2009 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2274

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2274

Senate Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: January 28, 2009

Recorder Job Number: 7993

Committee Clerk Signature	Eva Lubelt

Minutes:

Chairman Klein: We will call the meeting back to order.

Rod St.Aubyn, Blue Cross and Blue Shield of ND: Written Testimony Attached.

Senator Behm: Would you clarify the difference between internal and external?

Rod: Internal process is what we have and external is handled outside of Blue Cross.

Senator Andrist: Who is the provider?

Rod: The hospital, medical provider or the physician.

Chairman Klein: We have a provider that has overstepped the internal review even though we thought that was the rule?

Rod: That is correct, it is not clear in the statue that they have to go internal first.

Chairman Klein: You feel the intent was there but it is not written in the language?

Rod: That is correct.

Senator Horne: Who does the external review?

Rod: It is located out of Minot. It is Peer review; they handle a lot for Medicare.

Bruce Levi, ND Medical Association: Written Testimony Attached. In opposition of the bill and gave a proposed amendment.

Chairman Klein: What we're doing here is making it clear and the concern on the provider side or trying to make it easier for the provider?

Bruce: I think the problem is the words exhaust all internal appeals process. What are those?

Senator Andrist: Perhaps we don't know what kind of cost are we talking about?

Bruce: I believe the seven hundred and fifty dollars put into escrow.

Rod: I am a little confused; the process is available on the web to the provider. It is included.

Chairman Klein: You and I and Bruce will get together to see if we can work this out. We will close the hearing.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2274

Senate Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: February 2, 2009

Recorder Job Number: 8374

Committee Clerk Signature	Eva Lutelt

Minutes:

Chairman Klein: Committee 2274 was a bill that outlines the way we handles external reviews from the last session, this just defines it more clearly.

Senator Andrist: I will move a do pass on Senate Bill 2274.

Senator Potter: I will second that.

Roll Call Vote: Yes:6 No: 0 Absent: 1

Floor Assignment: Senator Potter.

Date: 2/2/09
Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2274

Senate **Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number ____________

Action Taken ☑ **Pass** ☐ **Do Not Pass** ☐ **Amended**

Motion Made By Senator Andrist Seconded By Senator Potter

Senator	Yes	No	Senator	Yes	No
Senator Jerry Klein - Chairman	✓		Senator Arthur H. Behm		
Senator Terry Wanzek – V.Chair	✓		Senator Robert M. Horne	✓	
Senator John M. Andrist	✓		Senator Tracy Potter	✓	
Senator George Nodland	✓				

Total (Yes) 6 No 0

Absent 1

Floor Assignment Senator Potter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2274: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2274 was placed on the Eleventh order on the calendar.

2009 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2274

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2274

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: March 10, 2009

Recorder Job Number: 10552 starting at 18:11 minutes/seconds and job # 10553.

Committee Clerk Signature

Chairman Keiser: Opened the hearing on SB 2274 relating to health insurance policies for telemedicine.

Senator Judy Lee~District 13 what is part of West Fargo. The bill deals with external reviews. We want to make sure every step in the process is used before we move to the external process.

Dean Haas~North Dakota Medical Association. See testimony & amendment attachments.

Vice Chairman Kasper: Can you explain in simple language what the problem is and why you need the solution.

Haas: I did pool BCBS internal grievance policies and it's quite a big book. As a provider, before you can come to independent review, you have to exhaust this kind of procedure. There are multiple levels and it's hard to know where you are in BCBS internal grievance. To get to the external review, you have to get through the cumbersome internal policies that are not very clear and are confusing. If we added that protection here and said that is what this internal review is governed by your detailed definitions that will assist us.

Vice Chairman Kasper: Forget the language here, in the process, what are the impediments and why do you need this bill to clarify?

Haas: As a provider you receive notice. A medical necessity technically would fall under this utilization review chapter. You take this up with the BCBS and you tell them why you preformed this treatment for the patient for X & Y reasons. There is a very convoluted BCBS procedure here, but eventually you get some sort of an answer. People get lost in their way and where they are in this process, it's not clearly defined. If they go to an external review process and lose, the non-prevailing party picks up the tab.

Chairman Keiser: We know what the current law is, how does this bill with the amendment change?

Haas: The way it would change is instead of being lost in the process, you would know that the internal review processing would have to be described in the utilization review section code. You could open up the utilization review chapter and see what BCBS was telling in precise parameters of your utilization process. There are also proposed costs of having this independent tribunal on the insurance company instead of us, as the provider.

Vice Chairman Kasper: What has happened is a provider has performed a service. Then BCBS has denied the service as not medically necessary and you are trying to get to the next step where you can have an external review of the denial. Your frustration is that you can't get to that step and you have to pay for it if you do get to that step, is that what we are dealing with here?

Haas: Exactly.

Representative Amerman: This is an engrossed bill, are these amendments off the senate side?

Haas: Yes.

Representative Amerman: The independent or the external review, who does that?

Haas: My understanding is that the internal review is done by BCBS contracted individuals.

Representative Amerman: What the independent external review?

Haas: The external review will be done by an outside entity.

Chairman Keiser: These amendments were placed on in the senate?

Haas: Yes, I think all of them were but there may be one that wasn't.

Representative Boe: They were placed but not adopted?

Haas: Correct.

Dan Ulmer~Blue Cross Blue Shield of North Dakota. See testimony attachment.

We are not interested in any amendment to this bill.

Representative Schneider: If the provider skipped the internal process and went into external review, would they still have to pay the $750?

Ulmer: Defer the question to their attorney who is present.

Bob Straup~Deputy General Council to BCBS. The $750 is not in the current bill. It was a dollar amount that was established by this independent external review company out of Minot as what they felt was the mean cost of going through this process. They felt very strongly that they didn't want to take on these appeals and then collect the total cost from BCBS or from the provider. The $750 is more like a down payment. The costs could vary.

Representative Schneider: My point was if the 236 decisions were upheld and didn't want to go to the next step, who would think that somebody would skip the internal process altogether and go right to the external.

Straup: I'm not sure how to answer that question except to say I think the reason is that internal process works. I'm not sure the cost is any factor at all. I disagree with earlier testimony today that this convoluted process is confusing to the providers. If the BCBS does one thing, is it communicates with the people in its processes.

Representative Schneider: Of the 268 decisions that were overturned, was there any cost to the providers for that service?

Straup: No.

Vice Chairman Kasper: Has BCBS published and disseminated to provider network you internal appeal process, step by step, so your providers know where they are at on the process?

Straup: It is my understanding that the communications that include those processes are provided to the provider at every step. It depend what the inquiry is or what the point of contact is.

Vice Chairman Kasper: I don't know if quality has anything to do with claims. I don't understand your terminology. Getting back to the internal review process itself, if a provider understands that here's step one, step two and so on, until they get to the bottom where they have exhausted all of their process, a little more clarity on how this process works would help.

Straup: When it comes to claims, you are talking health care, our review of health care determination. So when I say quality issues, that another point of contact. The claims are a different point of contact. What I will tell you is that I frankly find it hard to believe for claims review, that the providers do not know what the process is and where they are at. They get one review and one appeal and then it's over. That is communicated to them all the way through the process and they are referenced to web sites that explain to them what we are doing, where they are at in the process and how to contact us with any questions they have.

Vice Chairman Kasper: Where do you see their problem because there perspective seems to be different than what you are saying? Where is this problem that they are not getting?

Straup: You put me in a tough spot to speak on behave of the health care association. I can tell you in looking at the proposed amendments, this is the first time that I've seen where they

have tried to take the independent external review statue. This statue that is given in bold is the contracting statue. This is the first time I've seen it. It's difficult for me to understand how this ties back into external review process. There is just some sense of frustration from the provider community that we don't give them a fair shake. Frankly, I disagree with that. A lot of the processes that we follow, especially in the claims area where you are honing in on, are set by Federal Law. There is a Federal Claims and Appeals process that the Federal government, through ERISA, has imposed that governs how we interact with our insurers.

Vice Chairman Kasper: On the ERISA publication is that a lengthy publication because we are mirroring a North Dakota law what an ERISA law is. Is it 20, 40 or 100 pages?

Straup: The ERISA provision statutory itself is about four sentences. The CFA is about 20 and our benefit plan is about four pages with our contract members. I think the policy that's there with the providers; you can go on line and is about 12 pages.

Vice Chairman Kasper: May I have a copy of that?

Representative Amerman: On the testimony Dan Ulmer gave, 236 decisions were upheld. Not one of those opted to go to next step of the external review?

Straup: That's correct.

Chairman Keiser: There appears to be several tiers, levels and other parts of your process that is difficult for providers and certainly consumers to understand. Do you have in one place some kind of flow chart or is it in the 12 page document that shows the steps to go through?

Straup: If it's for the claim, our decision whether to pay you for the services you provided to one of our members, I would not agree that confusing or its multi-leveled and we do not have a set policy. We will provide that to you. I believe there is a flow chart within that document. On top of that, in our member plan, there is a graph that shows you that if it's a pre-service, urgent care, post-service claims, here are the time frames. That's for the claim process, not for the

other points of contact that you are talking about for a quality issue, for example, we do a good job of communicating to the provider initially what the first correspondence that references them to specific policies that apply to that. If it's a quality matter, what the quality policies, time frames and encourages them to communicate with us so we can answer any questions that they may have.

Vice Chairman Kasper: Is there a statue that outlines the internal appeals process in North Dakota law or does each insurance company develops on their own?

Straup: There is not a statue that I'm aware of that outlines the internal process. I believe that our internal process is driven by claims and appeals ERISA provision that has mandated time frames. It requires us to consider and respond.

Representative Nottestad: Back to the internal appeals pertaining to whether it's in statue or not, what about others states? Are we unique or is it similar in other states?

Straup: I don't think we are unique. There are concepts under ERISA and North Dakota law that clearly say that there is an interest and public policy that the parties working it out informally and internally before going to court. To answer your question, as far as I know, Montana, South Dakota & Minnesota there are not specific statues that require internal appeals. In Minnesota there is some legislation that specifically limits those internal appeals.

Representative Nottestad: Dan Ulmer made a reference to an organization that was billing and being denied. When you have a situation like that where you have billings and being denied several times, does BCBS make specific contact to that provider saying, we need to talk. Is that type of thing done?

Straup: Yes, that exactly what happens.

John Kapsner~Attorney with Vogel Law Firm in Bismarck & I counsel to North Dakota Healthcare Association. See testimony attachment.

Vice Chairman Kasper: How would you define "offered"?

Kapsner: Right now, the way I define offer is "any internal appeal process that goes with the side to implement and by way of policy would be required before an external review could occur".

Vice Chairman Kasper: If you could define offered because you are concerned about that, how would you define it so that it would be clear?

Kapsner: There are two ways. The way the medical association was focus on the utilization review procedures that are currently in North Dakota statue. Those procedures a little slightly different that procedures that have been identified by Mr Straup and I would be content if those procedures were for reference as being the internal review procedures that are utilized. The notion that we have a term that grant a huge amount of discretion on what will and will not be offered is not a good idea.

Representative Nottestad: You made the statement that BCBS has added layers of procedure and you just dropped it at that. Could you give me examples of what you are speaking of?

Kapsner: It's unknown at this point what levels of procedure could be utilized. If you just authorize them to utilize any procedure that they offer by policy, there is no actual limit to what can be done.

Representative Nottestad: That's not what you said. You said it in the past tense, "BCBS had added additional layers".

Kapsner: If you are looking at "appear to add layers of internal review". Is that what you are referencing?

Representative Nottestad: It was said in that reference.

Kapsner: When I say it appears to add layers of review, I don't know what those layers are going to be. That the intent of my testimony.

Representative Amerman: I confused, do you support this bill or do you support the bill with these amendments. Where are we exactly?

Kapsner: We support with the proposed amendments. Whether the amendment would be to reference the existing utilization review procedures as by proposed in the AMA or that you don't have in front of you to codify the existing requirement of existing federal statue. Either way it would define the term offered, which is the subject.

Representative Thorpe: On the internal review issues, does not the insurance commissioner be surprised at all of their qualification that they put out there?

Kapsner: He certainly should. It's unimaginable that the commissioner would not have the policies in that are in place for BCBS.

Representative Schneider: One of the things that I'm concerned about is there has been 236 decisions upheld and none of those have been to an external review, even though they have the option to do so. Now if you require the insurance company to pay for all the bills, it seems like you may have an abundance of unnecessary frivolous appeals.

Kapsner: I'm not sure we can really know the answer to that question. We don't know how the process would work if it was actually utilized. It's not without cause. If providers are going to have pay, we are not going to have external reviews and we are not going to know whether or not if we get too many external reviews until we actually have the company pay. At this stage we just don't know.

Representative Schneider: You mentioned that providers aren't going to pay for an external appeal, if they think they have a pretty good case and there is a substantial amount of money involved, why won't they take it to the next step?

Kapsner: Because it is an expensive process. If you go to an external review, providers are going to have lawyers and lawyers cost money, the process itself is expensive. BCBS is going to have lawyers involved in internal costs, its internal positions. You lose and you lose a fair amount of money. These are not cheap. When they say $750 for a review, I'm very skeptical of that. Any significant review is going to cost several thousand dollars.

Chairman Keiser: We do have the insurance department here today. In the contract, does the insurance department have oversight and approval over the contract?

Kapsner: The insurance commissioner approves the contract that comes in. How frequently they come in I'm not entirely sure. As I have said in the past, the way contracts are currently are allowed to be amended, they can be amended by a consignor (sp). I know for certain that there is not one hospital in North Dakota that knows what its actual contract is because there are stacks of amendments and alterations. There isn't anyone who could put together their actual contract. The form of the actual contract itself is approved by the commissioner.

Chairman Keiser: Are those amendment approved or not by the consignor (sp)?

Kapsner: There isn't anyone who could put together their actual contract. The form of the contract itself is approved by the commissioner.

Chairman Keiser: Are those amendment approved or not?

