SENATE BILL 228:
Allow Insurers to Offer EPO Benefit Plans.

2021-2022 General Assembly

Committee:	House Health. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	August 23, 2021
Introduced by:	Sens. Edwards, Krawiec, Burgin	**Prepared by:**	Jason Moran-Bates
Analysis of:	PCS to Fourth Edition S228-CSBC-54		Committee Staff

OVERVIEW: The PCS to Senate Bill 228 would allow insurers to offer exclusive provider benefit health plans and establish continuity of care provisions for those plans. It would also require insurers to issue payments directly to health care providers if there is a reimbursement contract between the provider and insurer or if an insured executes a valid assignment of benefits.

CURRENT LAW: Insurers may offer preferred provider organization health benefit plans to consumers. There is no current statutory authority for them to offer exclusive provider organization health benefit plans. G.S. 58-3-225 requires insurers to promptly pay benefits owed for claims under a health benefits plan. There is nothing in that section that requires benefits owed under a reimbursement contract to be paid directly to health care providers.

BILL ANALYSIS:

Section 1 of the PCS Senate Bill 228 would allow insurers to offer exclusive provider benefit plans where out-of-network services would not be covered unless they were emergency services or medically necessary services provided when an in-network provider was not reasonably available.

The bill would create definitions for "exclusive provider benefit plan," "exclusive provider organization or EPO," "insurer," and "participating provider."

Insurers would be required to allow any provider to participate in the EPO and furnish the Commissioner of Insurance with the criteria it uses to select participating providers. They would also be required to document all requests for payment from non-participating providers and create an appeals process to ensure insureds have reasonable access to providers near their homes or workplaces. Finally, insurers would be required to notify insureds and employers about changes in the provider network and to provide a clear statement that out-of-network healthcare services would not be covered, except in the case of emergency care or when an in-network provider was not reasonably available.

No insurer could offer an EPO without also offering a preferred provider benefit plan. Any employer offering an EPO to its employees would have to offer a preferred provider benefit plan as well.

Providers who were members of one insurer's exclusive network would be permitted to participate in networks with other insurers. Insurers offering exclusive provider benefit plans would have to make annual reports to the Department of Insurance on the terms of their agreements with providers in the exclusive network. The existing insurance rules for preferred provider organizations would also apply to exclusive provider organizations.

Jeffrey Hudson
Director

Legislative Analysis Division
919-733-2578

The bill would also establish continuity of care provisions for EPOs. This transitional coverage would be available to individuals who are newly insured by the EPO and to individuals whose healthcare providers left the EPO's network.

- In general, the insurer would have to continue paying the provider for treatment received within 90 days of the provider leaving the network.
- If the care is related to surgery, organ transplantation, or inpatient care, coverage must be continued for 90 days after discharge.
- If the care is related to pregnancy, and the insured was in her second trimester when the provider left the network, coverage must continue through 60 days of postpartum care.
- Coverage for terminal illness must be extended for the duration of the insured's life.

Insurers may condition coverage for continuing care on the following:

- The provider agreeing to accept reimbursement from the insurer and not charge the patient a greater cost-share.
- The provider agreeing to comply with the insurer's quality assurance programs and policies for in-network providers.
- The provider agreeing to discontinue providing services to the insured at the end of the transition period and assist the insured in finding an in-network provider.

Insurers would not be required to:

- Cover benefits during the transition period that would not have been covered previously.
- Provide continuing coverage when the provider is removed from the network for reasons of fraud.
- Provide transition coverage when the insurer determines the provider's continuing services would result in serious danger to the health or safety of the insured.

Section 2 of the PCS would require reimbursement contracts between insurers and providers to contain a provision that reimbursement payments be issued directly to the providers. It would also require insurers to accept assignment of benefits agreements executed by insureds.

EFFECTIVE DATE: This bill would be effective Ocotber 1, 2021, and apply to contracts entered into, renewed, or amended on or after that date.