

Sixty-second  
Legislative Assembly  
of North Dakota

**HOUSE BILL NO. 1476**

Introduced by

Legislative Management

(Health Care Reform Review Committee)

1 A BILL for an Act to amend and reenact section 26.1-36-46 of the North Dakota Century Code,  
2 relating to the external review procedures for health insurance; and to provide an effective date.

3 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

4 **SECTION 1. AMENDMENT.** Section 26.1-36-46 of the North Dakota Century Code is  
5 amended and reenacted as follows:

6 **26.1-36-46. External ~~appeals~~review procedures.**

7 1. As used in this section, unless the context otherwise requires:

8 a. "Adverse benefit determination" means a denial of, reduction of, termination of, or  
9 a failure to provide or make payment for a claim for benefits which involves  
10 medical judgment and involves the cancellation or discontinuation of coverage  
11 that has retroactive effect. The term includes a determination based on the  
12 requirements of an insurance company, nonprofit health services corporation, or  
13 health maintenance organization for medical necessity, appropriateness, health  
14 care setting, level of care, or effectiveness of a covered benefit and a  
15 determination that a treatment is experimental or investigational. The term does  
16 not include a denial of, reduction of, termination of, or failure to provide or make  
17 payment related to a claimant's eligibility for benefits under the terms of  
18 coverage.

19 b. "Claim for benefits" means a request for one or more benefits which is made by  
20 a claimant in accordance with the reasonable procedure for submitting benefit  
21 claims offered by an insurance company, nonprofit health services corporation, or  
22 health maintenance organization. A reasonable procedure includes an external  
23 review procedure that complies with this section.

c. "Claimant" means an individual who makes a claim for benefits under this section.

d. "Expedited external review" means an adverse benefit determination that involves:

(1) An admission, availability of care, a continued stay, or a health care service for which the claimant received emergency services but has not been discharged from the facility; or

(2) A medical condition for which the standard external review timeframes would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function.

e. "External review" is a review of an adverse benefit determination conducted pursuant to this section.

f. "Final external review determination" means a determination by an independent review organization at the conclusion of an external review.

g. "Independent review organization" means an entity that conducts independent external reviews of adverse benefit determinations.

2. An insurance company, nonprofit health services corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage meets the minimum requirements of 42 U.S.C. 300gg-19 and complies with 29 U.S.C. 1133, 29 CFR 2560.503-1; 42 U.S.C. 300gg-19, 26 CFR 54.9815-2719T; 29 U.S.C. 1185d, 29 CFR 2590.715-2719; and 26 U.S.C. 9815, 45 CFR 147.136. ~~The insurance commissioner may take steps~~ shall adopt rules as necessary to ensure compliance with this section and the federal minimum consumer protection standards. If federal laws or rules relating to external appeals review are amended, repealed, or otherwise changed, the insurance commissioner shall adopt rules that track such changes to the federal external review rules to ensure the external appeals review procedure set forth in this section is in compliance with and substantively equivalent and parallel to the federal requirements. An external review procedure must meet the requirement set forth in this section.

- 1       3. An external review process offered by an insurance company, nonprofit health  
2       services corporation, or health maintenance organization pursuant to this section must  
3       include each of the following:
- 4       a. An external review must be available to a claimant for:
- 5           (1) An adverse benefit determination involving medical necessity,  
6           appropriateness, health care setting, level of care, or effectiveness of a  
7           covered benefit;
- 8           (2) A determination that a treatment is experimental or investigational if it is  
9           ensured that adequate clinical and scientific protocols are taken into  
10          account as part of the external review for determinations involving  
11          experimental or investigative claims for benefits; and
- 12          (3) An adverse benefit determination involving the cancellation or  
13          discontinuation of coverage that has a retroactive effect. For purposes of  
14          this paragraph, an adverse benefit determination does not include a denial,  
15          a reduction, a termination, or a failure to provide or make payment related to  
16          a claimant's eligibility for benefits under the terms of coverage.
- 17       b. An effective written notice must be provided to each claimant of the claimant's  
18       rights related to external review of an adverse benefit determination.
- 19       c. The insurance company, nonprofit health services corporation, or health  
20       maintenance organization may require a claimant to exhaust the internal claims  
21       and appeals process; however, a claimant may not be required to exhaust all  
22       internal and external claims and appeals processes if the insurance company,  
23       nonprofit health services corporation, or health maintenance organization waives  
24       this requirement, the claimant is considered to have exhausted the internal  
25       claims and appeals process under applicable law, or the claimant has filed for  
26       expedited external review. A claimant may file for an expedited external review  
27       without fully exhausting all internal claims and appeals requirements at the same  
28       time any internal appeal is being processed and the claimant meets the defined  
29       criteria for requesting an expedited external review.
- 30       d. The insurance company, nonprofit health services corporation, or health  
31       maintenance organization against which a request for external review is

submitted shall pay the cost of the independent review organization for completing the external review. An insurance company, nonprofit health services corporation, or health maintenance organization may require the claimant to pay a nominal filing fee from the claimant requesting an external review under this section. This fee may not exceed twenty-five dollars and must be refunded to the claimant if the adverse benefit determination is reversed by the independent review organization. A fee must be waived if payment imposes an undue hardship on the claimant. The fees charged by an insurance company, nonprofit health services corporation, or health maintenance organization to a claimant in any single plan year may not exceed seventy-five dollars.

