

**FIRST ENGROSSMENT  
with House Amendments**Fifty-sixth  
Legislative Assembly  
of North Dakota**ENGROSSED SENATE BILL NO. 2400**

Introduced by

Senators Kilzer, DeMers

Representatives Berg, Rose

1 A BILL for an Act to create and enact three new subsections to section 26.1-04-03, two new  
2 subsections to section 26.1-26.4-02, and four new sections to chapter 26.1-36 of the North  
3 Dakota Century Code, relating to fairness in health insurance practices, disclosure of health  
4 plan information, confidentiality of medical information maintained by health carriers, contract  
5 limitations, and health care grievance procedures; and to amend and reenact subsection 14 of  
6 section 26.1-04-03, subsection 9 of section 26.1-26.4-04, and section 26.1-47-02 of the North  
7 Dakota Century Code, relating to prohibited health insurance practices, health care utilization  
8 review procedures, and preferred provider arrangements.

**9 BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:****10 SECTION 1. AMENDMENT.** Subsection 14 of section 26.1-04-03 of the 1997

11 Supplement to the North Dakota Century Code is amended and reenacted as follows:

12 14. As used in subsections 15 ~~and~~, 16, and section 2 of this Act, unless the context  
13 otherwise requires:

14 a. "Entity" includes a third-party administrator ~~or other person with responsibility~~  
15 for contracts with health care providers under a health plan, an insurance  
16 company as defined in section 26.1-02-01, a health maintenance  
17 organization, or any other entity providing a plan of health insurance subject  
18 to state insurance regulation.

19 b. "Health care provider" means a person that delivers, administers, or  
20 supervises health care products or services, for profit or otherwise, in the  
21 ordinary course of business or professional practice.

22 c. "Health plan" means any public or private plan or arrangement that provides  
23 or pays the cost of health benefits, including any organization of health care

- 1 providers that furnishes health services under a contract or agreement with  
2 this type of plan.
- 3 d. "Medical communication" means any communication, other than a knowing  
4 and willful misrepresentation, made by a health care provider to a patient  
5 regarding the health care needs or treatment options of the patient and the  
6 applicability of the health plan to the patient's needs or treatment. The term  
7 includes communications concerning:
- 8 (1) Tests, consultations, and treatment options;  
9 (2) Risks or benefits associated with tests, consultations, and options;  
10 (3) Variation in experience, quality, or outcome among any health care  
11 providers or health care facilities providing any medical service;  
12 (4) The process, basis, or standard used by an entity to determine whether  
13 to authorize or deny health care services or benefits; and  
14 (5) Financial incentives or disincentives based on service utilization  
15 provided by an entity to a health care provider.
- 16 e. "Patient" includes a former, current, or prospective patient or the guardian or  
17 legal representative of any former, current, or prospective patient.

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

20 Incentives to withhold medically necessary care. An entity may not offer a health  
21 care provider, and a contract with a health care provider under a health plan may  
22 not contain, an incentive plan that includes a specific payment made to, or withheld  
23 from, the provider as an inducement to deny, reduce, limit, or delay medically  
24 necessary care covered by the health plan and provided with respect to a patient.  
25 This subsection does not prohibit incentive plans, including capitation payments or  
26 shared-risk arrangements, that are not tied to specific medical decisions with  
27 respect to a patient. In addition to the proceedings and penalties provided in this  
28 chapter, a contract provision violating this subsection is void. As used in this  
29 subsection, "medically necessary care" means health care services, supplies, or  
30 treatments that a reasonably prudent physician or other health care provider would  
31 provide to a patient for the prevention, diagnosis, or treatment of illness, injury,

1           disease, or its symptoms which are in accordance with generally accepted  
2           standards of medical practice, clinically appropriate in terms of type, frequency,  
3           extent, site, and duration, and not primarily for the convenience of the patient,  
4           physician, or other health care provider. This definition does not preclude an entity  
5           from establishing a definition of "medically necessary care" for determining which  
6           services are covered by the health plan.

7           Retaliation for patient advocacy. An entity may not take any of the following  
8           actions against a health care provider solely because the provider, in good faith,  
9           reports to state or federal authorities an act or practice by the entity that  
10           jeopardizes patient health or welfare, or advocates on behalf of a patient in a  
11           utilization review program or grievance procedure:

- 12           a. Refusal to contract with the health care provider;  
13           b. Termination of or refusal to renew a contract with the health care provider;  
14           c. Refusal to refer patients to or allow others to refer patients to the health care  
15           provider; or  
16           d. Refusal to compensate the health care provider for covered services that are  
17           medically necessary.