Kapsner: To my knowledge, no because until just recently, BCBS could amend its contractual perimeters unilaterally. Now it can't unilaterally alter its rates but unilaterally amend the contract.

Chairman Keiser: Is there anyone here to testify in opposition of SB 2274, neutral?

(?) : The term "offered" is regulated by 26.1-26.4 that has to do with utilization review. We have to be approved.

Dean Haas: I would offer to bring down to the committee the internal review process procedure BCBS has filed with the insurance commissioner and get those for you.

Chairman Keiser: We are going to hold this bill.

Chairman Keiser: Closes the hearing on SB 2274.

Voting roll call was taken on SB

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2274

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: March 10, 2009

Recorder Job Number: 10623

Committee Clerk Signature Ellen LeTang

Chairman Keiser: Opened the committee work session on SB 2274 with unconstructed discussion.

Chairman Keiser: Further discussion?

Vice Chairman Kasper: What I heard from the providers that they don't understand where the appeal process is and how far they need to go before they get to that end result. Internally, how do your people communicate with the provider?

Dan Ulmer~Blue Cross Blue Shield of North Dakota. As you go through this, what you discover is that you can write, call in or e-mail. See attachments for discussion of the appeal process as the committee ask questions about the handouts.

Keiser: What are the wishes of the committee?

Vice Chairman Kasper: Hold it.

2009 HOUSE STANDING COMMITTEE MINUTES

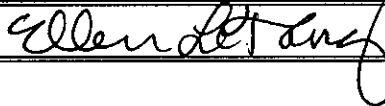
Bill/Resolution No. 2274

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: March 11, 2009

Recorder Job Number: 10065 ends at 4:30.

Committee Clerk Signature 

Chairman Keiser: Opened the committee work session on SB 2274.

Vice Chairman Kasper: I think the situation here is like the injured worker situation where they are going through the WSI process, they don't know for sure what the process is and they want clarification. We had a bill earlier that tried to deal with the injured worker notification and clarification. Even though we have all these things about the process, if there would be a way to BCBS to write about the process that is simple. I think that is what they are asking for.

Representative Ruby: Even the insurance department had some information have the policy down anyway.

Representative Schneider: I have the sense that this is just clarification and it wasn't a big issue. Their internal process is working. They turn over more claims back to the providers in their favor than they uphold their original recommendation. None were taken to external review at that point. I'm concerned about legislating what is really a contractual issue between providers and insurance provider.

Chairman Keiser: What are the wishes of the committee?

Representative Schneider: moves a Do Pass on SB 2274.

Representative Nottestad: Second.

Chairman Keiser: Further discussion.

(?): Is that with our without the amendment?

Chairman Keiser: Without.

Voting rolling was taken on SB 2274 for a Do Pass with 13 ayes, 0 nays, 0 absent and Representative Sukut is the carrier.

Date: Mar 11 - 2009

Roll Call Vote # 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2274

House House, Business & Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ As Amended

Motion Made By Schneider Seconded By Nottestad

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	✓		Representative Boe	✓	
Representative Clark	✓		Representative Gruchalla	✓	
Representative N Johnson	✓		Representative Schneider	✓	
Representative Nottestad	✓		Representative Thorpe	✓	
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Sukut

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2274: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2274 was placed on the Fourteenth order on the calendar.

2009 TESTIMONY

SB 2274

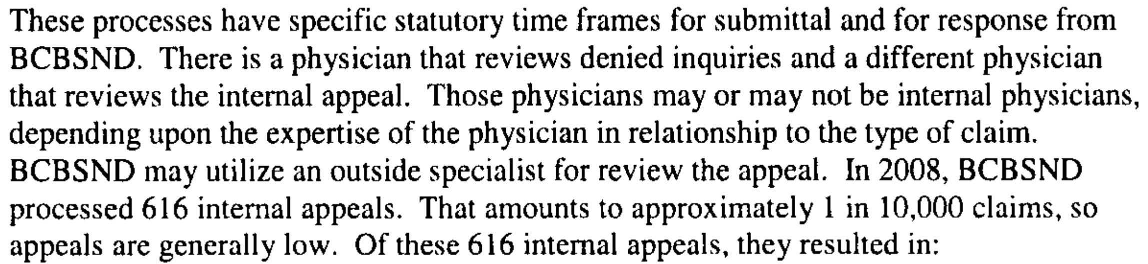
Testimony on SB 2274
Senate Industry Business and Labor Committee
January 28, 2009

Mr. Chairman and Committee Members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota. We asked that this bill be introduced to make it explicitly clear that a provider must exhaust internal appeals before proceeding to the Independent External Review process specified in NDCC 26.1-36-44. The bill that established that process was heard by this committee during the 2005 Legislative Session. Testimony during that hearing implied and examples given made it clear that this external review process would occur after the internal reviews were exhausted. However, the statute is silent.

This past summer, we experienced some medical necessity issues with a provider. We discovered through some complaints from our members that the provider was allegedly misusing the members' benefits for some in-patient hospitalization benefits. Our medical staff investigated the issues and discovered a pattern of inappropriate billings that were not supported by the chart notes. Our staff went back to past claims to determine if this pattern was consistent. The provider ultimately complained to the insurance commissioner and wanted to pursue the denied claims directly through the Independent External Review process bypassing all internal processes. It was our contention that this process can only be utilized after the internal appeal processes have been exhausted.

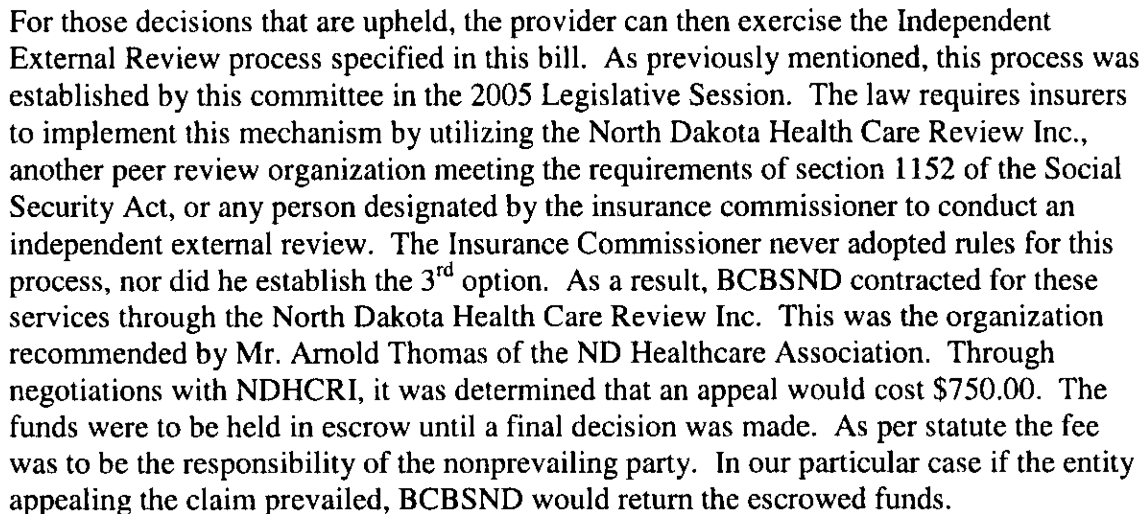
To fully understand the process I will explain the internal appeal process. This process was basically dictated for our ERISA plans (self-funded plans) through Department of Labor regulations. We sought legislation (SB 2184) in 2003 to incorporate these internal appeal processes within Chapter 26.1-26.4, Health Care Service Utilization Review, so that we would have the same process for self-funded and our fully insured plans. That bill was passed and has been the internal process we have followed since. These processes meet URAC standards for which we are accredited. URAC requires extensive record keeping and does both announced and unannounced audits to ensure that the entity is in compliance with their standards. As far as those processes for providers, there are 3 separate categories for inquiries and appeals. Those categories include:

1. Provider Pre-Service Claim for Benefits Inquiry and Appeal Policy. This is for those services requiring a pre-authorization or prior approval and it is denied.
2. Provider Retrospective Review Claim for Benefits Inquiry and Appeal Policy. This is for those services requiring a pre-authorization or prior approval, which was not secured, and the claim or part of the claim is later denied.
3. Provider Post-Service Claim for Benefits Inquiry and Appeal Policy. This is for those services not requiring any pre-authorization or prior approval, and the claim or part of a claim is denied.



These processes have specific statutory time frames for submittal and for response from BCBSND. There is a physician that reviews denied inquiries and a different physician that reviews the internal appeal. Those physicians may or may not be internal physicians, depending upon the expertise of the physician in relationship to the type of claim. BCBSND may utilize an outside specialist for review the appeal. In 2008, BCBSND processed 616 internal appeals. That amounts to approximately 1 in 10,000 claims, so appeals are generally low. Of these 616 internal appeals, they resulted in:

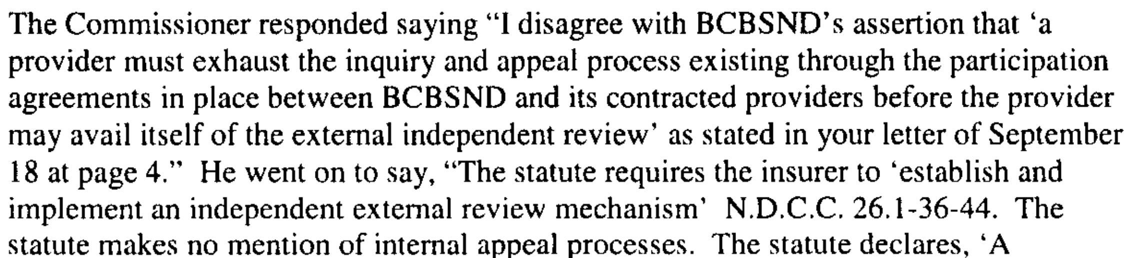
- 236 decisions upheld
- 268 decisions overturned
- 112 decisions considered partial decisions or misc.



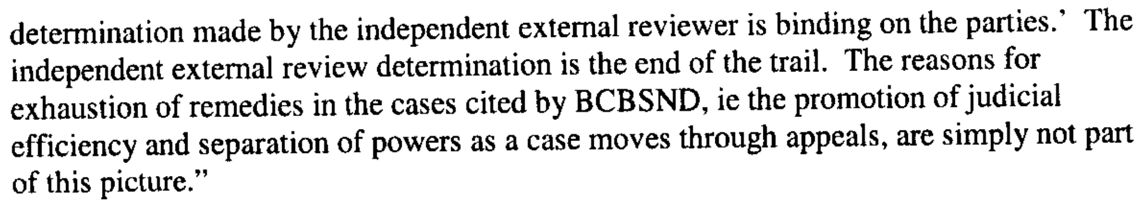
For those decisions that are upheld, the provider can then exercise the Independent External Review process specified in this bill. As previously mentioned, this process was established by this committee in the 2005 Legislative Session. The law requires insurers to implement this mechanism by utilizing the North Dakota Health Care Review Inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the insurance commissioner to conduct an independent external review. The Insurance Commissioner never adopted rules for this process, nor did he establish the 3rd option. As a result, BCBSND contracted for these services through the North Dakota Health Care Review Inc. This was the organization recommended by Mr. Arnold Thomas of the ND Healthcare Association. Through negotiations with NDHCRI, it was determined that an appeal would cost $750.00. The funds were to be held in escrow until a final decision was made. As per statute the fee was to be the responsibility of the nonprevailing party. In our particular case if the entity appealing the claim prevailed, BCBSND would return the escrowed funds.

We have received no requests for appeals through this Independent External Review process since it was passed in 2005. As you will note in the statistics above, many of the internal appeals are overturned to the providers benefit upon the receipt of more information substantiating the claim. If we permit the provider to go directly to an outside reviewer on every inquiry or appeal, it will be costly and would totally contradict the intent of Chapter 26.1-26.4 and 26.1-36-44.

In discussions with the Insurance Commissioner this past summer concerning the provider's complaint, one of our attorneys elaborated why he felt that the internal processes must be exhausted before pursuing the Independent External Review process. He substantiated his case based on legislative history (past testimony), participating contracts with the providers and case law.

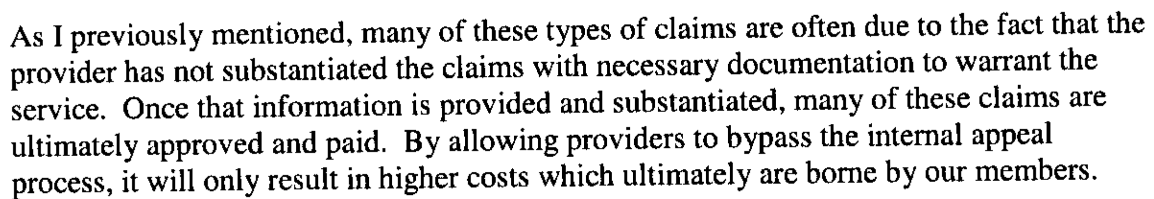


The Commissioner responded saying "I disagree with BCBSND's assertion that 'a provider must exhaust the inquiry and appeal process existing through the participation agreements in place between BCBSND and its contracted providers before the provider may avail itself of the external independent review' as stated in your letter of September 18 at page 4." He went on to say, "The statute requires the insurer to 'establish and implement an independent external review mechanism' N.D.C.C. 26.1-36-44. The statute makes no mention of internal appeal processes. The statute declares, 'A

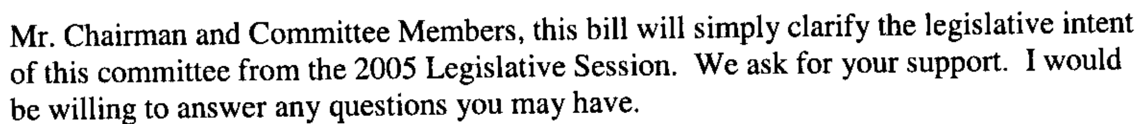


determination made by the independent external reviewer is binding on the parties.' The independent external review determination is the end of the trail. The reasons for exhaustion of remedies in the cases cited by BCBSND, ie the promotion of judicial efficiency and separation of powers as a case moves through appeals, are simply not part of this picture."

