LEGISLATIVE BILL 279

Approved by the Governor May 9, 1997

Introduced by Wesely, 26; Matzke, 47; Schimek, 27

AN ACT relating to insurance; to adopt the Managed Care Patient Protection Act.

Be it enacted by the people of the State of Nebraska,

Section 1. Sections 1 to 24 of this act shall be known and may be cited as the Managed Care Patient Protection Act.

Sec. 2. The purposes of the Managed Care Patient Protection Act are to (1) establish standards and requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons and (2) establish standards for access to and delivery of emergency medical services.

Sec. 3. For the purposes of the Managed Care Patient Protection Act, the definitions found in sections 4 to 19 of this act shall apply.

Sec. 4. Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

Sec. 5. Covered benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan.

Sec. 6. Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

Sec. 7. Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (2) serious impairment to such person's bodily functions, (3) serious impairment of any bodily organ or part of such person, or (4) serious disfigurement of such person.

Sec. 8. Emergency services means health care items and services necessary to screen and stabilize a covered person in connection with an emergency medical condition. For purposes of this section, stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(1) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(2) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.

Sec. 9. Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

Sec. 10. Health benefit plan means a policy contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse the costs of health care services.

Sec. 11. Health care professional means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care service consistent with state law.

Sec. 12. Health care provider means a health care professional or a facility.

Sec. 13. Health care services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Sec. 14. Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a

nonprofit hospital and health service corporation, a prepaid limited health service organization, or any other entity providing a plan of health insurance, health benefits, or health care services.

Sec. 15. Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

Sec. 16. Network means the group of participating providers providing services to a managed care plan.

Sec. 17. Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

Sec. 18. Participating provider means a health care provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

Sec. 19. Person means an individual, a corporation, a partnership, an association, a joint venture, joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

Sec. 20. The Managed Care Patient Protection Act applies to all health carriers that offer managed care plans.

Sec. 21. A health carrier shall not offer an inducement under a managed care plan to a health care provider to provide less than medically necessary services under the terms of the managed care plan to a covered person.

Sec. 22. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

Sec. 23. (1) A health carrier which provides a covered benefit for emergency services is, subject to the terms and conditions of the health benefit plan, responsible for charges for medically necessary emergency services provided to a covered person, including services furnished outside the network and services deemed approved under subsection (2) of this section.

(2) If a treating physician or other emergency department personnel who have provided emergency services to a person covered by a health carrier determine that additional medically necessary services are promptly needed by the covered person and they have requested health carrier approval for such services, the health carrier is deemed to have approved the request if the treating physician or other emergency department personnel involved:

(a) Has made a reasonable effort to contact the individual at the health carrier authorized to approve such requests and the health carrier has not provided access to that individual; or

(b) Has requested authorization from the individual at the health carrier authorized to approve such requests and the individual has not denied authorization within thirty minutes after the time the request was made, unless the plan can document that it had made a good faith effort but was unable to reach the emergency physician within thirty minutes after receiving a request for authorization.

A request which is deemed approved under this subsection shall be treated as approval for any medically necessary covered benefits that are required to treat the medical condition identified by the treating physician or other emergency department personnel.

(3) A health carrier may impose a reasonable copayment for emergency services to deter inappropriate use of services of hospital emergency departments if the copayment is the same without regard to whether the health care professional or facility has a contractual or other arrangement with the health carrier.

Sec. 24. The Department of Insurance shall enforce the Managed Care Patient Protection Act. The department may use the types of penalties and remedies available under the Health Maintenance Organization Act to enforce the Managed Care Patient Protection Act.