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

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

26           "Emergency medical condition" means a medical condition of recent onset and  
27           severity, including severe pain, that would lead a prudent layperson acting  
28           reasonably and possessing an average knowledge of health and medicine to  
29           believe that the absence of immediate medical attention could reasonably be  
30           expected to result in serious impairment to bodily function, serious dysfunction of

1           any bodily organ or part, or would place the person's health, or with respect to a  
2           pregnant woman the health of the woman or her unborn child, in serious jeopardy.

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

6           **SECTION 4. AMENDMENT.** Subsection 9 of section 26.1-26.4-04 of the North Dakota  
7 Century Code is amended and reenacted as follows:

8           9. ~~Utilization review agents shall allow a minimum of twenty four hours following an~~  
9           ~~emergency admission, service, or procedure for an enrollee or the enrollee's~~  
10           ~~representative to notify the utilization review agent and request certification or~~  
11           ~~continuing treatment for that condition. When conducting utilization review or~~  
12           ~~making a benefit determination for emergency services:~~

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

15           b. Coverage of emergency services is subject to applicable copayments,  
16           coinsurance, and deductibles.

17           **SECTION 5.** A new section to chapter 26.1-36 of the North Dakota Century Code is  
18 created and enacted as follows:

19           **Information disclosure.** An insurance company, as defined in section 26.1-02-01, a  
20 health maintenance organization, or any other entity providing a plan of health insurance  
21 subject to state insurance regulation may not deliver, issue, execute, or renew a health  
22 insurance policy or health service contract unless that insurer makes available to persons  
23 covered under the policy or contract a plan description that discloses in writing the terms and  
24 conditions of the policy or contract. The plan description must use the plain and ordinary  
25 meaning of words so as to reasonably ensure comprehension by a layperson and must be  
26 made available to each person covered under the contract, in any manner reasonably assuring  
27 availability prior to the delivery, issuance, execution, or renewal of the policy or contract.

28           1. The information required to be disclosed by the insurer must include, in addition to  
29           any other disclosures required by law:

- 1           a. A general description of benefits and covered services, including benefit limits  
2                   and coverage exclusions and the definition of medical necessity used by the  
3                   insurer in determining whether benefits will be covered;
- 4           b. A general description of the insured's financial responsibility for payment of  
5                   premiums, deductibles, coinsurance, and copayment amounts, including any  
6                   maximum limitations on out-of-pocket expenses, any maximum limits on  
7                   payments for health care services, and the maximum out-of-pocket costs for  
8                   services that are provided by nonparticipating health care professionals;
- 9           c. A general explanation of the extent to which benefits and services may be  
10                   obtained from nonparticipating providers, including any out-of-network  
11                   coverage or options;
- 12           d. A general explanation of the extent to which a person covered under the  
13                   policy or contract may select from among participating providers and any  
14                   limitations imposed on the selection of participating health care providers;
- 15           e. A general description of the insurer's use of any prescription drug formulary or  
16                   any other general limits on the availability of prescription drugs;
- 17           f. A general description of the procedures and any conditions for persons  
18                   covered under the policy or contract to change participating primary and  
19                   specialty providers;
- 20           g. A general description of the procedures and any conditions for obtaining  
21                   referrals;
- 22           h. A general description of the procedure for providing emergency services,  
23                   including an explanation of what constitutes an emergency situation and  
24                   notice that emergency services are not subject to prior authorization, the  
25                   procedure for obtaining emergency services and any cost-sharing applicable  
26                   to emergency services, including out-of-network services, and any limitation  
27                   on access to emergency services;
- 28           i. A general description of any utilization review policies and procedures,  
29                   including a description of any required prior authorizations or other  
30                   requirements for health care services and appeal procedures;

- 1           j. A general description of all complaint or grievance rights and procedures  
2           used to resolve disputes between the insurer and persons covered under the  
3           policy or contract or a health care provider, including the method for filing  
4           grievances and the timeframes and circumstances for acting on grievances  
5           and appeals;
- 6           k. A general description of any methods used by the insurer for providing  
7           financial payment incentives or other payment arrangements to reimburse  
8           health care providers;
- 9           l. Notice of appropriate mailing addresses and telephone numbers to be used  
10          by persons covered under the policy or contract in seeking information or  
11          authorization for treatment;
- 12          m. If applicable, notice of the provisions required by section 26.1-47-03 that  
13          ensure access to health care services in preferred provider arrangements;  
14          and
- 15          n. Notice that the information described in subsection 2 is available upon  
16          request.
- 17          2. An insurer shall provide the following written information if requested by a person  
18          covered under a policy or contract:
- 19           a. A description of any process for credentialing participating health care  
20           providers;
- 21           b. A description of the policies and procedures established to ensure  
22           confidentiality of patient information;
- 23           c. A description of the procedures followed by the insurer to make decisions  
24           about the experimental nature of individual drugs, medical devices, or  
25           treatments;
- 26           d. With regard to any preferred provider arrangement or other network health  
27           plan, a list by specialty of the name and location of participating health care  
28           providers and the number, types, and geographic distribution of providers  
29           participating in the health plan; and
- 30           e. Whether a specifically identified drug is included or excluded from coverage.

