§ 58-67-88. Continuity of care.

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

(1) "Ongoing special condition" means:

a. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

b. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

c. In the case of pregnancy, pregnancy from the start of the second trimester.

d. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

(2) "Terminated or termination". – Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by an HMO for failure to meet applicable quality standards or for fraud.

(b) Termination of Provider. – If a contract between an HMO benefit plan that is not a point-of-service plan and a health care provider is terminated by the provider or by the HMO, or benefits or coverage provided by the HMO are terminated because of a change in the terms of provider participation in a health benefit plan of an HMO that is not a point-of-service plan, and an individual is covered by the plan and is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, the HMO shall:

(1) Upon termination of the contract by the HMO or upon receipt by the HMO of written notification of termination by the provider, notify the individual on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the provider under this section if the individual has filed a claim with the HMO for services provided by the terminated provider or the individual is otherwise known by the HMO to be a patient of the provider.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(c) Newly Covered Insured. – Each health benefit plan offered by an HMO that is not a point-of-service plan shall provide transition coverage to individuals who are undergoing treatment from a provider for an ongoing special condition and are newly covered under the health benefit plan because the individual's employer has changed health benefit plans, and the HMO shall:

(1) Notify the individual on the date of enrollment of the right to elect continuation of coverage of treatment by the provider under this section.

(2) Subject to subsection (h) of this section, permit the individual to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in subsections (e), (f), and (g) of this section, the transitional period under this subsection shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the

individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subdivision (c)(1) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual before the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, or if the individual on that date was on an established waiting list or otherwise scheduled to have the surgery, transplantation, or other inpatient care, the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend beyond the period under subsection (d) of this section through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through postdischarge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an insured has entered the second trimester of pregnancy on the date of the notice required under subdivision (b)(1) of this section, or the date of enrollment in a new plan described in subdivision (c)(1) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the new plan, the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an insured was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section, or at the time of enrollment in the new plan under subdivision (c)(1) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the new plan, the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An HMO may condition coverage of continued treatment by a provider under subdivision (b)(2) or (c)(2) of this section upon the following terms and conditions:

(1) When care is provided pursuant to subdivision (b)(2) of this section, the provider agrees to accept reimbursement from the HMO and individual involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full. When care is provided pursuant to subdivision (c)(2) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment, as reimbursement in full from the HMO and the insured for all covered services.

(2) The provider agrees to comply with the quality assurance programs of the HMO responsible for payment under subdivision (1) of this subsection and to provide to the HMO necessary medical information related to the care provided. The quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the patient.

(3) The provider agrees otherwise to adhere to the HMO's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by the HMO, and member hold harmless provisions.

(4) The insured or the insured's representative notifies the HMO within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subdivision (c)(1) of this section, that the insured elects to continue receiving treatment by the provider.

(5) The provider agrees to discontinue providing services at the end of the transition period pursuant to this section and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.

(i) Construction. – Nothing in this section:

(1) Requires the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, requires the coverage of benefits not provided under the new policy under which the person is covered.

(2) Requires an HMO to offer a transitional period when the HMO terminates a provider's contract for reasons relating to quality of care or fraud; and refusal to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibits an HMO from extending any transitional period beyond that specified in this section.

(4) Prohibits an HMO from terminating the continuing services of a provider as described in this section when the HMO has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. Such terminations shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each HMO shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description. (2001-446, s. 1.)