We strongly disagreed with the Commissioner's interpretation. We considered asking for an Attorney General opinion and discussed the issue with the bill sponsor. She commented that she wholehearted agreed that external appeals are always after internal reviews are exhausted and that is how other states processes work. She used the logical example of someone can't go directly to the ND Supreme Court (final determination) before going through District court. In addition, testimony from this committee in 2005 included a handout from one of the proponents of this law which clearly identified the process being implemented upon completion of internal processes. (attached) Instead of asking the AG's opinion it was our decision to make the intent clear in the law. That is the reason for the bill you have before you today. I must mention that the provider reconsidered and we still have not had any requests for the Independent External Review.



As I previously mentioned, many of these types of claims are often due to the fact that the provider has not substantiated the claims with necessary documentation to warrant the service. Once that information is provided and substantiated, many of these claims are ultimately approved and paid. By allowing providers to bypass the internal appeal process, it will only result in higher costs which ultimately are borne by our members.



Mr. Chairman and Committee Members, this bill will simply clarify the legislative intent of this committee from the 2005 Legislative Session. We ask for your support. I would be willing to answer any questions you may have.

Same handout given to House.

CALIFORNIA HEALTH POLICY ROUNDTABLE

ISSUE BRIEF: Independent Review of Health Plan Decisions

State Capitol, Room 112 - Sacramento, California
1:00-3:00 p.m. - August 3, 1998

Juliette Cubanski, M.P.P., and Helen H. Schauffler, Ph.D.
University of California, Berkeley, School of Public Health

The Purpose of This Roundtable

- To inform the policy debate in California about the issues, policy options, and public and private sector initiatives in the area of independent review of health plan decisions.

Key Questions to Explore at This Roundtable

- What can California learn from the experiences of other states in establishing an independent review system for appeals of health plan decisions?
- What are the costs and benefits associated with an independent review system?
- What independent review mechanisms are currently available for health plan enrollees in California?
- What are the key elements of proposals to implement an independent review system in California?
- How does the Center for Health Dispute Resolution (CHDR) conduct independent review for Medicare?

About the Roundtable Speakers

vin Hanley, Director of the State of California Office of the Insurance Advisor in Sacramento, California, will discuss the position of the Wilson Administration on independent review.

Peter Lee, J.D., Director of Consumer Protection Programs at the Center for Health Care Rights in Los Angeles, California, will address the consumer protection component of independent review.

Karen Pollitz, M.P.P., Project Director at the Institute for Health Care Research and Policy at Georgetown University in Washington, D.C., will discuss the key aspects of existing state independent review programs.

David Richardson, President of the Center for Health Dispute Resolution (CHDR) in Pittsford, New York, will discuss the role CHDR plays in independently reviewing Medicare coverage decisions.

Michael Shapiro, Staff Director for the California State Senate Committee on Insurance in Sacramento, California, will discuss the existing legislative proposals to implement an independent review program in California.

Alan Zwerner, M.D., J.D., Senior Vice President and Chief Medical Officer of Health Net in Woodland Hills, California, will discuss the independent review process available to Health Net members and the view of the HMO industry on pending independent review legislation in California.

What Is Independent Review?

The current regulatory practice of most states in overseeing the health insurance industry is to require health plans to establish an internal process for the resolution of consumer complaints—be they disputes over coverage, contracts, or denials of service. Consumers in most states can appeal to the appropriate state regulatory agency for external review of health plan decisions, but this process may be informal and consumers may be unaware of their appeal rights.

Currently, there are no formal standards at the federal level or in California for the independent review of health plan decisions for enrollees who have exhausted a health plan's internal appeals process and are dissatisfied with the resolution of their grievances. Independent reviews are conducted by agencies and/or individuals that have no financial or professional affiliation with health plans and no financial or professional interest in the outcome.

Independent review of health plan decisions is one component of several health care consumer protection proposals. Both the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and the California Managed Health Care Improvement Task Force recommended an independent system of external review of health plan decisions. Independent review is also one component of pending managed care reform proposals in Congress and the subject of California legislation.

Proponents of independent review suggest that establishing a process for independent review of health plan decisions would enhance consumer confidence in health plan decision-making, verify the accuracy of utilization reviews, and ensure that health plans are held accountable for their decisions. However, opponents of independent review suggest an independent review system would impose an administrative burden on health plans, lead to overutilization of health care services and the delivery of inappropriate care, and raise legal liability issues for health plans and independent review entities.

How Will Independent Review Affect Health Plan Premiums?

Price Waterhouse conducted an analysis, prepared for the Kaiser Family Foundation, of the benefits and costs of selected provisions of the California Managed Health Care Improvement Task Force recommendations, including the recommendation for independent review. This analysis indicated that if California established an independent review process through which consumers could appeal certain health plan coverage decisions, the estimated direct cost impact would be an increase of three cents per enrollee per month, or an increase in premiums of .03 percent.

In a separate study commissioned by the Kaiser Family Foundation, Coopers & Lybrand conducted a cost analysis of the President's Consumer Bill of Rights and the Congressional Patient Access to Responsible Care Act (PARCA).

Both proposals include provisions to allow enrollees to re-[illegible]st an independent review of health plan service requests [illegible]utilization decisions. This analysis estimated the inde-[illegible]dent review provision would increase premiums by 2 to [illegible]6 cents per enrollee per month, or by 0.02 to 0.13 percent.

The Congressional Budget Office (CBO) prepared a cost estimate of H.R. 3605/S. 1890, the federal Patients' Bill of Rights Act of 1998. According to the CBO analysis, establishing a grievance process, including internal and external appeals of adverse determinations, would increase premiums by 0.3 percent in the 10 years following enactment of the bill.

If utilization of health care services increases as the result of independent review, premiums could increase more than these analyses reported.

What Is the Structure of Independent Review Systems in Other States?

Seventeen states have established an independent review system for enrollee appeals of health plan decisions. Key features of these systems include:

- **What parties are eligible to request an independent review?** In five states, only enrollees are eligible to appeal health plan decisions; in 12 others, an enrollee can designate a representative and/or a physician to act on his or her behalf.
- **What health plan decisions qualify for independent review?** Thirteen states allow only denials [illegible]ased on the medical necessity or appropriateness of a health care service to be eligible for independent review. Four states also allow enrollees to request independent review of coverage or contract disputes.
- **What entities conduct independent reviews?** Independent reviews are conducted by state insurance regulatory agencies in six states, but are more often conducted by independent review organizations (IROs) and/or by appropriately licensed or registered health care professionals (usually physicians and nurses) certified by a state to conduct reviews.
- **What entities select or contract with IROs?** In nine states, the state health insurance regulatory agency is responsible for contracting with IROs. Health plans contract with IROs in four states, and only one state allows the enrollee to choose the reviewing entity.
- **Who pays for independent reviews?** In 12 states, health plans pay most or all of the cost of reviews, either on a direct, per-review basis or indirectly through licensing fees. In six states, enrollees pay a filing fee ranging from $25 to $100. In one state, enrollees evenly share the cost with health plans.
- **What is the time allowed for the normal and expedited independent review process?** The normal independent review process ranges from 10 to 120 days, and the expedited independent review process (when the enrollee's life or health would be jeopardized) ranges from 24 hours to 45 days.
- **Are the decisions of the independent review entities binding on health plans and enrollees?** In 14 states, the decision of the independent reviewer is binding. In three states, either party can appeal the independent review decision at the judicial level.

What Independent Review Process Is Currently Available in California?

There is currently no formal process through which all insured people in California can request independent review of health plan decisions. Under the Knox-Keene Act, the California Department of Corporations (DOC) is responsible for providing an informal review process through which enrollees can file complaints against HMOs relating to grievances filed or pending with, or resolved by, HMOs.

The Friedman-Knowles Experimental Treatment Act (AB 1663 of 1996), effective July 1, 1998, allows HMO and disability insurer enrollees who have terminal conditions to request independent review of decisions to deny experimental or investigational treatment. The state has contracted with an accrediting entity that will contract with IROs to conduct these reviews.

What Are California's Proposals to Implement an Independent Review Program?

AB 1667 (Migden), SB 1504 (Rosenthal), and SB 1653 (Johnston) are the three legislative vehicles in California that would establish an independent review process for enrollees of HMOs and disability insurers.

These bills would require every HMO and disability insurer in California to provide an enrollee or insured with the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by the plan or insurer. These bills would also require the state DOC and Department of Insurance to contract with one or more IROs to conduct independent reviews, and with a private, nonprofit organization to accredit IROs.

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Testimony in Opposition to SB No. 2274
Senate Industry, Business & Labor Committee
January 29, 2009

Chairman Klein and Committee Members. I'm Bruce Levi and I represent the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for physicians, residents and medical students.

Theoretically in North Dakota, once a provider or patient has exhausted a plan's internal appeals process and receives notice of a final adverse determination, an independent external review is available to ensure an impartial review of such determinations and to ensure that the patient is receiving medically necessary care requested by the treating physician.

SB No. 2274 would require providers, before they can avail themselves of the statutory independent external appeal process, to exhaust "all internal appeal processes" offered by BlueCross BlueShield of North Dakota. While this may appear on its face to be a reasonable request, the problem is that BlueCross BlueShield does not clearly define in its policies or in the bill "all internal appeal processes" so that the provider is fully aware of what is required. Do "all internal appeal processes" include utilization review under NDCC chapter 26.1-26.4? Do "all internal appeal processes" include following all of BCBSND's grievance policies? Do "all internal appeal processes" include BCBSND medical management decisionmaking under their provider contracts and policies? Do "all internal appeal processes" include BCBSND corrective action plans for physicians and other health professionals?

The fact is BlueCross BlueShield of North Dakota, like many health plans, have multi-tiered internal grievance, medical management, corrective action and utilization review processes in place. I have consulted with physicians in North Dakota who are requested by BCBSND to provide medical records or are told their practices need adjustment, yet are often confused or are not told under what process BCBSND is operating.

In our view, BlueCross BlueShield of North Dakota has made this process extremely cumbersome by implementing multiple tiers and modes of review and, since they control the timing, agenda, setting, and participants involved in independent external review, we believe resulting frustration causes providers and patients in North Dakota to drop out of the review process long before reaching external review. It is our understanding that the independent external review in section 26.1-36-44 has never been used since its inception in 2005.

On behalf of NDMA (and on behalf of the North Dakota Healthcare Association as requested by Chip Thomas), we offer a proposed amendment that would address two issues relating to independent external review:

-Clarification that "all internal appeals processes" means only the utilization review processes set forth in NDCC section 26.1-26.4-04.

-Revision to ensure fair access to review by requiring that the costs associated with independent external review be the responsibility of the insurance company.

With incorporation of these amendments, we urge a "Do Pass As Amended" on SB 2274.

resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

9. "Utilization review agent" means any 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.

26.1-26.4-03. Certification. 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. The name, address, telephone number, and normal business hours of the utilization review agent.

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

3. A description of the appeal procedures for utilization review determinations.

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

A provider may request that a utilization review agent furnish the provider with the medical review criteria to be used in evaluating proposed or delivered health care services. Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

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

1. Notification of a determination by the utilization review agent must be provided to the enrollee or other appropriate individual in accordance with 29 U.S.C. 1133 and the timeframes set forth in 29 CFR 2560.503-1.

2. Any 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. Any notification of a determination not to certify an admission or service or procedure must include the information required by 29 U.S.C. 1133 and 29 CFR 2560.503-1.

4. 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 of determinations by the utilization review agent. The 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 must be made by a physician or, if appropriate, a licensed psychologist.

b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures in accordance with 29 U.S.C. 1133 and the timeframes for appeals set forth in 29 CFR 2560.503-1.

c. Utilization review agents shall provide for an expedited appeals process complying with 29 U.S.C. 1133 and 29 CFR 2560.503-1.

5. 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. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.

8. Psychologists making utilization review determinations shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

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

10. When an initial appeal to reverse a 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 must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate.

However, the commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.

26.1-26.4-04.1. Utilization review in this state - Conditions of employment. 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 when compensation of the review agent is contingent upon a denial or reduction in the payment for hospital, medical, or other health care services.

26.1-26.4-04.2. Utilization review - Duty of health care insurers. A health care insurer that contracts with another entity to perform utilization review on its behalf remains responsible to ensure that all the requirements of this chapter are met to the same extent the health care insurer would be if it performed the utilization review itself.

26.1-26.4-05. Utilization review agent violations - Penalty. Whenever the commissioner has reason to believe that a utilization review agent subject to this chapter has

North Dakota Medical Association
January 28, 2009

PROPOSED AMENDMENT TO SB NO. 2274

Page 1, line 16, overstrike "nonprevailing party" and insert immediately thereafter "insurance company, nonprofit health service corporation, or health maintenance organization"

Page 1, line 19, after the underscored period insert "For purposes of this section, "internal appeal processes" means only the utilization review appeal procedures included in section 26.1-26.4-04. Internal appeal processes are deemed exhausted if the provider files a grievance involving an adverse determination and does not receive a written decision on the grievance from the insurance company, nonprofit health service corporation, or health maintenance organization within thirty days from the date of filing the grievance."

Renumber accordingly

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Testimony on SB No. 2274
House Industry, Business & Labor Committee
March 10, 2009

Chairman Keiser and Committee Members. I'm Dean Haas and I represent the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for physicians, residents and medical students.

Theoretically in North Dakota, once a provider or patient has exhausted a plan's internal appeals process and receives notice of a final adverse determination, an independent external review is available to ensure an impartial review of such determinations and to ensure that the patient is receiving medically necessary care requested by the treating physician.