1           3. Nothing in this section may be construed as preventing an insurer from making the  
2           information under subsections 1 and 2 available to a person covered under the  
3           policy or contract through a handbook or similar publication.

4           **SECTION 6.** A new section to chapter 26.1-36 of the North Dakota Century Code is  
5 created and enacted as follows:

6           **Confidentiality of medical information.**

7           1. An insurance company, as defined in section 26.1-02-01, health maintenance  
8           organization, or any other entity providing a plan of health insurance subject to  
9           state insurance regulation may not deliver, issue, execute, or renew a health  
10          insurance policy or health service contract unless confidentiality of medical  
11          information is assured pursuant to this section. An insurer shall adopt and  
12          maintain procedures to ensure that all identifiable information maintained by the  
13          insurer regarding the health, diagnosis, and treatment of persons covered under a  
14          policy or contract is adequately protected and remains confidential in compliance  
15          with all federal and state laws and regulations and professional ethical standards.  
16          Unless otherwise provided by law, any data or information pertaining to the health,  
17          diagnosis, or treatment of a person covered under a policy or contract, or a  
18          prospective insured, obtained by an insurer from that person or from a health care  
19          provider, regardless of whether the information is in the form of paper, is preserved  
20          on microfilm, or is stored in computer-retrievable form, is confidential and may not  
21          be disclosed to any person except:

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

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

- 1                   that identifies a provider as part of mutually agreed upon terms and conditions  
2                   of the contract or agreement;
- 3                   c. If the data or information does not identify either the covered person or  
4                   prospective insured or the health care provider, the data or information may  
5                   be disclosed upon request for use for statistical purposes or research;
- 6                   d. Pursuant to statute or court order for the production or discovery of evidence;  
7                   or
- 8                   e. In the event of a claim or litigation between the covered person or prospective  
9                   insured and the insurer in which the data or information is pertinent.
- 10                  2. An insurer may claim any statutory privileges against disclosure that the health  
11                  care provider who furnished the information to the insurer is entitled to claim.
- 12                  3. This section may not be construed to prevent disclosure necessary for an insurer  
13                  to conduct utilization review or management consistent with the standards  
14                  imposed by chapter 26.1-26.4, to facilitate payment of a claim, to analyze health  
15                  plan claims or health care records data, to conduct disease management  
16                  programs with health care providers, or to reconcile or verify claims under a shared  
17                  risk or capitation arrangement. This section does not apply to data or information  
18                  disclosed by an insurer as part of a biomedical research project approved by an  
19                  institutional review board established under federal law. Nor may this section be  
20                  construed to limit the insurance commissioner's access to records of the insurer for  
21                  purposes of enforcement or other activities related to compliance with state or  
22                  federal laws; however, medical records acquired by the commissioner as part of an  
23                  examination of an insurer's business practices under section 26.1-03-19.2 or any  
24                  other regulatory action or proceeding commenced by the commissioner are  
25                  confidential.

26                  **SECTION 7.** A new section to chapter 26.1-36 of the North Dakota Century Code is  
27 created and enacted as follows:

28                  **Contract limitations.**

- 29                  1. An insurance company as defined by section 26.1-02-01 issuing a health and  
30                  accident policy, a health maintenance organization, or any other entity providing a  
31                  plan of health insurance subject to state insurance regulation may not terminate a

1           practitioner's participating contract, designate a practitioner as nonpayable, or  
2           otherwise impose sanctions on any practitioner solely for an excessive or  
3           inappropriate practice pattern unless the requirements of this section are met. If a  
4           practitioner engages in an excessive or inappropriate practice pattern for the  
5           practitioner's specialty, the entity shall inform the practitioner, in writing, as to the  
6           manner in which the practitioner's practice is excessive or inappropriate. The  
7           entity shall consult with the practitioner and provide a reasonable time period of not  
8           less than six months within which to modify the practitioner's practice pattern. If  
9           the excessive or inappropriate practice pattern continues, the entity may impose  
10           reasonable sanctions on the practitioner, terminate the practitioner's participating  
11           contract, or designate the practitioner as nonpayable. If considered for sanction,  
12           termination, or nonpayable status, the affected practitioner must first be given the  
13           opportunity to be present and to be heard by a committee appointed by the entity  
14           which must include at least one representative of the practitioner's specialty. The  
15           entity may not impose sanctions on a practitioner, terminate a practitioner, or  
16           designate a practitioner as nonpayable in the absence of the committee's  
17           recommendation to do so. All reports, practice profiles, data, and proceedings of  
18           the entity relative to a practitioner who is sanctioned, terminated, or considered for  
19           designation as nonpayable are confidential and may not be disclosed or be subject  
20           to subpoena or other legal process. Nonpayable status under this section may not  
21           commence until after appropriate notification to the entity's subscribers and the  
22           affected practitioner. As used in this section "practitioner" includes an optometrist,  
23           a physician, a chiropractor, or an advanced registered nurse practitioner duly  
24           licensed to practice in this state.

