Fifty-sixth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2400

Introduced by

Senators Kilzer, DeMers

Representatives Berg, Rose

A BILL for an Act to create and enact four new subsections to section 26.1-04-03, four new subsections to section 26.1-26.4-02, and four new sections to chapter 26.1-36 of the North Dakota Century Code, relating to fairness in health insurance practices, disclosure of health plan information, confidentiality of medical information maintained by health carriers, contract limitations, and health care grievance procedures; and to amend and reenact subsection 14 of section 26.1-04-03, subsections 4 and 5 of section 26.1-26.4-02, sections 26.1-26.4-03, 26.1-26.4-04, 26.1-26.4-04.1, 26.1-47-02, and subsection 2 of section 26.1-47-03 of the North Dakota Century Code, relating to prohibited health insurance practices, health care utilization review procedures, and preferred provider arrangements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 14 of section 26.1-04-03 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

14. As used in subsections 15 ~~and~~, 16, and section 2 of this Act, unless the context otherwise requires:
    a. "Entity" includes a third-party administrator ~~or other person with responsibility for contracts with health care providers under a health plan~~, an insurance company as defined in section 26.1-02-01, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.
    b. "Health care provider" means a person that delivers, administers, or supervises health care products or services, for profit or otherwise, in the ordinary course of business or professional practice.
    c. "Health plan" means any public or private plan or arrangement that provides or pays the cost of health benefits, including any organization of health care

providers that furnishes health services under a contract or agreement with this type of plan.

d. "Medical communication" means any communication, other than a knowing and willful misrepresentation, made by a health care provider to a patient regarding the health care needs or treatment options of the patient and the applicability of the health plan to the patient's needs or treatment. The term includes communications concerning:

(1) Tests, consultations, and treatment options;

(2) Risks or benefits associated with tests, consultations, and options;

(3) Variation in experience, quality, or outcome among any health care providers or health care facilities providing any medical service;

(4) The process, basis, or standard used by an entity to determine whether to authorize or deny health care services or benefits; and

(5) Financial incentives or disincentives based on service utilization provided by an entity to a health care provider.

e. "Medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury, or disease or their symptoms in a manner that is in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider.

f. "Patient" includes a former, current, or prospective patient or the guardian or legal representative of any former, current, or prospective patient.

SECTION 2. Four new subsections to section 26.1-04-03 of the 1997 Supplement to the North Dakota Century Code are created and enacted as follows:

Incentives to withhold medically necessary care. An entity may not offer a health care provider, and a contract with a health care provider under a health plan may not contain, an incentive plan that includes a specific payment made to, or withheld from, the provider as an inducement to deny, reduce, limit, or delay medically necessary care covered by the health plan and provided with respect to a patient.

This subsection does not prohibit incentive plans, including capitation payments or shared-risk arrangements, that are not tied to specific medical decisions with respect to a patient. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void.

Retaliation for patient advocacy. An entity may not take any of the following actions against a health care provider solely because the provider, in good faith, reports to state or federal authorities an act or practice by the entity that jeopardizes patient health or welfare, advocates on behalf of a patient in a utilization review program or grievance procedure, or protests a decision, policy, or practice on behalf of a patient that the provider reasonably believes interferes with the provider's ability to provide medically necessary care:

a. Refusal to contract with the health care provider;

b. Termination of or refusal to renew a contract with the health care provider;

c. Refusal to refer patients to or allow others to refer patients to the health care provider; or

d. Refusal to compensate the health care provider for covered services that are medically necessary.

Unfair reimbursement. An entity may not require that a health care provider receive under a health plan, pursuant to policies of the entity or a contract with the health care provider, the lowest payment for services and items that the health care provider charges or receives from any other entity. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void.

Unfair participation requirements. An entity that offers multiple health plans or products may not require a health care provider, as a condition of participation in a health plan or product of the entity, to participate in any of the entity's other health plans or products. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void.

SECTION 3. Four new subsections to section 26.1-26.4-02 of the North Dakota Century Code are created and enacted as follows:

"Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

"Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

"Health insurance carrier" includes an insurance company as defined in section 26.1-02-01 or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

"Medical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a utilization review agent to determine whether health care services are medically necessary.