SB No. 2274 would require providers, before they can avail themselves of the statutory independent external appeal process, to exhaust "all internal appeal processes" offered by the health insurer. While exhaustion of internal review processes may appear on its face to be a reasonable requirement—most states require such exhaustion—the problem in North Dakota is that BlueCross BlueShield does not clearly define in its policies or in the bill "all internal appeal processes" so that the provider is fully aware of what is required. Do "all internal appeal processes" include utilization review under N.D.C.C. chapter 26.1-26.4? Do "all internal appeal processes" include following all BCBSND's grievance policies? Do "all internal appeal processes" include BCBSND medical management decision-making under their provider contracts and policies? Do "all internal appeal processes" include BCBSND corrective action plans for physicians and other health professionals?

The fact is BlueCross BlueShield of North Dakota, like many health plans, have multi-tiered internal grievance, medical management, corrective action and utilization review processes in place. NDMA has consulted with physicians in North Dakota who are requested by BCBSND to provide medical records or are told their practices need adjustment, yet are often confused or are not told under what process BSBSND is operating.

In our view, BlueCross BlueShield of North Dakota has made this process extremely cumbersome by implementing multiple tiers and modes of review and, since they control the timing, agenda, setting, and participants involved in independent external review, we believe resulting frustration causes providers and patients in North Dakota to drop out of the review process long before reaching external review. **It is our understanding that the independent external review in section 26.1-36-44 has never been used since its inception in 2005.**

On behalf of NDMA we offer proposed amendments that would address several issues relating to independent external review and render the process somewhat more user-friendly:

> First, our proposal amends N.D.C.C. § 26.1-36-41, which provides certain procedural protections relating to insurer termination of participating contracts of "practitioners" alleged to have engaged in "excessive or inappropriate practice patterns." The amendment expands the definition of "practitioner," from optometrists, chiropractors, physicians, and advanced registered nurse practitioners, to include other licensed health care professionals, and health care facilities, including hospitals, nursing, assisting living, and ambulatory surgery centers.
>
> Second, the amendment clarifies that "all internal appeals processes" means only the utilization review processes set forth in N.D.C.C. § 26.1-26.4-04, and termination and nonpayable status determinations due to "excessive or inappropriate practice patterns" under N.D.C.C. § 26.1-36-41.
>
> The final amendment ensures fair access to independent external review by requiring that the costs associated with independent external review be the responsibility of the insurance company. Most consumers cannot afford to pay the costs of the external review, and unless a decision threatens access to an important health care service, providers don't have sufficient incentive to seek external review at their own cost. On the other hand, insurers have obvious incentives to deny care as medically unnecessary. Imposing the costs of review on the insurer slightly reduces this incentive. It is only fair to provide an independent review on the insurance company's nickel, and this amendment would ensure that at last the independent external review mechanism would actually be used by North Dakotans.

With incorporation of these amendments, we urge a "Do Pass As Amended" on SB 2274.

PROPOSED AMENDMENT TO SB NO. 2274

Page 1, line 1, after "reenact" insert "subsection 1 of section 26.1-36-41 and"

Page 1, line 2, after "to" insert "health insurance contract limitations and"

Page 1, after line 3, insert:

"SECTION 1. AMENDMENT. Subsection 1 of section 26.1-36-41 of the North Dakota Century Code is amended and reenacted as follows:

"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 subject to state insurance regulation may not terminate a practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose sanctions on any practitioner solely for an excessive or inappropriate practice pattern unless the requirements of this section are met. If a practitioner engages in an excessive or inappropriate practice pattern for the practitioner's specialty, the entity shall inform the practitioner, in writing, as to the manner in which the practitioner's practice is excessive or inappropriate. The entity shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the practitioner's practice pattern. If the excessive or inappropriate practice pattern continues, the entity may impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable. If considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner 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 practitioner 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. Nonpayable status under this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section "practitioner" includes an optometrist, a physician, a chiropractor, ~~or~~ an advanced registered nurse practitioner or other health care professional duly licensed to practice in this state, hospital, or nursing, basic, or assisted living facility licensed by this state, or any other health care organization, including an ambulatory surgery

center or group of physicians operating a clinic or outpatient care facility."

Page 1, line 10, after "provider" insert ",including utilization review determinations under section 26.1-26.4-04 and sanctions, termination or nonpayable status determinations made under section 26.1-36-41"

Page 1, line 16, overstrike "nonprevailing party" and insert immediately thereafter "insurance company, nonprofit health service corporation, or health maintenance organization"

Page 1, line 19, after the underscored period insert "For purposes of this section, "internal appeal processes" means only the utilization review appeal procedures included in section 26.1-26.4-04 or once a sanction, termination, or nonpayable status determination is made under section 26.1-36-41.

Renumber accordingly

Testimony on SB 2274
House Industry Business and Labor Committee
March 10, 2009

Mr. Chairman and Committee Members, for the record I am Dan Ulmer, representing Blue Cross Blue Shield of North Dakota. We asked that this bill be introduced to make it explicitly clear that a provider must exhaust internal appeals before proceeding to the Independent External Review process specified in NDCC 26.1-36-44. The bill that established that process was heard by this committee during the 2005 Legislative Session. Testimony during that hearing implied and examples given made it clear that this external review process would occur after the internal reviews were exhausted. However, the statute is silent.

This past summer, we experienced some medical necessity issues with a provider. We discovered through some complaints from our members that the provider was allegedly misusing the members' benefits for some in-patient hospitalization benefits. Our medical staff investigated the issues and discovered a pattern of inappropriate billings that were not supported by the chart notes. Our staff went back to past claims to determine if this pattern was consistent. The provider ultimately complained to the insurance commissioner and wanted to pursue the denied claims through the Independent External Review process. It was our contention that this process can only be utilized after the internal appeal processes have been exhausted.

To fully understand the process I will explain the internal appeal process. This process was basically dictated for our ERISA plans (self-funded plans) through Department of Labor regulations. We sought legislation (SB 2184) in 2003 to incorporate these internal appeal processes within Chapter 26.1-26.4, Health Care Service Utilization Review, so that we would have the same process for self-funded and our fully insured plans. That bill was passed and has been the internal process we have followed since. These processes and our company have received URAC accreditation. URAC requires extensive record keeping and does both announced and unannounced audits to ensure that the entity is in compliance with their standards. As far as those processes for providers, there are 3 separate categories inquiries and appeals. Those categories include:

1. Provider Pre-Service Claim for Benefits Inquiry and Appeal Policy. This is for those services requiring a pre-authorization or prior approval and it is denied.
2. Provider Retrospective Review Claim for Benefits Inquiry and Appeal Policy. This is for those services requiring a pre-authorization or prior approval, which was not secured, and the claim or part of the claim is later denied.
3. Provider Post-Service Claim for Benefits Inquiry and Appeal Policy. This is for those services not requiring any pre-authorization or prior approval, and the claim or part of a claim is denied.

These processes have specific statutory time frames for submittal and for response from BCBSND. There is a physician that reviews inquiries and a different physician that reviews the internal appeal. Those physicians may or may not be internal physicians, depending upon the expertise of the physician in relationship to the type of claim. BCBSND may utilize an outside specialist to review the appeal. In 2008, BCBSND processed 616 inquiries or appeals. That amounts to approximately 1 in 10,000 claims, so appeals are generally low. Of these 616 inquiries and appeals, they resulted in:

- 236 decisions upheld
- 268 decisions overturned
- 112 decisions considered partial decisions or misc.

For those decisions that are upheld, the provider can then exercise the Independent External Review process specified in this bill. As previously mentioned, this process was established by this committee in the 2005 Legislative Session. The law requires insurers to implement this mechanism by utilizing the North Dakota Health Care Review Inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the insurance commissioner to conduct an independent external review. The Insurance Commissioner never adopted rules for this process, nor did he establish the 3rd option. As a result, BCBSND contracted for these services through the North Dakota Health Care Review Inc. This was the organization recommended by Mr. Arnold Thomas of the ND Healthcare Association. Through negotiations with NDHCRI, they estimated an appeal would cost around $750.00. They refused to participate unless they received payment in advance from the party appealing the claim. They insisted that they did not want to be a collection company. The funds were to be held in escrow until a final decision was made. As per statute the fee was to be the responsibility of the nonprevailing party. If the entity appealing the claim prevailed, BCBSND would reimburse the provider for the appeal fee.

We have received no requests for appeals through this Independent External Review process since it was passed in 2005, until this past summer when the provider did not want to go through the internal appeal process and instead wanted to go directly to the Independent External Review process. As you will note in the statistics above, many of the internal appeals are overturned to the providers benefit upon the receipt of more information substantiating the claim. If we permit the provider to go directly to an outside reviewer on every inquiry or appeal, it will be costly and would totally contradict the intent of Chapter 26.1-26.4 and 26.1-36-44.

In discussions with the Insurance Commissioner this past summer, one of our attorneys elaborated why he felt that the internal processes must be exhausted before pursuing the Independent External Review process. He substantiated his case based on legislative history (past testimony), participating contracts with the providers and case law.

The Commissioner responded saying "I disagree with BCBSND's assertion that 'a provider must exhaust the inquiry and appeal process existing through the participation agreements in place between BCBSND and its contracted providers before the provider may avail itself of the external independent review' as state in your letter of September

18 at page 4." He went on to say, "The statute requires the insurer to 'establish and implement an independent external review mechanism' N.D.C.C. 26.1-36-44. The statute makes no mention of internal appeal processes. The statute declares, 'A determination made by the independent external reviewer is binding on the parties.' The independent external review determination is the end of the trail. The reasons for exhaustion of remedies in the cases cited by BCBSND, ie the promotion of judicial efficiency and separation of powers as a case moves through appeals, are simply not part of this picture."

We strongly disagreed with the Commissioner's interpretation. We considered asking for an Attorney General opinion and discussed the issue with the bill sponsor. Sen. Lee commented that she wholehearted agreed that external appeals are always after internal reviews are exhausted and that is how other states processes work. She used the logical example of someone can't go directly to the ND Supreme Court (final determination) before going through District court. In addition, testimony from this committee in 2005 included a handout from one of the proponents of this law which clearly identified the process being implemented upon completion of internal processes. (attached) Instead of asking for an AG opinion it was our decision to make the intent clear in the law. That is the reason for the bill you have before you today. I must mention that the provider reconsidered and we still have not had any requests for the Independent External Review.

As I previously mentioned, many of these types of claims are often due to the fact that the provider has not substantiated the claims with necessary documentation to warrant the service. Once that information is provided and substantiated, many of these claims are ultimately approved and paid. By allowing providers to bypass the internal appeal process, it will only result in higher costs which ultimately are borne by our subscribers.

Mr. Chairman and Committee Members, this bill will simply clarify the legislative intent of this committee from the 2005 Legislative Session. We ask for your support. I would be willing to answer any questions you may have.

TESTIMONY OF
NORTH DAKOTA HEALTHCARE ASSOCIATION
ON SENATE BILL 2274
HOUSE COMMITTEE ON INDUSTRY, BUSINESS AND LABOR

My name is John Kapsner. I am an attorney with the Vogel Law Firm in Bismarck and I am counsel to the North Dakota Healthcare Association.

Senate Bill 2274 proposes to amend Section 26.1-36-44 governing independent external review of decisions made by health insurance companies. As currently constituted, Senate Bill 2274 proposes to limit external review unless the provider has first exhausted all internal appeal processes offered by the insurance company.

As proposed, a health insurance company could, through company policy alone, create internal appeal processes sufficient to frustrate real independent external review of its decision-making. NDHA supports the North Dakota Medical Association's proposed amendments. Specifically the proposed amendment would define the phrase "internal appeal processes" to include only those utilization review appeal procedures currently included in North Dakota law – Section 26.1-26.4-04. The language currently proposed in SB 2274 appears to add layers of internal review in addition to those now required by law. Such additional layers frustrate effective external review.

NDHA also supports the North Dakota Medical Association's proposed amendment making the insurance company responsible for the costs of external review. Absent a life or death decision by the insurance company denying coverage, consumers are likely priced out of the external review process. And unless the decision of the company affects a significant line of service of a provider, that provider has little incentive to seek external review.

In conclusion, NDHA supports the proposed amendments offered on Senate Bill 2274 by the North Dakota Medical Association.

BlueCross BlueShield of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

4510 13th Ave. S.
Fargo, ND 58121-0001

FAX COVER SHEET

* Indicates required fields.

TO

***NAME:** Dan Ulmer
COMPANY:
***PHONE:**
FAX:

FROM Jane Nephew

***DATE:** ✓
***NAME:**
COMPANY: BCBSND
***PHONE:**
FAX: 701-277-2253 Medical Mgmt
EMAIL:

Urgent ☐ **Reply** ☐ **FYI** ☐

____ ***NUMBER OF PAGES** *(including cover)*

NOTES: *(Do not include confidential information on the coversheet.)*

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Blue Cross Blue Shield of North Dakota is proud to serve the provider community and continuously strives to be the best in our market.

The Provider Inquiry and Appeals section is a reference guide that will provide you with information needed to effectively work with Blue Cross Blue Shield of North Dakota. This information is subject to change at any given time without given notice.

This information should be used as a tool in conjunction with the Health Care News, ProviderNews, Provider Agreements and other publications.

Note: Due to the large size of some of the manuals and billing guides, some documents may take several minutes to download

Provider Inquiry and Appeal Process

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Inquiry 2
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Appeal Process 4

The following is the BCBSND health care provider inquiry and appeal process. The inquiry and appeals definitions, as well as the different types of each, are identified below. This process does not include questions related to fee schedule amounts, reimbursement or the DRG Validation Program.

Inquiry

An inquiry is defined as a health care provider initiating a request to BCBSND to prior approve, preauthorize or research a benefit or payment. Initiate an inquiry or Appeal by contacting BCBSND's Provider Services Department.

Inquiries will fall into the following categories.

Type of Inquiry	Time Frame for BCBSND to respond
Standard Pre-Service Claim for Benefits	Written response within 15 calendar days
Emergency Pre-Service Claim for Benefits	Verbal response within 72 hours, followed by written response within 3 calendar days.
Retrospective Review Claim for Benefits	Written response within 30 calendar days
Post-Service Claim for Benefits	Written response within 30 calendar days

Pre-Service Claim for Benefits Inquiry

A Pre-Service Claim for Benefits inquiry is defined as a request, either verbal or written, that is conditioned on a Member obtaining approval in advance of obtaining the benefit or service.

