lifetime maximums for in-plan covered services. [N.C.G.S. § 58-50-56, 11 N.C.A.C. § 12.1800, 1803].

Covered Services

POS plans must make all benefits available for in-plan covered services. But they need not cover preventive services on an out-of-plan basis. Any out-of-plan covered service must also be available on an in-plan basis. POS products must give enrollees the option to choose in-plan or out-of-plan covered services each time the enrollee seeks services. POS products must provide incentives for enrollees to use in-plan services [11 N.C.A.C. § 12.1403].

Disclosure of Cost-Sharing to Enrollees

All marketing materials, evidence of coverage, member handbooks and other materials must explain the method of reimbursement, applicable cost-sharing amounts, and any uncovered costs or charges. Materials should also explain covered benefits that an enrollee may receive on an out-of-plan basis and instructions to submit claims for out-of-plan covered services [11 N.C.A.C. § 12.1404].

PROCEDURAL PROTECTIONS

Free-Look Period

State law gives insurance consumers a “free-look” period in which to review and revoke a new policy if they are not fully satisfied. In order for you to receive a full

refund on a policy, you must return the policy to the company within ten days from the date the policy is received [N.C.G.S. § 58-51-10]. Medicare supplement (“Medigap”) policies and long-term care policies have a 30-day “free look” period [N.C.G.S. §§ 58-54-30, 58-55-30(f),(g)].

Grace Period to Pay Premiums

All policies must contain a grace period for late payment of premiums. Neither insurance companies nor HMOs may cancel a policy for nonpayment of the premium if it is paid during the grace period. Grace periods are not less than seven days for policies with weekly premium payments, 10 days for monthly premiums, and 31 days for all other policies [N.C.G.S. § 58-51-15(a)(3)].

Inadvertent Misstatements by Consumers

Health insurance contracts may not be valid, and the insurance company may not be responsible for the payment of claims, if there was a misstatement in the application or if the information about the medical history of the insured person was omitted. Thus, it is very important for consumers to provide accurate and complete information in the application process.

In the past, some insurance companies have used inadvertent mistakes in the original application as a way to avoid paying medical bills. State laws were enacted to give consumers some protection from their own inadvertent mistakes. During the first two years after the date of issuance of a major medical or catastrophic hospitalization policy, the insurance company may use inadvertent misstatements as grounds for voiding a policy or denying a claim. After two years, however, inadvertent misstatements may not be so used. Fraudulent misstatements (that is, statements submitted with the intent to deceive) are grounds for voiding a policy whenever the misstatement is discovered [N.C.G.S. § 58-51-15].

Notice of Nonrenewal or Discontinuance

Individuals who are covered by group policies must be given at least 45 days’ written notice before termination of an insurance policy. [N.C.G.S. § 58-51-80(g)].

Individuals covered by individual or blanket hospitalization and accident health policies must be given between 30 days’ and two years’ notice before the premium renewal date if the insurer refuses to renew the policy. In general, the notice must be equal to one-fourth the number of months of continuous coverage. So, for instance, if a policy has been in effect for two years, the insurer must give you six months’ notice that the policy is not going to be renewed. There is a minimum of 30 days’ notice for a policy that has been in effect for one year or less, up to a maximum of two years’ notice for four or more years of continuous coverage. [N.C.G.S. § 58-51-20].

Unfair Claims Settlement Practices

Insurance companies that routinely fail to acknowledge a claim or to act reasonably promptly on the payment of claims, or that fail to settle claims promptly where liability has become reasonably clear, may be committing “unfair claims settlement practices.” In these instances, the Commissioner of Insurance has the right to suspend, revoke, or refuse to renew the insurer’s license. Insurers do have the right to ask for additional claims information if the information submitted is insufficient to process the claim. Delays in settling a claim while waiting for sufficient information are not considered an unfair claims settlement practice. [N.C.G.S. §§ 58-3-100(c), 58-63-15(11)].

PROVIDER PROTECTIONS

“Gag Clauses” Prohibited

Insurers may *not* limit providers’ ability to discuss clinical treatment options with their patients, whether or not these options are covered under the benefit package. Insurers may not limit providers’ professional responsibilities to patients [N.C.G.S. § 58-3-176(a)]. Physicians and other providers have an ethical duty to explain all treatment options to their patients, regardless of whether the health plan will pay for the treatment.