SECTION 4. AMENDMENT. Subsections 4 and 5 of section 26.1-26.4-02 of the North Dakota Century Code are amended and reenacted as follows:

4. "Utilization review" means a system for prospective ~~and~~, concurrent, or retrospective review of the medical necessity ~~and appropriateness in the allocation~~ of health care ~~resources and~~ services given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.
5. "Utilization review agent" means a health insurance carrier performing utilization review or any other person or entity performing utilization review, except:
   a. An agency of the federal government; or
   b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services.

SECTION 5. AMENDMENT. Section 26.1-26.4-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-03. Certification - Medical review criteria.

1. A utilization review agent may not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with section 26.1-26.4-04. Certification must be made annually on or before March first of each calendar year. In addition, a utilization review agent must file the following information:

~~1.~~ a. The name, address, telephone number, and normal business hours of the utilization review agent.

~~2.~~ b. The name and telephone number of a person for the commissioner to contact.

~~3.~~ c. A description of the appeal procedures for utilization review determinations and any other written utilization review program descriptions and procedures required by section 26.1-26.4-04.

~~4.~~ d. A list of the third-party payers for whom the ~~private~~ utilization review agent is performing utilization review in the state.

2. A utilization review agent shall, prior to implementing new medical review criteria or substantially or materially altering existing medical review criteria, obtain input from physicians actively practicing in this state and practicing in the relevant specialty areas. The input must include input from physicians who are not employees of or consultants to the utilization review agent. The input must be documented in a manner permitting verification by the insurance commissioner. A ~~provider may request that a~~ utilization review agent shall furnish ~~the~~ a provider, upon request, with the medical review criteria ~~to be~~ used in evaluating proposed or delivered health care services.

3. Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

SECTION 6. AMENDMENT. Section 26.1-26.4-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-04. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Utilization review program. The utilization review agent shall maintain and implement a written utilization review program that describes all review activities, both delegated and nondelegated, for covered services provided. The program document must describe the following:
   a. Procedures to evaluate the medical necessity of health care services;
   b. Data sources and medical review criteria used in decisionmaking;
   c. The appeal procedures for utilization review decisions, including procedures for notifying enrollees and providers of record of its decisions;
   d. Mechanisms to ensure consistent application of medical review criteria;
   e. Data collection processes and analytical methods used in assessing utilization of health care services;
   f. Data systems used to support utilization review and enable the utilization review agent to monitor health care services effectively;
   g. Provisions for assuring confidentiality of clinical and proprietary information;
   h. The organizational structure or committee that periodically assesses utilization review activities and reports to the health insurance carrier's governing body; and
   i. The staff position functionally responsible for daily program management.
2. Administration. A utilization review program must be administered by a physician or other health care professional.
3. Medical review criteria. A utilization review program must use documented medical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy and consistent application.
4. Prior authorization or approval determinations. For a determination involving a review conducted prior to an admission or a course of treatment, a utilization review agent shall make the determination and provide notice by telephone of the determination to the provider of record or the enrollee as soon as possible in accordance with the medical exigencies of the case and no later than three business days after receiving all necessary information. The utilization review agent shall provide written confirmation of the telephone notification within two business days of making the telephone notification.

5. Initial determination. Notification of ~~a~~ an initial determination by the utilization review agent to certify or not to certify an admission or a course of treatment not included in subsection 4, must be ~~mailed or otherwise~~ communicated by telephone to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review.

~~2.~~ The utilization review agent shall provide written confirmation of the telephone notification within two business days of making the telephone notification. Any adverse determination by a utilization review agent as to the necessity ~~or appropriateness~~ of an admission, service, or procedure must be reviewed by a physician or, if appropriate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist.

~~3.~~ 6. Specification of reasons and notice. Any notification of a determination under this section not to certify an admission or ~~service or procedure~~ course of treatment must include the principal reason for the determination and the procedures to initiate an appeal of the determination.

7. Concurrent review. For a concurrent review determination with respect to a patient's hospital stay or course of treatment, a utilization review agent shall make the determination within one business day of obtaining all necessary information and shall notify by telephone the provider of record or the enrollee within one business day of making the determination of the decision to certify or deny an extended stay or additional services. The utilization review agent shall provide written confirmation of the telephone notification within one business day of making the telephone notification.

8. Retrospective review. For retrospective review determinations involving reviews of medical necessity conducted after services have been provided to a patient, a utilization review agent shall make the determination regarding the services and provide written notice of the determination to the provider of record or the enrollee within thirty days of receiving all necessary information.