There are two levels of pre-service inquiry

- Standard
- Emergency

A Standard Pre-Service Claim for Benefits inquiry will be responded to by BCBSND in writing within 15 days upon receipt of all relevant information related to the inquiry

OR

An Emergency Pre-Service Claim for Benefits inquiry is when the above timeframe for the Standard Pre-Service Claim for Benefits inquiry would seriously jeopardize the Member's life, health or ability to regain maximum function. If the services in question meet the following definition of Emergency Medical Condition, the inquiry will be considered an emergency. An Emergency Medical condition is defined as:

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.

Retrospective Review Claim for Benefits Inquiry

A Retrospective Review Claim for Benefits Inquiry is defined as a request, either verbal or written, for a medical review of services that is conditioned on a Member obtaining approval in advance of obtaining the benefit or service; however advance approval was not obtained and services were provided to the Member. Determinations regarding Retrospective Review Claim for Benefits are based solely on the medical information available to the attending physician or ordering health care provider at the time the medical care was provided. The health care provider is responsible for providing BCBSND with a Retrospective Review Claim for Benefits within 180 days after the date the benefits or services offered under their Benefit Plan were incurred. Any Inquiry received after the 180 days will be returned to the health care provider without review.

Post-Service Claim for Benefits Inquiry

A Post-Service Claim for Benefits inquiry is defined as a written request expressing disagreement with a claim that has been processed correctly according to the Member's Benefit Plan. The health care provider has 180 days from the claim processed date to make such an inquiry. BCBSND will respond to these inquiries within 30 calendar days upon receipt of all relevant information. Any inquiry received after the 180 days will be returned to the health care provider without review.

The inquiry determination will be provided in writing, by telephone or through the health care provider remittance. Post-Service Claim for Benefits inquiries will include claim adjustments.

Appeal

An Appeal is defined as a health care provider expressing disagreement with an inquiry determination. There are Pre-Service Claim for Benefits Appeals, Retrospective Review Claim for Benefits Appeals and Post-Service Claim for Benefits Appeals.

Pre-Service Appeals can be either verbal or written; however, Post-Service Appeals must be written.

Pre-Service Claim for Benefits Appeals are those Appeals that occur before the service in question is rendered. The Pre-Service Claim for Benefits Appeals are further categorized as Standard and Emergency. Retrospective Review Claim for Benefits Appeals and Post Service Claim for Benefits Appeals occur after the service has been rendered. The table below indicates the different types of Appeals and the timeframes that apply to each. The definitions of Standard and Emergency are the same as noted above.

Type of Appeal	Time Frame for BCBSND to respond
Standard Pre-Service Claim for Benefits *	Written response within 30 calendar days
Emergency Pre-Service Claim for Benefits *	Verbal response within 72 hours, followed by written response within 3 calendar days.
Retrospective Review Claim for Benefits *	Written response within 30 calendar days.
Post Service Claim for Benefits*	Written response within 60 calendar days

*See definitions under Inquiry.

**Subject to different timeframes as set by regulators.

Appeal Process

The health care provider may Appeal the inquiry determination. This Appeal must be within 180 days from the date BCBSND notifies the health care provider of the inquiry determination. The Appeal must specifically state the nature of the Appeal and include all supporting information and rationale for overturning the inquiry determination. Any Appeal received after the 180 days will be returned to the health care provider without review.

BCBSND will take all the information into account during the Appeal process without regard to whether the information was submitted or considered in the initial consideration of the case.

A BCBSND Medical Director/Medical Consultant who was **not involved** in the original inquiry determination will review the Appeal. This individual will be board certified in the same or similar specialty as the provider who typically manages the medical condition appealed and is not the individual who made the original non-certification, or the subordinate of such an individual. BCBSND will implement the decision of the Appeal if the initial denial is overturned and respond with a written notice of the final determination including an explanation of the reason for the determination within the time frames shown above. Emergent Pre-Service Appeal response will be via telephone and writing.

Magnuson, Vance G.

From: Johnson, Charles E.

Wednesday, February 21, 2007 11:39 AM

Magnuson, Vance G.; Fix, Michael L.

Subject: FW: Appeals and Grievance Manual

FYI. cj.

From: Bob Stroup [mailto:Bob.Stroup@bcbsnd.com]
Sent: Wednesday, February 21, 2007 11:01 AM
To: Johnson, Charles E.
Subject: RE: Appeals and Grievance Manual

Chuck,

I am double-checking on this but I believe that the "grievance" filing was made pursuant to Section 26.1-36-42, N.D.C.C., as required and has not changed since it was initially filed in 1999 or 2001(?).

The recommendations in the examination made by the Department appear to relate to provider appeals, so this is what BCBSND focused on in its response. I understand that BCBSND Medical Management Department is updating the aforementioned Appeals and Grievance Manual, and it will be submitted as required by statute, either Section 26.1-26.4-03(3), or Section 26.1-36-42, N.D.C.C., or both. I was merely trying to explain the response provided by BCBSND to recommendations 15 and 19 in light of the information I had gathered internally. Either way, I am hopeful that the Department has the information necessary to react to the response submitted by BCBSND to the examination. I will add, however, that I believe BCBSND has made the appropriate filings as required by law in this regard.

Fra[redacted]hen we enter the word of "grievances", "claims", "claims for benefits", "complaints", "appeals", etc., all of these terms bec[redacted]uch "terms of art" and the context of the discussion becomes so hypercritical semantically that it makes my head spin.

I look forward to reviewing the marked up copy. I am sure we'll be in touch.

Thanks.

Bob Stroup

> -----Original Message-----
> **From:** Johnson, Charles E. [mailto:cejohnso@nd.gov]
> **Sent:** Wednesday, February 21, 2007 10:06 AM
> **To:** bob.stroup@noridian.com
> **Cc:** Fix, Michael L.; Magnuson, Vance G.
> **Subject:** Appeals and Grievance Manual
>
> Bob, it appears that the Company should make a formal filing of the Manual as noted by Vance below. Let me know if you have any questions.
>
> I've made some revisions in the Market Conduct Report and will be sending you a marked up copy. Let me know what you think after you've had a chance to look at the changes. Thanks. Chuck J.
>
> ---
>
> **From:** Magnuson, Vance G.
> **Sent:** Wednesday, February 21, 2007 9:09 AM
> Johnson, Charles E.
> Fix, Michael L.
> **Subject:** RE: Market conduct report
>
> Chuck,

Technically, the information that was submitted was to comply with 26.1-26.4-03(3) describing the UR appeal procedures as part of the annual UR certification. Yvonne handles the annual UR certifications, so should have a copy of this.

What BCBSND failed to do was file their "Grievance procedures" for approval as required under 26.1-36-42. This is why we do [illegible]t have an approved copy of the latest Noridian Appeals and Grievance Manual. This would be a formal form filing as [illegible]posed to the UR annual certification. Vance

---

From: Johnson, Charles E.
Sent: Tuesday, February 20, 2007 4:00 PM
To: Magnuson, Vance G.
Subject: FW: Market conduct report

Vance, are you aware of the filing referred to by Bob below? If so, can you get me a copy of the pages that are relevant to the Market Conduct filing, also as referred to by Bob below? Thanks. cj.

From: Bob Stroup [mailto:Bob.Stroup@bcbsnd.com]
Sent: Tuesday, February 20, 2007 10:25 AM
To: Johnson, Charles E.
Subject: RE: Market conduct report

Chuck,

There was some internal confusion surrounding the existence of this referenced manual, whether or not it was filed with the Insurance Department, and the relevant material as referenced in the BCBSND response and your request. I apologize for the delay in getting this material to you, but it took some time to garner a working understanding of this document and its current use in the context of the Market Conduct Exam and BCBSND's response.

[illegible]CBSND had previously filed an Appeals and Grievance Manual with the Department pursuant to Chapter 26.1-26.4, [illegible].C.C. This manual was amended and a new procedure adopted late in 2005, and this new procedure was published for [illegible]alth care providers in the BCBSND HealthCare News in September 2005. A description of the current BCBSND appeals procedure, as referenced by the Noridian Appeals and Grievance Manual included in the BCBSND Market Conduct Response, along with a ten-dollar filing fee, was submitted to the Insurance Department on January 23, 2006, and is attached to an Insurance Department document entitled "Utilization Review Agent Annual Renewal of Certification". BCBSND did not receive a filing number or approval date for the submitted material but it did receive acknowledgement that the material was submitted through written confirmation from the Department stamped as "Paid" and dated January 26, 2006. On this Department form there is a checkbox indicating, "The appeal procedure has changed. A description of the current procedure is enclosed" and the new appeals procedure is described in a two-page document attached to the form. This outline of the amended procedure forms the basis of changes to the Appeals and Grievance Manual previously filed with the Department and is referred to internally at BCBSND as the Appeals and Grievance Manual, however, an updated full blown manual incorporating these changes is still awaiting completion.

As far as the pertinent pages you requested, I refer you to the description of the appeals process in the attachment submitted with this filing. This updated appeals procedure, along with sample letters utilized in the amended process and the HealthCare News bulletin were provided to the Department auditors during the examination and form the basis for this response. There appears to be a discrepancy in that some of the claims reviewed by the auditors reflected the process and relevant correspondence *before* it was amended and the examination results outline its deficiencies even though these deficiencies were addressed and amended as recommended in the Market Conduct Examination. This explains the response submitted by BCBSND to Recommendation 15 and Recommendation 19.

This amended appeals process and correspondence reflecting the recommendations requested by the Department have already been incorporated into the BCBSND appeals procedure. This information was provided to the auditors and the amended appeals procedure was filed with the Department. If you want this information resubmitted for your review, please let me know, or call me and we can discuss further.

[illegible]pologize if this is more confusing in light of your request, but it is what I am able to discern at the current time.

[illegible]anks.

Bob Stroup

-----Original Message-----

From: Johnson, Charles E. [mailto:cejohnso@nd.gov]
Sent: Tuesday, January 16, 2007 4:22 PM
To: bob.stroup@noridian.com
Subject: Market conduct report

Bob, I've been trying to work through your response letter to the report.

On pages 9 and 10 of your letter you refer to the Appeals and Grievance Administrative Manual revised in late 2005. We don't seem to have a copy of it here in the office.

Could you provide me with a copy of the pertinent pages relating to your discussion of Recommendations fifteen and nineteen.

It may be that the manual was filed along with other filings and was logged into our system under the other filing. If so, could you provide me with the filing number or approval date or something else so that we can retrieve the manual from our files.

If you need more info, let me know. Thanks. Chuck J.

BlueCross BlueShield
of North Dakota

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Quality Management
Corrective Action Policy

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Approved by:	Board of Directors	Effective Date:	June 24, 2005	Revision Date:	May 20, 2005
Reviewed by:	Board of Directors Quality Committee	Review Date(s):	November 9, 2007		

Quality Management Corrective Action Policy

1. PURPOSE

The purpose of this policy is to ensure Blue Cross Blue Shield of North Dakota (BCBSND) implements timely, effective actions when indicators reveal a need for improved performance by a Health Care Provider. This policy outlines how BCBSND may initiate a corrective action if a Health Care Provider does not comply with BCBSND's performance standards.

2. PERFORMANCE STANDARDS

2.1 The following is a non-exclusive summary of BCBSND's performance standards:

Health Care Providers shall:

a. Cooperate, in good faith, to facilitate BCBSND's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from BCBSND, providing information and documents requested by BCBSND and cooperating with BCBSND staff members as they perform their quality management activities.

b. Render or order Medically Necessary and Appropriate services for Members.

c. Obtain prior authorization of services in accordance with applicable Quality Management Program policies and procedures.

d. Comply fully with the terms of their Participation Agreement(s).

e. Comply with accepted professional standards of care, conduct, competence, practices and reputation.

f. Comply with accepted coding and billing standards.

g. Engage in accepted practice patterns that are not aberrant, excessive or inappropriate.

h. Continue to satisfy BCBSND's credentialing requirements, including, without limitation:

   1. Licenses or certifications must be in good standing.

   2. Liability insurance coverage must remain in full force and effect.

   3. No unreported material changes in the Health Care Provider's status such that the credentialing information submitted to BCBSND is no longer accurate.

2.2 This policy does not apply in the following instances:

a. Non-acceptance of a participation application because the Health Care Provider fails to satisfy BCBSND's pre-credentialing application standards (e.g. failure to provide evidence of licensure or insurance).

b. Termination of a Health Care Provider's participation other than by reason of the Health Care Provider's failure to comply with applicable performance standards (e.g. the Participation Agreement is terminated without cause).

c. Disputes intended to be resolved according to BCBSND's appeals process.

3. DEFINITIONS

Corrective Action Plan: A formally defined disciplinary process, intended to direct a Health Care Provider back into compliance with the performance standards, during which, for a specified period of time, practice restrictions can be imposed and/or payment for care administered by a Health Care Provider can be denied, restricted or reduced for all or certain services.

Health Care Provider: A person licensed, certified, or otherwise authorized by state law to provide health care services.

Non-participating: a Health Care Provider that does not have a participation agreement or whose participation agreement has been terminated.

Non-payable: A Health Care Provider that is not reimbursable. No benefits are available for Covered Services prescribed by, performed by or under the direct supervision of a non-payable Health Care Provider.

Quality Committee of the Board: The Committee responsible for overseeing and directing the Quality Management Program. This subcommittee of the Board of Directors consists of five (5) Directors, appointed and designated by the Chairman of the Board.

Quality Management Committee: The Committee responsible for coordinating the functions of credentialing, medical management, utilization management, case management, quality management and improvement initiatives with oversight by the Quality Committee of the Board of Directors. Members of this Committee include representatives from the following areas: Medical Management, Development/Business Strategies, Legal, Provider Relations, Claims Administration and Member Services.