Nondiscrimination Against Certain Health Professionals

Insurers cannot discriminate against providers who are located in geographic areas that contain high-risk populations. Nor can they discriminate against providers who treat patients that present a risk of higher-than-average claims or use of health care services [N.C.G.S. § 58-3-200(e)]. This section is intended to ensure that insurers do not intentionally exclude certain providers from their networks because they are more likely to treat high-risk populations.

Prohibition on Certain Managed Care Provider Incentives

Managed care plans may not offer or pay any type of material financial incentive (such as an incentive payment or bonus) to a network provider to deny, delay, or withhold medically necessary services to any specific enrollee. However, insurers are not prohibited from paying providers a financial incentive based on the provider’s aggregate services or the insurer’s financial performance [N.C.G.S. §§ 58-3-265, 135-39.4A(g)].

Prompt Payment

Normally, insurers must either pay providers or, if appropriate, deny the claim within 30 calendar days of receiving a health care bill. However, the insurer need not pay the bill immediately if the provider failed to submit information needed to process the claim or submitted the claim on the wrong form. In addition, the insurer need

not immediately pay the claim if the insurer is waiting for the enrollee to pay premiums. In these cases, the insurer must notify the provider of the missing information or other reason for the delay within the 30-day time period. Once the needed information is received, the insurer has 30 days to make the payment. If the health plan payments are not made in the proper time period, then the insurer is responsible for paying interest on the outstanding payment (at an 18% interest rate) [N.C.G.S. § 58-3-225].

Providers Protected From Retaliation When Filing Appeals on Behalf of Enrollees

Insurers are prohibited from discriminating against providers who appeal a plan's decision affecting the availability, delivery, or quality of health care services. For example, an insurer cannot retaliate against a physician who appeals the insurer's decision to deny or limit care [N.C.G.S. § 58-50-62(j)].

QUALITY ASSURANCE

Internal Quality Assurance Systems

HMOs must have an internal quality assurance system to ensure the overall performance of the HMO and the quality of health care services provided to its enrollees [11 N.C.A.C. § 20.0501 *et seq.*]. The HMO must employ a variety of tools to assess the quality of health care services provided in different types of treatment settings. The HMO must also ensure the quality of its internal administrative and utilization review operations. In addition, the system must include procedures to investigate and take corrective action in response to patient complaints about the providers' or HMO's decisions. Any HMO that delegates the quality management activities to another organization must ensure that the other organization follows state laws.

Provider Credentialing Procedures

HMOs must have systems to ensure the minimum competency of the health care providers in their networks. These are called credentialing procedures. The HMO must check physicians' credentials before listing them in its provider directory or other materials given to enrollees [11 N.C.A.C. § 20.0401 *et seq.*]. For example, the HMO must check the following information on physicians:

- ◆ Personal information
- ◆ Practice information, including the non-work hours that the provider can be contacted (call coverage)
- ◆ Education and training history
- ◆ Current provider license, registration, or certification. States where the provider has previously been licensed, certified, or registered should be listed.
- ◆ Drug Enforcement Agency registration and any prescribing restrictions

- ◆ Specialty board certification, professional and hospital affiliation
- ◆ The amount of professional liability coverage and the provider's malpractice history
- ◆ Any disciplinary actions by medical organizations and/or regulatory agencies
- ◆ Any felony or misdemeanor convictions
- ◆ The type of affiliation requested
- ◆ A statement signed and dated by the applicant attesting to the truthfulness and completeness of the information submitted

HMOs must also obtain information on health care facilities, including accreditation status from the Joint Commission on Accreditation of Health Care Organizations, state licensure information, Medicaid and Medicare certification, and evidence of current malpractice insurance.

HMOs must verify all information included in the provider's application for credentials and must reverify the provider's credentials not less than once every three years. The HMO is responsible for ensuring that these rules are followed, even if it subcontracts the credentialing process to another organization.