9. Appeals process. A utilization review agent shall provide, at a minimum, an appeals process for an enrollee or provider of record to appeal any adverse

determination which meets the standards for first appeals and expedited appeals pursuant to subsection 10 and for final appeals pursuant to subsection 15. Nothing in this section otherwise prohibits an agent from providing an appeals process that allows for more than two levels of appeals, except for an expedited appeals process.

~~4.~~ 10. First appeal. Utilization review agents shall maintain and make available a written description of ~~the appeal~~ procedure by which enrollees or the provider of record may seek ~~review~~ a first appeal of adverse determinations by the utilization review agent. The first appeal procedure must provide for the following:

a. ~~On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate~~ Appeals must be ~~made~~ evaluated by a physician who has not been involved in the initial adverse determination or, if appropriate, a licensed psychologist who has not been involved in the initial adverse determination.

b. Utilization review agents shall complete the adjudication of appeals of adverse determinations ~~not to certify admissions, services, and procedures~~ and notify in writing the provider of record or the enrollee as soon as possible in accordance with the medical exigencies of the case but no later than ~~thirty~~ twenty days from the date the appeal is filed and the receipt of all information necessary to complete the appeal. If the appeal upholds the adverse determination, the written decision must contain:

(1) Any qualifying credentials, including specialties, of the physician or psychologist evaluating the appeal;

(2) A statement of the utilization review agent's understanding of the reason for the request for an appeal by the enrollee or provider of record;

(3) A description of the agent's decision in clear terms and the medical rationale in sufficient detail for the enrollee or provider of record to respond further to the decision;

(4) A reference to the evidence or documentation used as the basis for the decision, including the medical review criteria used to make the

determination, and instructions for requesting the medical review criteria; and

(5) A description of the process for a subsequent appeal or a final appeal pursuant to subsection 15.

c. Expedited appeal. Utilization review agents shall ~~provide for~~ maintain and make available a written description of an expedited appeals process ~~for emergency or life-threatening~~ by which an enrollee or the provider of record may seek review of adverse determinations by the utilization review agent in situations involving an emergency medical condition, including determinations concerning an admission, availability of care, continued stay, or health care service for an enrollee who has received emergency services but has not been discharged. The appeal process must provide for the following:

(1) An expedited appeal must be evaluated by a physician trained in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review who has not been involved in the initial adverse determination.

(2) Utilization review agents shall complete the adjudication of expedited appeals and notify by telephone the provider of record or the enrollee, as expeditiously as the enrollee's medical condition requires, but within forty-eight hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal. The utilization review agent shall provide written confirmation of the telephone notification within two business days of making the telephone notification.

(3) If the appeal upholds the adverse determination, the written decision must contain the provisions specified in subdivision b of subsection 10 and the enrollee or provider of record may appeal the adverse determination as a final appeal pursuant to subsection 15.

(4) A description of the process for a final appeal pursuant to subsection 15.

~~5.~~ 11. Telephone system. Utilization review agents shall make staff available by toll-free telephone at least forty hours per week during normal business hours.

~~6.~~ Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two working days.

~~7.~~ 12. Confidentiality of patient records. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records, including section 9 of this Act.

~~8.~~ 13. ~~Physicians or psychologists~~ Licensure requirement. A psychologist making utilization review determinations ~~shall~~ must have a current ~~licenses~~ license from ~~a state licensing agency in the United States~~ the state board of psychologist examiners. A physician making utilization review determinations must have a current license from the state board of medical examiners.

~~9. Utilization review agents shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for an enrollee or the enrollee's representative to notify the utilization review agent and request certification or continuing treatment for that condition.~~

14. Emergency services. When conducting utilization review or making a benefit determination for emergency services:

a. A utilization review agent may not deny coverage for emergency services and may not require prior authorization of these services.

b. A utilization review agent may not deny coverage for emergency services if the agent, acting through a participating provider or other authorized representative, has authorized the provision of emergency services. If a participating provider or other authorized representative of a utilization review agent authorizes emergency services, the agent may not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or service furnished in reliance on approval unless the approval was based on a material misrepresentation about the enrollee's health condition made by the provider of emergency services.

c. Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

~~10.~~ 15. Final appeal. When an initial appeal, any subsequent appeal, or any expedited appeal to reverse ~~a~~ an adverse determination is unsuccessful, ~~a subsequent determination regarding hospital, medical, or other health care services provided or to be provided to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service~~ the enrollee or provider of record may initiate a final appeal of the adverse determination pursuant to the utilization review agent's appeals process. A final appeal must include the following:

a. The appointment of a review panel comprised of physicians or other health care professionals who have appropriate expertise and who were not previously involved in the adverse determination. However, a final decision to uphold the adverse determination must include the evaluation, findings, and concurrence of a physician licensed to practice medicine in this state and trained in the ~~relevant~~ same or similar specialty as typically manages the medical condition, procedure, or treatment under review to make a final determination that care provided or to be provided was, is, or may be medically ~~inappropriate~~ necessary. The physician may not have been previously involved in the adverse determination.

b. The holding of a meeting of the review panel within forty-five days of receiving the request from an enrollee or provider of record for a final appeal. However, if the request is from an adverse determination upheld on an expedited appeal, the utilization review agent shall hold the review panel meeting as expeditiously as the enrollee's medical condition requires.

c. The review panel meeting must provide the opportunity for the enrollee or provider of record or their representative to appear in person before the authorized representatives of the utilization review agent to present the enrollee's case, submit supporting material, and ask questions of the representatives of the utilization review agent. If the enrollee or provider of record requests to appear, the review panel meeting must be held at a time and location in this state reasonably accessible to the enrollee or the provider of record. The enrollee or provider of record must be notified in writing at

least fifteen days in advance of the review date. Upon request of an enrollee or provider of record, the utilization review agent shall provide the enrollee or the provider of record with all relevant information that is not confidential or privileged.

d. If the appeal upholds the adverse determination, the written decision must contain the provisions specified in subdivision b of subsection 10. The decision must contain the telephone number and address of the insurance commissioner's office.

16. ~~However, the~~ The insurance commissioner may find that the standards in this ~~section~~ chapter have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization that imposes standards that meet or exceed the standards imposed by this chapter, as determined by the commissioner.

SECTION 7. AMENDMENT. Section 26.1-26.4-04.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-04.1. Utilization review in this state - Conditions of employment - Scope of chapter.

1. A utilization review agent is deemed to be conducting utilization review in this state if the agent conducts utilization review involving services rendered or to be rendered in the state regardless of where the agent actually performs the utilization review. No person may be employed or compensated as a private review agent under any agreement or contract where compensation of the review agent is contingent upon a denial ~~or~~, reduction, limitation, or delay in the payment for hospital, medical, or other health care services.

2. This chapter applies to a health insurance carrier that provides or performs utilization review services. The requirements of this chapter also apply to any designee of the health insurance carrier that performs utilization review functions on the carrier's behalf. A health insurance carrier shall monitor all utilization review activities carried out by or on behalf of the carrier and ensure that the requirements of this chapter and any related rules of the insurance commissioner are met. If a health insurance carrier contracts to have utilization review performed by another

entity, the commissioner shall hold the health insurance carrier responsible for ensuring that the requirements of this chapter and any related rules of the commissioner are met.

SECTION 8. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Information disclosure. An insurance company, as defined in section 26.1-02-01, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless that insurer provides the insured with a plan description that discloses in writing the terms and conditions of the policy or contract. The plan description must use the plain and ordinary meaning of words so as to reasonably ensure comprehension by a layperson and must be made available to each insured prior to the delivery, issuance, execution, or renewal of the policy or contract.

1. The information required to be disclosed by the insurer must include, in addition to any other disclosures required by law:
   a. A general description of benefits and covered services, including benefit limits and coverage exclusions and the definition of medical necessity used by the insurer in determining whether benefits will be covered;
   b. A general description of the insured's financial responsibility for payment of premiums, deductibles, coinsurance, and copayment amounts, including any maximum limitations on out-of-pocket expenses, any maximum limits on payments for health care services, and the maximum out-of-pocket costs for services that are provided by nonparticipating health care professionals;
   c. A general explanation of the extent to which benefits and services may be obtained from nonparticipating providers, including any out-of-network coverage or options;
   d. A general explanation of the extent to which a person covered under the policy or contract may select from among participating providers and any limitations imposed on the selection of participating health care providers;
   e. A general description of the insurer's use of any prescription drug formulary or any other general limits on the availability of prescription drugs;

f. A general description of the procedures and any conditions for persons covered under the policy or contract to change participating primary and specialty providers;