Quality Management Program: The Program provides planned, systematic activities and processes to monitor and evaluate patient care and services for the primary purpose of assisting Health Care Providers to improve quality.

4. INVESTIGATION

4.1 BCBSND's staff will investigate and report any apparent non-compliance with the performance standards to the Quality Management Committee, after making a reasonable effort to obtain material facts concerning the matter. The Quality Management Committee shall consider information it receives during its next regularly scheduled meeting or at a special meeting called to consider the matter.

4.2 Health Care Providers must submit requested information and fully cooperate with staff members as a condition of their continued participation with BCBSND. The Quality Management Committee may, at their discretion do any or all of the following:

a. Consult with the Health Care Provider concerning the alleged non-compliance;

b. Review material documents, including members' medical records and other specified information submitted by the Health Care Provider upon request;

c. Contact other Health Care Providers or persons who have knowledge concerning the matter being investigated;

d. Submit information regarding the Health Care Provider's conduct to another committee (i.e. Fraud) for further consideration and action.

4.3 An evaluation will be made to determine areas where, following assessment, intervention is most likely to provide improvements in compliance with the performance standards. Data sources may include:

- BCBSND Fraud Committee
- Appeals and complaints filed by members and Health Care Providers
- State Board of Medical Examiners or other Professional Boards
- High volume, high-risk procedure and diagnostic reports
- Inpatient indicators such as readmission rates
- Health Care Provider profile reports
- Drug utilization and Health Care Provider prescribing reports
- Utilization and claim reports
- Health Care Providers, members and employers
- Member and Health Care Provider satisfaction surveys
- Any other report which may provide relevant and credible information

4.4 All findings of the investigation, with any recommendations for corrective action, will be communicated to the Quality Committee of the Board within a reasonable period of time. Upon determining that a Health Care Provider has not complied with the performance standards, the Quality Management Committee, in conjunction with the Quality Committee of the Board, may initiate a Corrective Action Plan.

5. PROCEDURE FOR IMPOSING A CORRECTIVE ACTION PLAN

5.1 In conjunction with the Quality Committee of the Board, the Quality Management Committee shall immediately notify the Health Care Provider, by certified or overnight mail, that a Corrective Action Plan will be imposed. The Corrective Action Plan shall become effective as of the date of the notice letter, unless the Quality Management Committee or Quality Committee of the Board elect to defer the effective date.

The Health Care Provider is permitted to see any records accumulated regarding the investigation pertaining to the Health Care Provider's individual practice at any time.

5.2 The written Corrective Action Plan will include the following:

a. A description of the complaint or violation.

b. A description of the investigation process.

c. A description of the corrective action, including associated activities and timelines, such as:

- Counseling the Health Care Provider concerning specific actions that should be taken to address identified problems

- Focused Review: a process of identifying Health Care Providers whose practices do not fall within peer group parameters established on a specialty-by-specialty analysis of utilization patterns, notifying them of their responsibilities, and involving intense review of claims.

- Mandatory Prior Authorizations for specified treatments or services

- Continuing medical education

- Closure of the Health Care Provider's practice to new members

- Any other action deemed appropriate

d. A list of the activities the Quality Management Committee will use to monitor compliance and effectiveness of the corrective action related to the incident.

e. A statement that the Health Care Provider has no less than 6 months from the receipt of the notice to make corrections.

f. A statement that the investigation and Corrective Action Plan will be reviewed six (6) months from receipt of this notice. Results of the review will be reported to the Quality Committee of the Board.

g. A statement explaining how to request an appeal of the Corrective Action Plan, specifying that such an appeal must be requested within thirty (30) days of the date of the Notice letter.

h. If applicable, a statement that the Corrective Action Plan may be reported to the State licensing board or other entities as mandated by law if the Health Care Provider doesn't request an appeal or if the Corrective Action Plan is affirmed following exhaustion of the appeal process.

6. APPEAL OF CORRECTIVE ACTION PLAN

6.1 The Health Care Provider may appeal an imposed Corrective Action Plan by submitting a written statement of his or her position within thirty (30) days of receipt of the notice of the imposed corrective action.

6.2 The Health Care Provider must comply with the terms and conditions of the Corrective Action Plan while the appeal is pending, unless specifically directed otherwise by the Quality Management Committee.

6.3 The Quality Management Committee will consider the appeal and may continue, modify or reverse the Corrective Action Plan, at its discretion. **The Health Care Provider shall not have the right to participate in the Quality Management Committee's deliberations or to appeal the Quality Management Committee's final decision.** The Quality Management Committee shall notify the Health Care Provider of its decision within ten (10) business days after receiving the Health Care Provider's written appeal.

6.4 **If, after reviewing the appeal, the imposition of the Corrective Action Plan is:**

a. reversed and the corrective action is rescinded, the Corrective Action Plan will be terminated and the Health Care Provider has no obligation to continue the plan.

b. **upheld, the plan will continue or may be modified. The Health Care Provider shall comply with the Corrective Action Plan as written or modified.**

7. CORRECTIVE ACTION PLAN REVIEW AND ACTIONS

The Quality Management Committee reviews all Corrective Action Plans after 6 months and presents its recommendation at the next regularly scheduled meeting of the Quality Committee of the Board.

7.1 If the Quality Management Committee determines that the Corrective Action Plan has been satisfactorily completed, the Health Care Provider will be notified.

7.2. If the Quality Management Committee determines that the Health Care Provider has not complied with the Corrective Action Plan, the Quality Management Committee may take other disciplinary action proper and appropriate to the circumstances, which may include:

a. Notifying the Health Care Provider that the Corrective Action Plan will be continued for a specified period of time, after which the case would be reviewed again.

b. Notifying the Health Care Provider that the Corrective Action Plan is modified. The notice will include an updated description, associated activities and timelines.

c. Changing the Health Care Provider's status to non-participating.

- The Quality Management Committee shall notify Members who are or have been under the care of the non-participating Health Care Provider within the past 12 months.
- The Health Care Provider shall have the right to re-apply for participation status no less than 18 months after the date their status was changed to non-participating, and they have demonstrated compliance with the performance standards.
- The Quality Management Committee shall notify Quality Committee of the Board of its decision.

7.3 If the Quality Management Committee changes the Health Care Provider's status to non-participating, the Health Care Provider will be notified of the Quality Management Committee's decision within ten (10) business days. The Health Care Provider will have ten (10) business days from the date of the notice to appeal the decision by submitting a written statement of his or her position to the Quality Committee of the Board. The Health Care Provider will be given at least ten (10) business days written notice that the Quality Committee of the Board shall meet to discuss the appeal. The letter shall inform the Health Care Provider:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf; and

c. That a representative Health Care Provider who is not a member of the Quality Committee of the Board and who is of the same specialty as the Health Care Provider under investigation shall be present in an advisory capacity only.

The Quality Committee of the Board must report its findings to the Board of Directors and shall notify the Health Care Provider of its decision within ten (10) business days of the meeting.

7.4. If the Health Care Provider's status is changed to non-participating, the Quality Management Committee will continue to monitor the Health Care Provider. If the Quality Management Committee finds that the Health Care Provider continues to be out of compliance with the performance standards required of a non-participating Health Care Provider, the Health Care Provider will receive at least 10 business days written notice that the Quality Committee of the Board shall meet to discuss the continued investigation. The letter will inform the Health Care Provider:

a. Of their right to be present at that meeting;

b. Of their right to present any additional information on their behalf; and

c. That a representative Health Care Provider who is not a member of the Quality Committee of the Board and who is of the same specialty as the Health Care Provider under investigation will be present in an advisory capacity only.

7.5. If the Quality Committee of the Board finds that the Health Care Provider continues to be out of compliance with the performance standards required of a non-participating Health Care Provider, the Quality Committee of the Board may recommend to the Board of Directors that the Health Care Provider's status be changed to non-payable.

7.6 The Quality Committee of the Board's recommendation to change the Health Care Provider's status to non-payable will be submitted to the Board of Directors for consideration during its next regularly scheduled meeting, unless the Board calls a special meeting to consider that report. The Board may accept, modify or reverse the Quality Committee of the Board's recommendation, at its discretion. The Health Care Provider shall not have the right to appeal or to otherwise participate in the Board's deliberations concerning the Quality Committee of the Board's recommendation. Within ten (10) business days after the date of that meeting, the Board shall notify the Health Care Provider of its determination, that this is the final decision and that all avenues of appeal have been exhausted. If the Health Care Provider continues to disagree with the determination, he/she may pursue normal remedies of law, if any.

7.7 If the Health Care Provider's status is changed to non-payable, the Quality Management Committee shall notify Members who are or have been under the care of the non-payable Health Care Provider within the past 12 months.

8. IMMEDIATE ACTION

8.1 **Temporary Suspension.** BCBSND reserves the right to place the Health Care Provider under temporary suspension, immediately making the Health Care Provider non-participating, non-payable or ineligible under any of the following circumstances:

a. If the state agency responsible for licensing, registration, or certification suspends or revokes a Health Care Provider's license, registration or certification.

b. There is reason to believe that the Health Care Provider has violated BCBSND's rules and regulations.

c. There is reason to believe that the Health Care Provider's actions may result in imminent danger to a Member's health or welfare.

d. There is reason to believe that the Health Care Provider's actions will impair BCBSND's reputation or operations.

The Quality Management Committee shall notify the Health Care Provider, by certified mail, of the temporary suspension of the Health Care Provider's participation or status as payable.

8.2 **Confirmation of Suspension.** If the Quality Management Committee requires additional time to investigate allegations, the temporary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within fourteen (14) days after the imposition of the temporary suspension. The Quality Management Committee shall notify the Health Care Provider of the results of the investigation and any further action to be taken.

8.3 The Quality Management Committee will present results of the investigation to the Quality Committee of the Board for final determination:

a. The Health Care Provider's temporary suspension is lifted.

b. The Health Care Provider is designated non-participating, non-payable, or ineligible.

8.4 If the Health Care Provider is designated non-participating, non-payable or ineligible, the Quality Management Committee may notify Members who are or have been under the care of the Health Care Provider within the past 12 months.

8.5 The provider shall have the right to request a hearing with the Quality Committee of the Board to discuss the final determination.

9. CONFIDENTIALITY AND REPORTING REQUIREMENTS

Records or information concerning the activities of the Quality Committee of the Board and/or the Quality Management Committee shall be treated and maintained as privileged and confidential records to the fullest extent permitted by state and federal laws. Reports to the committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this policy shall not alter the status of such records or information as privileged and confidential information.

CHAPTER 26.1-36
ACCIDENT AND HEALTH INSURANCE

26.1-36-01. Scope. No section of this chapter applies to or affects any policy of workforce safety and insurance or any policy of liability insurance with or without supplementary expense coverage therein; or any policy or contract of reinsurance; or any blanket or group insurance policy, except when the section refers to a blanket or group insurance policy; or life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as provide additional benefits in case of death or dismemberment or loss of sight by accident, or as operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

26.1-36-02. Accident and health insurance policy defined. "Accident and health insurance policy" includes any contract policy insuring against loss resulting from sickness or bodily injury, or death by accident, or both.

26.1-36-02.1. Accident and health policies and certificates - Notice of free examination. Accident and health policies and certificates must have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the applicant may return the policy or certificate within ten days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

26.1-36-03. Form of policy.

1. No accident and health insurance policy may be delivered or issued for delivery to any person in this state unless:

   a. The entire money and other considerations for the policy are expressed in the policy.

   b. The time at which the insurance takes effect and terminates is expressed in the policy.

   c. The policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is deemed the policyholder, any two or more eligible members of that family, including spouse, dependent children or any children under a specified age which may not exceed twenty-two years, and any other person dependent upon the policyholder.

   d. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which is uniform and not less than ten point with a lowercase unspaced alphabet length not less than one hundred twenty point. The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

   e. The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 26.1-36-04, are printed at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". If an exception or reduction specifically applies only to a

particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

f. Each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page thereof.

g. It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

2. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the insurance department of that state has advised the commissioner that the policy is not subject to approval or disapproval by that official, the commissioner may by ruling require that the policy meet the standards set forth in subsection 1 and in section 26.1-36-04.

26.1-36-03.1. 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 subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless that insurer makes available to persons covered under the policy or contract 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 person covered under the contract, in any manner reasonably assuring availability 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;

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.

26.1-36-04. Accident and health policy provisions.

1. Except as provided in subsection 3, each accident and health insurance policy delivered or issued for delivery to any person in this state must contain provisions described in this section. The provisions contained in any policy may not be less favorable in any respect to the insured or the beneficiary.

a. A provision that the policy, including the endorsements and the attached papers, if any, constitutes the entire insurance contract and that no change in the policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy.

b. A provision that no insurance producer has authority to change the policy or to waive any of its provisions.

c. A provision that the validity of the policy may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy may not be contested on the basis of a statement made relating to insurability by any person covered under the policy after the insurance has been in force for two years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement; provided, however, that no such provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy.

d. A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a preexisting disease or physical condition for which medical advice or treatment was received by the person during the two-year period before the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the end of the two-year period commencing on the effective date of the person's coverage.

e. A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which the policy continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

f. A provision that if any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, reinstates the policy; provided, however, that if the insurer or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by the insurer or, lacking the approval, upon the forty-fifth day following the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The policy must provide that the reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to any sickness that begins more than ten days after the date. The policy must provide that in all other respects the insured and insurer have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed thereon or attached thereto in connection with the reinstatement. The provision may include a statement that any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement. This statement may be omitted from any policy which the insured has the right to continue in force subject to its

terms by the timely payment of premiums until at least age fifty or in the case of a policy issued after age forty-four, for at least five years from its date of issue.

g. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within this time does not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

h. A provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, the forms usually furnished for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making the claim is deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims are made.

i. A provision that in the case of claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety days after the date of loss. Failure to furnish the proof within this time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

j. A provision that all benefits payable under the policy other than benefits for loss of time will be payable according to the provisions of section 26.1-36-37.1, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of proof of loss.

k. A provision that benefits for loss of life of the person insured will be payable to the beneficiary designated by the insured person. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the insured person. All other benefits of the policy are payable to the insured person. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of the person deemed by the insurer to be equitably entitled to the benefit.

l. A provision that the insurer may examine the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also may make an autopsy in case of death if the autopsy is not prohibited by law.

m. A provision that no action may be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the

requirements of the policy and that no such action may be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy.

n. A provision that in the event of the death of an insured, the insurer will refund within thirty days after notice to the insurer of the insured's death the portion of the premium, fees, or other sum paid beyond the month of death after deducting any claim for losses during the current term of the policy. This provision does not apply if the insurer has a valid defense to the payment of benefits under the policy.