25           2. If the entity uses a practice profile as a factor to evaluate a practitioner's practice  
26           pattern, the entity shall provide upon request of the practitioner at any time, a  
27           description of the criteria, data sources, and methodologies used to compile the  
28           practice profile concerning the practitioner and the manner in which the practice  
29           profile is used to evaluate the practitioner. An entity may not sanction a  
30           practitioner, terminate a practitioner's participating contract, or designate a  
31           practitioner as nonpayable on the basis of a practice profile without informing the

1           practitioner of the specific data underlying those findings. For purposes of this  
2           section, a "practice profile" means a profile, summary, economic analysis, or other  
3           analysis of data concerning the cost, quality, or quantity of services rendered by an  
4           individual practitioner, group of practitioners, or preferred provider. In addition, an  
5           entity in developing practice profiles or otherwise measuring practitioner  
6           performance shall:

- 7           a. Make severity adjustments, including allowances for the severity of illness or  
8           condition of the patient mix and allowances for patients with multiple illnesses  
9           or conditions;
- 10          b. Periodically evaluate, with input from specialty-specific practitioners as  
11          appropriate, the quality and accuracy of practice profiles, data sources, and  
12          methodologies;
- 13          c. Develop and implement safeguards to protect against the unauthorized use or  
14          disclosure of practice profiles; and
- 15          d. Provide the opportunity for any practitioner at any time to examine the  
16          accuracy, completeness, or validity of any practice profile concerning the  
17          practitioner and to prepare a written response to the profile. The entity shall  
18          negotiate in good faith with the practitioner to correct any inaccuracies or to  
19          make the profile complete. If the inaccuracies or deficiencies are not  
20          corrected to the satisfaction of the practitioner, the entity shall submit the  
21          written response prepared by the practitioner along with the profile at the time  
22          the profile is used pursuant to subsection 1 or provided to any third party  
23          consistent with section 6 of this Act.

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

26           **Grievance procedures.**

- 27          1. An accident and health insurance policy may not be delivered or issued for delivery  
28          by an insurance company, as defined in section 26.1-02-01, or any other entity  
29          providing a plan of health insurance subject to state insurance regulation to a  
30          person in this state unless the entity establishes and maintains a grievance  
31          procedure for resolving complaints by covered persons and providers and

1           addressing questions and concerns regarding any aspect of the plan, including  
2           access to and availability of services, quality of care, choice and accessibility of  
3           providers, and network adequacy. The procedure must include a system to record  
4           and document all grievances since the date of its last examination of the  
5           grievances.

6           2. The procedure must be approved by the insurance commissioner. The  
7           commissioner may examine the grievance procedures.

8           **SECTION 9. AMENDMENT.** Section 26.1-47-02 of the North Dakota Century Code is  
9 amended and reenacted as follows:

10           **26.1-47-02. Preferred provider arrangements.** Notwithstanding any provision of law  
11 to the contrary, any health care insurer may enter into preferred provider arrangements.

12           1. Preferred provider arrangements must:

13           a. Establish the amount and manner of payment to the preferred provider. The  
14           amount and manner of payment may include capitation payments for  
15           preferred providers.

16           b. Include mechanisms, subject to the minimum standards imposed by chapter  
17           26.1-26.4, which are designed to minimize the cost of the health benefit plan.  
18           ~~These mechanisms may:~~

19           ~~(1) Provide for the review and control of the utilization of health care~~  
20           ~~services:~~

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

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

25           d. With regard to an arrangement in which the preferred provider is placed at  
26           risk for the cost or utilization of health care services, specifically include a  
27           description of the preferred provider's responsibilities with respect to the  
28           health care insurer's applicable administrative policies and programs,  
29           including utilization review, quality assessment and improvement programs,  
30           credentialing, grievance procedures, and data reporting requirements. Any  
31           administrative responsibilities or costs not specifically described or allocated

- 1                   in the contract establishing the arrangement as the responsibility of the  
2                   preferred provider are the responsibility of the health care insurer.
- 3           2. Preferred provider arrangements may not unfairly deny health benefits to persons  
4           for covered medically necessary services.
- 5           3. Preferred provider arrangements may not restrict a health care provider from  
6           entering into preferred provider arrangements or other arrangements with other  
7           health care insurers.