g. A general description of the procedures and any conditions for obtaining referrals;

h. A general description of the procedure for providing emergency services, including an explanation of what constitutes an emergency situation and notice that emergency services are not subject to prior authorization, the procedure for obtaining emergency services and any cost-sharing applicable to emergency services, including out-of-network services, and any limitation on access to emergency services;

i. A general description of any utilization review policies and procedures, including a description of any required prior authorizations or other requirements for health care services and appeal procedures;

j. A general description of all complaint or grievance rights and procedures used to resolve disputes between the insurer and persons covered under the policy or contract or a health care provider, including the method for filing grievances and the timeframes and circumstances for acting on grievances and appeals;

k. A general description of any methods used by the insurer for providing financial payment incentives or other payment arrangements to reimburse health care providers. This subdivision may not be construed as requiring public disclosure of individual contracts or the specific details of financial arrangements between a health care provider and an insurer;

l. Notice of appropriate mailing addresses and telephone numbers to be used by persons covered under the policy or contract in seeking information or authorization for treatment;

m. If applicable, notice of the provisions required by section 26.1-47-03 that ensure access to health care services in preferred provider arrangements; and

n. Notice that the information described in subsection 2 is available upon request.

2. An insurer shall provide the following written information if requested by a person covered under a policy or contract:
   a. A description of any process for credentialing participating health care providers;
   b. A description of the policies and procedures established to ensure confidentiality of patient information;
   c. A description of the procedures followed by the insurer to make decisions about the experimental nature of individual drugs, medical devices, or treatments;
   d. With regard to any preferred provider arrangement or other network health plan, a list by specialty of the name and location of participating health care providers and the number, types, and geographic distribution of providers participating in the health plan; and
   e. Whether a specifically identified drug is included or excluded from coverage.
3. Nothing in this section may be construed as preventing an insurer from making the information under subsections 1 and 2 available to a person covered under the policy or contract through a handbook or similar publication.

SECTION 9. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Confidentiality of medical information.

1. An insurance company, as defined in section 26.1-02-01, health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless confidentiality of medical information is assured pursuant to this section. An insurer shall adopt and maintain procedures to ensure that all identifiable information maintained by the insurer regarding the health, diagnosis, and treatment of persons covered under a policy or contract is adequately protected and remains confidential in compliance with all federal and state laws and regulations and professional ethical standards. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a person covered under a policy or contract, or a

prospective insured, obtained by an insurer from that person or from a health care provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except:

a. If the data or information identifies the covered person or prospective insured upon a written, dated, and signed approval by the covered person or prospective insured, or by a person authorized to provide consent pursuant to section 23-12-13 for a minor or an incapacitated person;

b. If the data or information identifies the health care provider upon a written, dated, and signed approval by the provider. However, this subdivision may not be construed to prohibit an insurer from disclosing data or information pursuant to chapter 23-01.1 or from disclosing, as part of a contract or agreement in which the health care provider is a party, data or information that identifies a provider as part of mutually agreed upon terms and conditions of the contract or agreement;

c. If the data or information does not identify either the covered person or prospective insured or the health care provider, the data or information may be disclosed upon request for use for statistical purposes only;

d. Pursuant to statute or court order for the production or discovery of evidence; or

e. In the event of a claim or litigation between the covered person or prospective insured and the insurer in which the data or information is pertinent.

2. An insurer may claim any statutory privileges against disclosure that the health care provider who furnished the information to the insurer is entitled to claim.

3. This section may not be construed to prevent disclosure necessary for an insurer to conduct utilization review consistent with the standards imposed by chapter 26.1-26.4 to facilitate payment of a claim or to reconcile or verify claims under a shared risk or capitation arrangement. Nor may this section be construed to limit the insurance commissioner's access to records of the insurer for purposes of enforcement or other activities related to compliance with state or federal laws; however, medical records acquired by the commissioner as part of an examination

of an insurer's business practices under section 26.1-03-19.2 or any other regulatory action or proceeding commenced by the commissioner are confidential.

SECTION 10. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Contract limitations.