2. Except as provided in subsection 3, no accident and health insurance policy delivered or issued for delivery to any person in this state may contain provisions respecting the matters described in this subsection unless the provisions in the policy are not less favorable in any respect to the insured or the beneficiary.

a. A provision that if the insured is injured or contracts sickness after having changed occupation to one classified by the insurer as more hazardous than that stated in the policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of proof, whichever is the more recent. The provision must provide that the classification of occupational risk and the premium rates will be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time the policy was issued; but if the filing was not required, then the classification of occupational risk and the premium rates will be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

b. A provision that if the age of the insured has been misstated, all amounts payable under the policy will be such as the premium paid would have purchased at the correct age.

c. A provision that if an accident or health or accident and health policy or policies previously issued by the insurer to the insured are in force concurrently therewith, making the aggregate indemnity for the type of coverage or coverages, in excess of the maximum limit of indemnity or indemnities, the excess insurance is void and all premiums paid for the excess will be returned to the insured or to the insured's estate. In lieu of this type of provision, the policy may provide that insurance effective at any one time on the insured under the policy and a like policy or policies in the insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

d. A provision that upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

e. Subject to chapter 26.1-36.4, a provision that the insurer may cancel the policy at any time by written notice delivered to the insured, or mailed to the insured's

last address as shown by the records of the insurer, stating when, not less than five days thereafter, the cancellation is effective; and after the policy has been continued beyond its original term the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in the notice. The provision must provide that in the event of cancellation, the insurer will return promptly the unearned portion of any premium paid, and, if the insured cancels, the earned premium will be computed by the use of the short-rate table last filed in the state where the insured resided when the policy was issued. The provision must provide that if the insurer cancels, the earned premium shall be computed pro rata. The provision must provide that cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

f. A provision that any provision of the policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.

g. A provision that the insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

h. A provision that the insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

i. A provision that after the loss-of-time benefit of the policy has been payable for ninety days, such benefit will be adjusted, as provided below, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed a percentage of the insured's earned income as provided in the policy; provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under the policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded an alternative percentage of the insured's earned income as provided in the policy, at the time of the application, such higher percentage will be used in place of the original percentage provided. The provision must provide that the adjusted loss-of-time benefit under the policy for any month will be only such proportion of the loss-of-time benefit otherwise payable under the policy as (1) the product of the insured's earned income and the original percent, or, if higher, the alternative percentage, bears to (2) the total amount of loss-of-time benefits payable for such month under the policy and all other valid loss-of-time coverage on the insured, without giving effect to the "overinsurance provision" in this or any other coverage, less in both (1) and (2) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an "overinsurance provision". The provision must provide that in making the computation, all benefits and earnings will be converted to a consistent basis weekly if the loss-of-time benefit of the policy is payable weekly, or monthly if the benefit is payable monthly, or otherwise, based upon the time period. If the numerator of the foregoing ratio is zero or is negative, no benefit is payable. The provision must provide that in no event does the provision operate to reduce the total combined amount of loss-of-time benefits for such month payable under the policy and all other valid loss-of-time coverage below the lesser of three hundred dollars and the total combined amount of loss-of-time benefits determined without giving effect to any "overinsurance provision", nor operate to increase the amount of benefits payable under the policy above the amount which would have been paid in the absence of the provision, nor take into account or operate to reduce any benefit other than the loss-of-time benefit. The provision must provide that:

(1) "Earned income", except when otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and the insured's average monthly earnings for a period of two years immediately preceding the commencement of the disability, and does not include any investment income or any other income not derived from the insured's vocational activities.

(2) "Overinsurance provision" includes this type of provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings.

This type of provision may be included only in a policy which provides a loss-of-time benefit which may be payable for at least fifty-two weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than sixty percent, selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage must be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy must include a definition of "valid loss-of-time coverage" which may include coverage provided by governmental agencies and by organizations subject to regulation by insurance law and by insurance departments of this or any other state or of any other country or subdivision thereof, coverage provided for the insured pursuant to any disability benefits statute or any workforce safety and insurance or employer's liability statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved.

3. If any requirement of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

4. The provisions that are subject to subsections 1 and 2 must be printed in the consecutive order of the requirements in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

5. A provision not subject to this section may not make a policy, or any portion of the policy, less favorable in any respect to the insured or to the beneficiary than any provision which is subject to this chapter.

6. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision that is not less favorable to the insured or the beneficiary than the provisions of this chapter and that is prescribed or required by the law of the state under which the insurer is organized. Any policy of a

domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

26.1-36-05. Group health policy or service contract standard provisions. Neither a group health insurance policy nor a group health service contract may be delivered in this state unless it contains in substance the following provisions, or provisions that in the opinion of the commissioner are more favorable to the persons insured and more favorable to the policyholder or contractholder; provided, however, that subsections 5, 7, and 12 do not apply to credit accident and health insurance policies, that the standard provisions required for individual health insurance policies do not apply to group health insurance policies, and that if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy or contract, the insurer shall omit from the policy or contract any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision to make the provision contained in the policy or contract consistent with the coverage provided by the policy or contract:

1. A provision that the policyholder or contractholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which the policy or contract continues in force, unless the policyholder or contractholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy or contract. The policy or contract may provide that the policyholder or contractholder is liable to the insurer for the payment of a pro rata premium for the time the policy or contract was in force during the grace period.

2. A provision that the validity of the policy or contract may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy or contract may not be contested on the basis of a statement made relating to insurability by any person covered under the policy or contract after the insurance has been in force for two years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement; provided, however, that no such provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or contract.

3. A provision that a copy of the application, if any, of the policyholder or contractholder will be attached to the policy or contract when issued, that all statements made by the policyholder or contractholder or by the persons insured are deemed representations and not warranties, and that no statement made by any insured person may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to that person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

5. A provision specifying the additional exclusions or limitations, if any, applicable under the policy or contract with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy or contract. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months before the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the earlier of the end of a continuance period of twelve months commencing on or after the effective date of

the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition, or the end of the two-year period commencing on the effective date of the person's coverage.

6. If the premiums or benefits vary by age, a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision must contain a clear statement of the method of adjustment to be used.

7. A provision that the insurer will issue to the policyholder or contractholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage.

8. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or contract. Failure to give notice within this time does not invalidate nor reduce any claim if it is shown that it was not reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

9. A provision that the insurer will furnish to the person making claim, or to the policyholder or contractholder for delivery to the person making claim, the forms usually furnished for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy or contract, the person making the claim is deemed to have complied with the requirements of the policy or contract as to proof of loss upon submitting within the time fixed in the policy or contract for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

10. A provision that in the case of claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of continuance of the disability must be furnished to the insurer at intervals the insurer may reasonably require, and that in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety days after the date of loss. Failure to furnish the proof within this time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

11. A provision that all benefits payable under the policy or contract other than benefits for loss of time or unless subject to section 26.1-36-37.1 will be payable not more than sixty days after receipt of due proof of loss. All accrued benefits payable under the policy or contract for loss of time will be paid at least monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of that period will be paid as soon as possible after receipt of proof of loss.

12. A provision that benefits for loss of life of the person insured will be payable to the beneficiary designated by the insured person. If the policy or contract contains conditions pertaining to family status, however, the beneficiary may be the family member specified by the policy or contract terms. In either case, payment of these benefits is subject to the provisions of the policy or contract in the event the designated or specified beneficiary is not living at the death of the insured person. All other benefits of the policy or contract are payable to the insured person. The policy or contract may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five

thousand dollars, to any relative by blood or connection by marriage of the person deemed by the insurer to be equitably entitled to the benefit.

13. A provision that the insurer may examine the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy or contract and also may make an autopsy in case of death when the autopsy is not prohibited by law.

14. A provision that no action may be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that the action may not be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy or contract.

26.1-36-06. Group health policy and medical service contract options for drugs and chiropractic care. No insurance company or health service corporation may deliver, issue, execute, or renew any health insurance policy or medical service contract that includes coverage of medical benefits on a group, blanket, franchise, or association basis unless the insurer makes available, at the option of the policyholder, the following coverages for which an additional premium may be charged:

1. All drugs and medicines prescribed by the provider of health services.

2. Services rendered and care administered by chiropractors licensed under chapter 43-06.

26.1-36-06.1. Coverage for off-label uses of drugs.

1. In this section:

   a. "Coverage of a drug" includes medically necessary services associated with the administration of the drug.

   b. "Medical literature" means scientific studies published in a peer review national medical journal.

   c. "Off-label use of drugs" means prescribing drugs for treatments other than those stated in the labeling approved by the federal food and drug administration.

   d. "Standard reference compendia" means the United States pharmacopeia drug information or American hospital formulary service drug information.

2. An insurance company, nonprofit health service corporation, or health maintenance organization that provides coverage for drugs may not issue, deliver, execute, or renew any health insurance policy or health service contract on an individual, group, blanket, franchise, or association basis which excludes coverage of a drug for a particular indication on the grounds the drug has not been approved by the federal food and drug administration for that indication if the drug is recognized for treatment of the indication in one of the standard reference compendia or medical literature.

3. The insurance commissioner may direct an insurer or contractor regulated by this section to make payments as required by this section.

4. The state health officer may appoint a panel of up to eight qualified medical experts to review off-label uses of drugs not included in the standard reference compendia or medical literature. This panel shall advise the insurance commissioner whether a particular off-label use is medically appropriate and shall make recommendations regarding payment of off-label use.

5. This section does not alter existing law regarding provisions limiting the coverage of drugs that have not been approved by the federal food and drug administration; does not require coverage for any drug when the federal food and drug administration has determined its use to be contraindicated; and does not require coverage for experimental drugs not otherwise approved for any indication by the federal food and drug administration.

26.1-36-07. Health insurance coverage for newborn and adopted children - Scope of coverage - Notification of birth or adoption.

1. All individual and group health insurance policies providing coverage on an expense-incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber must, as to the family members' coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth and are also payable from the date of physical placement by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 with respect to an adopted child.

2. The coverage for newly born children and for children placed for adoption by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or child placed for adoption by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth or date of physical placement by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 of the child in order to have the coverage continue beyond the thirty-one-day period.

26.1-36-08. Group health policy and health service contract substance abuse coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group, blanket, franchise, or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any individual covered under the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, which benefits meet or exceed the benefits provided in subsection 2.

2. The benefits must be provided for inpatient treatment, treatment by partial hospitalization, and outpatient treatment:

   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of sixty days of services covered under this section and section 26.1-36-09 in any calendar year. Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31.

   b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-09 in any calendar year. Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31. For services provided in regional human service

centers, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

c. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization, provided that no more than forty-six days of the inpatient treatment benefits required by this section may be traded for treatment by partial hospitalization.

d. In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of twenty visits for services covered under this section in any calendar year, provided the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, or the treatment services are provided within the scope of licensure by a licensed addiction counselor. The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five visits in any calendar year, and may not establish a copayment greater than twenty percent for the remaining visits. The deductible limitation of this subdivision does not apply to a high-deductible health plan used to establish a health savings account pursuant to and as defined in section 223 of the Internal Revenue Code [26 U.S.C. 223].

e. If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those visits after the first five visits in any calendar year.

f. As used in this section and section 26.1-36-08.1, partial hospitalization means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

3. This section does not prevent any insurance company, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, when the policy or contract is not subject to such provisions.

26.1-36-08.1. Alternative group health policy and health service contract substance abuse coverage.

1. As an alternative to the substance abuse coverage required under subsection 2 of section 26.1-36-08, an insurance company, a nonprofit health service corporation, or a health maintenance organization may provide substance abuse coverage under this section.

2. The provisions of section 26.1-36-08 apply to this alternative, except:

   a. In addition to the inpatient treatment, treatment by partial hospitalization, and outpatient treatment coverage required under section 26.1-36-08, the coverage must include residential treatment.

   b. In the case of coverage for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-09 in any calendar year.

c. For the purpose of computing the period for which benefits are payable for a combination of inpatient and partial hospitalization, no more than twenty-three days of inpatient treatment benefits required under subdivision a may be traded for treatment by partial hospitalization.

d. In the case of coverage for residential treatment, the benefits must be provided for a minimum of sixty days of services covered under this section in any calendar year. This residential treatment must be provided by an addiction treatment program licensed under chapter 50-31. If an individual receiving residential treatment services requires more than sixty days of residential treatment services, unused inpatient treatment benefits provided for under subdivision b may be traded for residential treatment benefits. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a residential treatment program, provided that no more than twenty-three days of inpatient treatment benefits required by this section may be traded for residential treatment benefits required under this section.

26.1-36-09. Group health policy and health service contract mental disorder coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental disorder and other related illness, which benefits meet or exceed the benefits provided in subsection 2.