Provider Discipline Systems

HMOs must have a mechanism to reduce, suspend, or terminate providers from participating in the network if the HMO believes the physician is providing poor quality of care or the physician drops malpractice coverage [11 N.C.A.C. § 20.0411]. In addition, HMOs, like other health care institutions, must report to the Board of Medical Examiners any time they revoke, suspend, or limit a physician's practice privileges or when a physician decides to stop participating in the plan [N.C.G.S. § 90-14.13]. This law was established to ensure that the Board of Medical Examiners is alerted to any potential provider competence issues.

REGULATORY OVERSIGHT BY THE NC DEPARTMENT OF INSURANCE

Accountability and Enforcement Mechanisms

The NC Department of Insurance inspects domestic insurers at least every five years [N.C.G.S. § 58-2-131, 11 N.C.A.C. § 19.0106]. Insurers that are not incorporated in North Carolina can be examined more frequently.

In addition, the Department can investigate complaints outside of the normal three-year cycle. If the Department finds problems, it can seek corrective action. If the problems are significant, the Department can seek to suspend or revoke the license, issue civil penalties, or seek injunctive relief. [N.C.G.S. §§ 58-2-60, 58-2-65, 58-2-70, 58-67-140, 58-67-165].

Consumer Services Division

Consumers can also file a complaint on-line by going to the consumer section of www.NCDOI.com.

The NC Department of Insurance has a Consumer Services Division which can help address consumer complaints. The Department can investigate the complaint and will intervene on behalf of the consumer if it thinks the health plan is acting improperly. The Consumer Services Division is open from 8:00 A.M to 4:50 P.M. Monday through Friday. The Division can be reached at: (800) 546-5664.

Financial Solvency

North Carolina state law offers several protections to insure the financial solvency of insurance companies and HMOs and to protect enrollees in the event of possible insolvency, including adequate financial reserves, insolvency protections and procedures to help enrollees obtain alternative coverage upon insolvency. Generally, the laws governing HMOs are different than the laws governing other health insurers.

Adequate Financial Resources

North Carolina laws mandate that insurers and HMOs have minimum financial resources to protect against insolvency. The statute sets out minimum requirements for working capital, deposits, net worth, surplus and reserves. For example, HMOs must have a minimum deposit of at least \$500,000 for full-service HMOs, and must maintain a minimum net worth of at least \$1 million. Insurers must also meet minimum capital and surplus requirements. [N.C.G.S. §§ 58-67-20(a), 25, 40, 110; 58-65-95, 58-3-71, 58-13-1 *et. seq.*, 58-49-40, 58-7-75].

Insolvency Protections

HMOs have different insolvency protections than other health insurers. HMOs must ensure that providers do not collect sums from enrollees that are owed by the HMO. If the HMO does not have this protection in its provider contracts then it must set up an additional special deposit to cover unpaid claims [N.C.G.S. § 58-67-115]. Each HMO must ensure that enrollees can obtain benefits for the duration of the contract period for which premiums have been paid, even if the HMO lacks sufficient funds to continue operating (insolvency). In case of hospitalization, this applies until a member's discharge. HMOs must also have other protections against insolvency that are approved by the Commissioner of Insurance, such as a reinsurance agreement that covers the HMO against excess losses, or any other arrangement that the Commissioner may require [N.C.G.S. § 58-67-120].

Other insurers are included in the North Carolina Life and Health Insurance Guarantee Association. This Guarantee Association was created to help enrollees in the event that an insurer becomes insolvent. The Association will help pay for services up to \$300,000 for an individual, and up to \$5,000,000 for a group contract. In addition, the Association will also help locate substitute coverage [N.C.G.S. § 58-62-2 *et. seq.*].

Obtaining Other Coverage Upon Insolvency

If an HMO does become insolvent, the Insurance Commissioner has the authority to order other carriers to offer a 30-day enrollment period for enrollees of the insolvent plan. HMOs that previously offered coverage to groups enrolled in the insolvent health care plan will be the first required to offer coverage. The Commissioner may allocate the insolvent HMO's group or non-group contracts to other HMOs [N.C.G.S. § 58-67-125]. Enrollees in other health insurance plans will be assisted in obtaining substitute coverage by the Life and Health Insurance Guarantee Association [N.C.G.S. § 58-62-2 *et. seq.*].