1. An insurance company as defined by section 26.1-02-01 issuing a health and accident policy, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation may not terminate a physician's participating contract, designate a physician as nonpayable, or otherwise impose sanctions on any physician unless the requirements of this section are met. If a physician engages in a practice pattern that indicates provision of care that is not medically necessary, the entity shall inform the physician, in writing, as to the manner in which the physician's practice pattern indicates provision of care that is not medically necessary. The entity shall consult with the physician and provide a reasonable time period of not less than six months within which to modify the physician's practice pattern. If the physician's practice pattern continues, the entity may impose reasonable sanctions on the physician, terminate the physician's participating contract or, if the physician's practice pattern thereafter continues to indicate provision of care that is not medically necessary, the physician may be designated as nonpayable. If considered for sanction, termination, or nonpayable status, the affected physician must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include a majority representation of the physician's specialty. The entity may not impose sanctions on a physician, terminate a physician, or designate a physician as nonpayable in the absence of the committee's recommendation to do so. All reports, practice profiles, data, and proceedings of the entity relative to a physician who is sanctioned, terminated, or considered for designation as nonpayable are confidential and may not be disclosed or be subject to subpoena or other legal process except in a legal proceeding between the physician and the entity.

2. If the entity uses a practice profile as a factor in its contract review to evaluate a physician's practice pattern, the entity shall disclose in its contract with the physician, and upon request of the physician provide at any time, a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the physician and the manner in which the practice profile is used to evaluate the physician. An entity may not sanction a physician, terminate a physician's participating contract, or designate a physician as nonpayable on the basis of a practice profile without informing the physician of the specific data underlying those findings. For purposes of this section, a "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning the cost, quality, or quantity of services rendered by an individual physician, group of physicians, or preferred provider. In addition, an entity in developing practice profiles or otherwise measuring physician performance shall:

   a. Make severity adjustments, including allowances for the severity of illness or condition of the patient mix and allowances for patients with multiple illnesses or conditions;

   b. Periodically evaluate, with input from specialty-specific physicians as appropriate, the quality and accuracy of practice profiles, data sources, and methodologies;

   c. Develop and implement safeguards to protect against the unauthorized use or disclosure of practice profiles; and

   d. Provide the opportunity for any physician at any time to examine the accuracy, completeness, or validity of any practice profile concerning the physician and to prepare a written response to the profile. The entity shall negotiate in good faith with the physician to correct any inaccuracies or to make the profile complete. If the inaccuracies or deficiencies are not corrected to the satisfaction of the physician, the entity shall submit the written response prepared by the physician along with the profile at the time the profile is used pursuant to subsection 1 or provided to any third party consistent with section 9 of this Act.

SECTION 11. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Grievance procedures.

1. An accident and health insurance policy may not be delivered or issued for delivery by an insurance company, as defined in section 26.1-02-01, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation to a person in this state unless the entity establishes and maintains a grievance procedure for resolving complaints by covered persons and providers and addressing questions and concerns regarding any aspect of the plan, including access to and availability of services, quality of care, choice and accessibility of providers, and network adequacy. The grievance procedure is in addition to compliance with utilization review standards, if applicable, under chapter 26.1-26.4. The procedure must include:
   a. A system to record and document, over a period of at least three previous years, all grievances and appeals;
   b. A process for the timely processing and resolution of grievances, and appeals of resolutions; and
   c. Procedures for followup action, including methods to inform the covered person or provider of the resolution of the grievance.
2. The procedure must be approved by the insurance commissioner. The commissioner may examine the grievance procedures.

SECTION 12. AMENDMENT. Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements. Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:
   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to ~~minimize the cost of the health benefit plan. These mechanisms may:~~

~~(1)~~ ~~Provide for the~~ review and control ~~of~~ the utilization of health care services~~.~~

~~(2)~~ ~~Establish~~ and establish a procedure for determining whether health care services rendered are medically necessary.

c. Include mechanisms which are designed to preserve the quality of health care.

d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, and any applicable federal or state programs. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

2. Preferred provider arrangements may not unfairly deny, reduce, limit, or delay health benefits to persons for covered medically necessary services or interfere with or alter the decision of a treating physician regarding the manner or setting in which particular services are delivered if the services are covered and medically necessary for treatment or diagnosis.

3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.

SECTION 13. AMENDMENT. Subsection 2 of section 26.1-47-03 of the North Dakota Century Code is amended and reenacted as follows:

2. If the policy or subscriber agreement provides differences in benefit levels payable to preferred providers compared to other providers, the differences may not unfairly

deny, reduce, limit, or delay payment for covered services and may be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.