e. A minimum dollar requirement may not be imposed for a claim for benefits to qualify for external review.

f. A claimant must have up to four months after receipt of notice of an adverse benefit determination to request external review.

g. A requirement that the commissioner assign external review to independent review organizations on a random basis or other method of assignment that assures the independence and impartiality of the assignment process, such as rotational assignment. The commissioner's process must provide for the maintenance of a list of at least three independent review organizations that are accredited by a nationally recognized private accrediting organization and are qualified to conduct the external review based on the nature of the health care service that is the subject of the review.

The commissioner may not use an independent review organization that has a conflict of interest that influences its independence. The independent review organization may not own or control, or be owned or controlled by, an insurance company, a nonprofit health services corporation, a health maintenance organization, a group health plan, the sponsor of a group health plan, a trade association of plans or insurance companies, or a trade association of health care providers. The independent review organization and clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the insurance company, nonprofit

1 health services corporation, or health maintenance organization or plan that is  
2 the subject of the external review; with the claimant whose treatment is the  
3 subject of the external review; with any officer, director, or management  
4 employee of the insurance company, nonprofit health services corporation, or  
5 health maintenance organization; with employees, administrator, or sponsor of  
6 the claimant's health plan; with the health care provider or with the health care  
7 provider's group or practice association recommending the treatment that is  
8 subject to the external review; with the facility at which the recommended  
9 treatment would be provided; or with the developer or manufacturer of the  
10 principal drug, device, procedure, or other therapy being recommended and that  
11 is the subject of the external review.

12 h. The claimant must be notified that the claimant is allowed up to five business  
13 days to submit additional written information to the independent review  
14 organization and that this information must be considered by the independent  
15 review organization when completing the external review. Any additional  
16 information submitted by a claimant to an independent review organization for  
17 consideration in any external review must also be forwarded to the insurance  
18 company, nonprofit health services corporation, or health maintenance  
19 organization within one business day of receipt by the independent review  
20 organization.

21 i. Any decision by an independent review organization through the external review  
22 process is binding on the claimant and on the insurance company, nonprofit  
23 health services corporation, or health maintenance organization, except to the  
24 extent other remedies are available under state or federal law and except that the  
25 requirement that the determination be binding does not preclude the insurance  
26 company, nonprofit health services corporation, or health maintenance  
27 organization from making payment on the claim for benefits or from failing to  
28 require such payment or benefits. The insurance company, nonprofit health  
29 services corporation, or health maintenance organization shall provide benefits,  
30 including making payment, pursuant to the final external review decision without  
31 delay, regardless of whether the insurance company, nonprofit health services

corporation, or health maintenance organization intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

j. Within forty-five days of the independent review organization's receipt of the request for external review, the independent review organization shall provide written notice to the commissioner, the claimant, and the insurance company, nonprofit health services corporation, or health maintenance organization of the independent review organization's decision to uphold or reverse the adverse benefit determination. In regard to a request for an expedited external review, within seventy-two hours of the independent review organization's receipt of a request for expedited review, the independent review organization shall make a decision to uphold or reverse the adverse benefit determination and notify the commissioner, the claimant, and the insurance company, nonprofit health services corporation, or health maintenance organization of the determination. If the notice by the independent review organization is not in writing, the independent review organization shall provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

k. An insurance company, nonprofit health services corporation, or health maintenance organization shall include a description of the external review process in or attached to the policy, certificate of coverage, or other plan documents or evidence of coverage provided to covered individuals.

l. The contract with an independent review organization to provide external review services must require the independent review organization to maintain written records and to make those records specifically involving an external review available to the commissioner.

4. An insurance company, nonprofit health services corporation, or health maintenance organization provides an effective and relevant notice in a culturally and linguistically appropriate manner with respect to any applicable non-English language if the insurance company, nonprofit health services corporation, or health maintenance organization provides, upon request, a notice in any applicable non-English language and a statement prominently displayed in any applicable non-English language clearly

1           indicating how to access the language services provided by the insurance company,  
2           nonprofit health services corporation, or health maintenance organization. With  
3           respect to an address in any United States county to which such notice is sent, an  
4           applicable non-English language means that at least ten percent of the population  
5           residing in the county is literate only in the same non-English language as determined  
6           in guidance issued under federal law.

7           **SECTION 2. EFFECTIVE DATE.** This Act becomes effective on December 1, 2011.