Premium Rate Oversight

Premium Rates Established

The Department of Insurance's authority to review and approve premium rates varies, depending on the type of insurer (HMO, commercial insurer, or nonprofit) and type of product line (group or non-group). In general, the Department of Insurance must review and approve health insurance premiums in the individual, non-group market. The Department also reviews premiums for group Medicare supplements, HMOs, and for any nonprofit health insurer (such as Blue Cross Blue Shield of North Carolina) [N.C.G.S. §§ 58-51-95; 58-65-40; 58-65-45].

In the small-group market, the Commissioner has the authority to review the rating methodology [N.C.G.S. § 58-50-130(b)]. In contrast, the Commissioner does not have the authority to review the premiums charged to large-group policyholders of commercial insurers (group is defined as having more than 50 employees). In most instances involving large-group health plans, insurers must provide evidence only that the rates are established using sound actuarial principles that are certified by a recognized actuary [N.C.G.S. §58-51-85]. The Commissioner does not have the authority to review the premiums or the rating methodology.

Premium Rates Periodic Adjustments

The premiums for non-group coverage cannot be adjusted more frequently than once every 12 months and may not become effective unless the insurer has given the enrollees at least 45 days advance notice [N.C.G.S. § 58-67-50(b)(3), 58-51-95(f)]. HMOs may not adjust group rates more frequently than once every six months, and this adjustment also requires at least 45 days' advance notice. The Department of Insurance is unlikely to approve a rate adjustment in the first 12 months of enrollment.

UTILIZATION REVIEW PROVISIONS

Assessing Utilization of Health Services

Each managed care organization (MCO) that uses utilization review must have a system that collects data and assesses the use of health care services. Specifically, the system must have mechanisms to evaluate medical necessity, as well as the appropriateness, effectiveness, and efficiency of health services. The utilization review criteria must be based on sound, up-to-date clinical criteria and must be applied consistently in all appropriate reviews. Managed care organizations must monitor health care to see if providers are providing unnecessary care (overutilization) or withholding necessary care (underutilization). Any problems identified in the utilization review process should be used to improve the system [N.C.G.S. § 58-50-61(c)].

Conducting Utilization Reviews

Qualified health professionals such as nurses must make all initial utilization review determinations. These reviewers act under the direction of one of the managed care organization's physicians. An MCO physician must also review all decisions to deny requested services. The person making the utilization review decisions may not be paid on the basis of the numbers of services or treatments denied or the money saved [N.C.G.S. § 58-50-61(d)].

The MCO can conduct utilization review procedures in-house, or it can contract these functions to another body called a utilization review organization. Whether it does its own review or contracts with another organization, the MCO has overall responsibility to ensure that the review process meets state law [N.C.G.S. § 58-50-61(b)].

Medical Necessity Standards

Any plan that limits coverage to medically necessary services and supplies must use the state statutory definition of medical necessity. The state law defines medical necessity as services or supplies that are:

- ◆ Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease
- ◆ Not for experimental, investigational, or cosmetic purposes, unless allowed under N.C.G.S. § 58-3-255
- ◆ Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
- ◆ Within generally accepted standards of medical care in the community
- ◆ Not solely for the convenience of the insured, the insured's family, or the provider

A health plan may examine cost-effectiveness when choosing between two or more services or supplies that are medically appropriate for the condition. However, a health plan may not consider cost-effectiveness in determining whether a service or supply is medically necessary [N.C.G.S. § 58-3-200(b)].

Notice to Enrollees about Utilization Review Procedures

MCOs and other utilization review organizations must notify enrollees and prospective enrollees about the review procedures, including the procedures to appeal denials of care. MCOs must have a toll-free telephone number for enrollees to use in seeking prior authorization, and must include this number on their enrollee membership cards [N.C.G.S. § 58-50-61(e)(3), (m)]. In addition, insurers must make sure the utilization review staff is accessible by telephone by monitoring the average speed of answer and call abandonment rates on at least a monthly basis.

Time Limits for Review

The MCO also has certain time limits to make utilization review determinations. MCOs must make all prospective and concurrent review determinations within three business days after the insurer obtains all necessary information about the admission, requested procedure, or health care service [N.C.G.S. § 58-50-61(f)]. Reviews of services and supplies that are conducted after the services have been provided (retrospective review) must be conducted within 30 days of the time the MCO receives the necessary information to make the determination [N.C.G.S. § 58-50-61(g)].