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Sixty-second
Legislative Assembly
of North Dakota

Introduced by

FIRST DRAFT:
Prepared by the Legislative Council staff for the
Health Care Reform Review Committee

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

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

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

1. As used in this section, unless the context otherwise requires:
   a. "Adverse benefit determination" means a denial of, reduction of, termination of, or a failure to provide or make payment for a claim for benefits which involves medical judgment and involves the cancellation or discontinuation of coverage that has retroactive effect. The term includes a determination based on the requirements of an insurance company, nonprofit health services corporation, or health maintenance organization for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit and a determination that a treatment is experimental or investigational. The term does not include a denial of, reduction of, termination of, or failure to provide or make payment related to a claimant's eligibility for benefits under the terms of coverage.
   b. "Claim for benefits" means a request for one or more benefits which is made by a claimant in accordance with the reasonable procedure for submitting benefit claims offered by an insurance company, nonprofit health services corporation, or health maintenance organization. A reasonable procedure includes an external 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 necessary to ensure compliance with this section.~~ If federal laws or rules relating to external ~~appeals~~review are amended, repealed, or otherwise changed, the insurance commissioner shall ~~adopt~~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.

3. An external review process offered by an insurance company, nonprofit health services corporation, or health maintenance organization pursuant to this section must include each of the following:

a. An external review must be available to a claimant for:

(1) An adverse benefit determination involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;

(2) A determination that a treatment is experimental or investigational if it is ensured that adequate clinical and scientific protocols are taken into account as part of the external review for determinations involving experimental or investigative claims for benefits; and

(3) An adverse benefit determination involving the cancellation or discontinuation of coverage that has a retroactive effect. For purposes of this paragraph, an adverse benefit determination does not include a denial, a reduction, a termination, or a failure to provide or make payment related to a claimant's eligibility for benefits under the terms of coverage.

b. An effective written notice must be provided to each claimant of the claimant's rights related to external review of an adverse benefit determination.

c. Although an insurance company, nonprofit health services corporation, or health maintenance organization may require a claimant to exhaust the internal claims and appeals process, a claimant may not be required to exhaust all internal and external claims and appeals processes if the insurance company, nonprofit health services corporation, or health maintenance organization waives this requirement, the claimant is considered to have exhausted the internal claims and appeals process under applicable law, or the claimant has filed for expedited external review. A claimant may file for an expedited external review without fully exhausting all internal claims and appeals requirements at the same time any internal appeal is being processed and the claimant meets the defined criteria for requesting an expedited external review.

d. The insurance company, nonprofit health services corporation, or health 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. An external review process must require 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.

h. 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

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

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

j. Any decision by an independent review organization through the external review process is binding on the claimant and on the insurance company, nonprofit health services corporation, or health maintenance organization, except to the extent other remedies are available under state or federal law and except that the requirement that the determination be binding does not preclude the insurance company, nonprofit health services corporation, or health maintenance organization from making payment on the claim for benefits or from failing to require such payment or benefits. The insurance company, nonprofit health services corporation, or health maintenance organization shall provide benefits, including making payment, pursuant to the final external review decision without 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.

k. 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.

l. 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.

m. 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

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

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