2. a. The benefits must be provided for each of the following services: inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment.

   b. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined under section 52-01-01 and rules of the state department of health pursuant thereto offering treatment for the prevention or cure of mental disorder or other related illness. An insurance provider may require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community.

   c. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-08 in any calendar year. Partial hospitalization must be provided by a hospital as defined under section 52-01-01 and rules of the state department of health pursuant thereto or by a regional human service center licensed under section 50-06-05.2, offering treatment for the prevention or cure of mental disorder or other related illness. For services provided in regional human service centers, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

   d. In the case of benefits provided for residential treatment, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section in any calendar year. Residential treatment services must be provided by a hospital as defined under section 52-01-01 and rules of the state department of health; by a regional human service center licensed under

section 50-06-05.2 offering treatment for the prevention or cure of mental disorder or other related illness; or by a residential treatment program. For services provided in a regional human service center, charges must be reasonably similar to the charges for care provided by a hospital as defined in this subsection.

e. Any individual receiving residential treatment services who requires residential treatment service beyond the minimum of one hundred twenty days may trade unused inpatient treatment benefits provided for under subdivision b. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a residential treatment program; provided, however, that no more than twenty-three days of the inpatient treatment benefits required by this section may be traded for residential treatment services.

f. (1) In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of thirty hours for services covered under this section in any calendar year if the treatment services are provided within the scope of licensure by a nurse who holds advanced licensure with a scope of practice within mental health or if the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, a licensed professional clinical counselor who is qualified in the clinical mental health counseling specialty in this state, or a licensed independent clinical social worker.

(2) A person who is qualified for third-party payment by the board of social work examiners on August 1, 1997, is exempt from paragraph 1.

(3) Upon the request of an insurance company, a nonprofit health service corporation, or a health maintenance organization, the North Dakota board of social work examiners shall provide to the requesting entity information to certify that a licensed certified social worker meets the qualifications required under this section.

(4) The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five hours in any calendar year, and may not establish a copayment greater than twenty percent for the remaining hours. The deductible limitation of this paragraph does not apply to a high-deductible health plan used to establish a health savings account pursuant to and as defined in section 223 of the Internal Revenue Code [26 U.S.C. 223].

(5) If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those hours after the first five hours in any calendar year.

g. "Partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

h. "Residential treatment" has the same meaning as provided in section 25-03.2-01, but only applies to individuals under twenty-one years of age.

3. This section does not prevent any insurance company, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, when the policy or contract is not subject to such provisions.

26.1-36-09.1. Health insurance policy and health service contract - Mammogram examination coverage.

1. An insurance company, nonprofit health service 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 provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

   a. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

   b. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age.

2. This section does not apply to individually guaranteed renewable supplemental, specified disease, long-term care, or other limited benefit policies.

26.1-36-09.2. Health insurance policy and health service contract - Involuntary complications of pregnancy coverage. No insurance company, nonprofit health service corporation, or health maintenance organization may 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 if the policy, contract, or evidence of coverage contains any exclusion, reduction, or other limitation as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless the provisions apply generally to all benefits paid under the policy, contract, or evidence of coverage. If a fixed amount is specified in the policy, contract, or evidence of coverage for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy must be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. If a fixed amount is payable for maternity benefits, involuntary complications of pregnancy are an illness and entitled to benefits otherwise provided by the policy, contract, or evidence of coverage. If the policy, contract, or evidence of coverage contains a maternity deductible, the maternity deductible applies only to expenses resulting from normal delivery and caesarean section delivery; however, expenses for caesarean section delivery in excess of the deductible must be treated as expenses for any other illness under the policy, contract, or evidence of coverage. For purposes of this section, "involuntary complications of pregnancy" includes nonelective caesarean section delivery.

26.1-36-09.3. Coverage for treatment of certain disorders. Except for policies that only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or a subscriber contract provided by a nonprofit health service corporation, preferred provider organization, or health maintenance organization, may be issued, renewed, continued, delivered, issued for delivery, or executed in this state after January 1, 1990, unless the policy, certificate, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage must be the same as that for treatment to any other joint in the body and applies if the treatment is administered or prescribed by a physician or a dentist. Benefits for the coverage may be limited to a lifetime maximum of ten thousand dollars per person for surgery, and two thousand five hundred dollars for nonsurgical treatment.

26.1-36-09.4. Preventive health care - Copayments. The standard health benefit plan developed under section 26.1-36.3-08 must provide coverage for prenatal care visits for a

covered person and recommended immunizations and well child visits for a covered person from birth to the age of five years. The plan may impose only a five dollar copayment for each prenatal care visit and a two dollar copayment for each well child visit or immunization visit.

26.1-36-09.5. Service of advanced registered nurse practitioner - Direct reimbursement required. The insured or any person covered by a health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis issued, delivered, executed, or renewed by an insurance company, nonprofit health service corporation, or health maintenance organization which provides for reimbursement or payment for services that are within the scope of practice of an advanced registered nurse practitioner who has received an advanced license under rules adopted by the North Dakota board of nursing is entitled to reimbursement or payment for services performed by an advanced registered nurse practitioner and the advanced registered nurse practitioner is entitled to direct reimbursement by the insurer.

26.1-36-09.6. Health insurance policy and health service contract - Prostate-specific antigen test coverage. An insurance company, nonprofit health service 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 provides an annual digital rectal examination and a prostate-specific antigen test for an asymptomatic male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.

26.1-36-09.7. Foods and food products for inherited metabolic diseases.

1. As used in this section:

   a. "Inherited metabolic disease" means maple syrup urine disease or phenylketonuria.

   b. "Low-protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.

   c. "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a physician.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prescription coverage on an individual, group, blanket, franchise, or association basis, unless the policy or contract provides, for any person covered under the policy or contract, coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease.

3. This section applies to any covered individual born after December 31, 1962. This section does not require coverage in excess of three thousand dollars per year total for low-protein modified food products or medical food for an individual with an inherited metabolic disease of amino acid or organic acid.

4. This section does not require medical benefits coverage for low-protein modified food products or medical food for an individual to the extent those benefits are

available to that individual under a state department of health or department of human services program.

26.1-36-09.8. Health insurance policy and health service contract - Postdelivery coverage for mothers and newborns.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides maternity benefits on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

   a. Inpatient care for at least forty-eight hours for a mother and her newborn child following a normal vaginal delivery, and inpatient care for at least ninety-six hours following a caesarean section, without requiring the attending physician or health care provider to obtain authorization to care for a mother and her newborn child in the inpatient setting for this period of time.

   b. Inpatient care in excess of forty-eight hours following a vaginal delivery and ninety-six hours following a caesarean section if the stay is determined to be reasonable and medically necessary.

2. Coverage is not required for postdelivery inpatient care for a covered mother and her newborn child during the entire minimum time period required under subdivision a of subsection 1 if:

   a. The attending physician or health care provider, in consultation with the mother, decides to discharge the mother and her newborn child early; and

   b. The mother and her newborn child meet the minimum medical criteria for discharge as recommended in the "Guidelines for Perinatal Care" prepared by the American college of obstetricians and gynecologists and the American academy of pediatrics.

3. A person covered under this section is not required to give birth in a hospital or stay in a hospital for a fixed period of time following the birth of her child or participate in any postdelivery visit.

4. An insurance company, nonprofit health service corporation, health maintenance organization, or provider may not:

   a. Provide monetary payments or rebates to any insured person to request less than the minimum coverage required under this section;

   b. Penalize or otherwise reduce or limit the reimbursement of an attending physician or health care provider for recommending or providing care that is covered under this section;

   c. Waive any deductible, coinsurance, or copayment requirement for providing the minimum coverage required under this section;

   d. Deny to the mother or newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely to avoid the requirements of this section; or

e. Provide incentives, monetary or otherwise, to an attending physician or health care provider to induce the physician or provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

5. The coverage required under subsection 1 may not exceed policy aggregate limits for this coverage.

6. This section does not prevent an insurance company, nonprofit health service corporation, or health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay relating to childbirth for a mother or newborn child under the plan.

26.1-36-09.9. Dental anesthesia and hospitalization coverage. An insurance company, nonprofit health service 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 provides benefits for anesthesia and hospitalization for dental care provided to a covered individual who is a child under age nine, is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. A carrier may require preauthorization of hospitalization for dental care procedures under this section in the same manner preauthorization is required for hospitalization for other covered diseases or conditions. Coverage under this section applies regardless of whether the services are provided in a hospital or an ambulatory surgery center.

26.1-36-09.10. Health insurance policy and health service contract - Prehospital emergency medical services.

1. In this section, unless the context or subject matter otherwise requires:

   a. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part.

   b. "Prehospital emergency medical services" means a service or its personnel either licensed under chapter 23-27 or certified by the state health department.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prehospital emergency medical services benefits on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides prehospital emergency medical services benefits in the case of an emergency medical condition.

3. The coverage required under this section does not require coverage in excess of policy aggregate limits or internal policy limits dealing specifically with prehospital emergency medical services.

4. This section does not prevent an insurance company, nonprofit health service corporation, or health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for prehospital emergency medical services.

26.1-36-09.11. Breast reconstruction surgery. An insurance company, nonprofit health service 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, or franchise basis unless the policy, contract, or evidence of insurance provides the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998 [Pub. L. 105-277; 112 Stat. 2681-337; 42 U.S.C. 300gg-6]. This section does not apply to individual or group supplemental, specified disease, long-term care, or other limited benefit policies.

26.1-36-09.12. Medical services related to suicide. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any hospital, surgical, medical, or major medical benefit policy on an individual, group, blanket franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. The medical benefits provided for in this section are exempt from section 54-03-28.

26.1-36-10. Health policy and health service contract coordination of benefit provisions. A group health insurance policy or a group health service contract may contain coordination of benefit provisions for the control of overinsurance. An individual health insurance policy or individual health service contract, except a specific disease, hospital indemnity, or other limited benefit plan, may contain coordination of benefit provisions for the control of overinsurance. These provisions must be in accordance with appropriate guidelines set forth in rules adopted by the commissioner.

26.1-36-11. Accident and health policy provision denying insured right to employ doctor or enter hospital prohibited. Any provision in any accident or health insurance policy issued by any insurance company denying the insured, in case of accident or sickness, the right to consult or employ any doctor licensed to practice in this state the insured may choose, or to enter any hospital or sanitarium organized and operating under the laws of this state the insured may select is void. The insurance company shall recognize any proof of claim duly certified by such doctor or hospital or sanitarium notwithstanding any provision contained in the policy.

26.1-36-12. Provisions prohibited in individual and group accident and health insurance policies, group health plans, and nonprofit health service contracts.

1. Any provision in any individual or group accident and health insurance policy, employee welfare benefit plan, or nonprofit health service contract issued by any insurance company, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 99-272; 100 Stat. 281; 29 U.S.C. 1167(1)], or nonprofit health service corporation denying or prohibiting the insured, participant, beneficiary, or subscriber from assigning to the department of human services any rights to medical benefits coverage to which the insured, participant, beneficiary, or subscriber is entitled under the policy, plan, or contract is void. An individual or group insurance company or nonprofit health service corporation shall recognize the assignment of medical benefits coverage completed by the insured, participant, beneficiary, or subscriber, notwithstanding any provision contained in the policy or contract to the contrary.

2. Any individual or group provision in any accident and health insurance policy, employee welfare benefit plan, or nonprofit health service corporation contract issued by any insurance company, group health plan, or nonprofit health service corporation which limits or excludes payments of medical benefits coverage to or on behalf of the insured, participant, beneficiary, or subscriber if the insured, participant, beneficiary, or subscriber is eligible for medical assistance benefits under chapter 50-24.1 is void.

26.1-36-12.1. Health service corporation contract provision denying insured or subscriber right to employ doctor or enter hospital prohibited. Any provision in any health service contract issued by a health service corporation denying the insured or subscriber, subscriber member, officer, or employee, in case of accident or sickness, the right to consult or

employ any doctor, including doctors of chiropractic, licensed to practice in this state whom the insured, subscriber, subscriber member, officer, or employee may choose, or to enter any hospital or sanitarium organized and operating under the laws of this state which the insured, subscriber, subscriber member, officer, or employee may select, is void. The health service corporation must recognize any proof of claim duly certified by the doctor, hospital, or sanitarium notwithstanding any provision contained in the contract.

26.1-36-12.2. Freedom of choice for pharmacy services.

1. No third-party payer, including a health care insurer as defined in section 26.1-47-01, providing pharmacy services and prescription drugs to any beneficiary may:

   a. Prevent a beneficiary from selecting the pharmacy or pharmacist of the beneficiary's choice to provide pharmaceutical goods and services, provided that pharmacist or pharmacy is licensed in this state;

   b. Impose upon any beneficiary selecting a participating or contracting provider a copayment, fee, or other condition not equally imposed upon all beneficiaries in the plan selecting a participating or contracting provider; or

   c. Deny any pharmacy or pharmacist the right to participate as a preferred provider under chapter 26.1-47 or as a contracting provider for any policy or plan, provided the pharmacist or pharmacy is licensed in this state, and accepts the terms of the third-party payer's contract.

2. Notwithstanding the provisions of subsection 1, the department of human services may exclude, from participation in the medical assistance program administered under chapter 50-24.1 and title XIX of the Social Security Act [Pub. L. 89-97; 79 Stat. 343; 42 U.S.C. 1396 et seq.], as amended, any provider of pharmacy services who does not agree to comply with state and federal requirements governing the program, or who, after so agreeing, fails to comply with those requirements.

3. Any provision in a health insurance policy in this state which violates the provisions in subsection 1 is void.

4. Any person who violates this section is guilty of a class A misdemeanor and each violation is a separate offense. The commissioner may levy an administrative penalty not to exceed ten thousand dollars for a violation of this section.

5. The insurance commissioner shall enforce the provisions of this section.

26.1-36-12.3. Basic health insurance coverage - Exception to required coverages. Expired under S.L. 1991, ch. 319, § 3.

26.1-36-12.4. 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 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 or research;

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 or management consistent with the standards imposed by chapter 26.1-26.4, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with health care providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law. 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.

26.1-36-12.5. Basic health insurance coverage - Exceptions to required coverage.

1. An insurance company, a nonprofit health service corporation, or a health maintenance organization may deliver, issue, execute, and renew a basic health insurance policy, health service contract, or evidence of coverage on an individual basis or an employer group, blanket, franchise, or association basis for employers with fewer than fifty employees.

2. The basic health insurance coverage policy, contract, or evidence of coverage under this section is not subject to sections 26.1-36-06.1, 26.1-36-08, 26.1-36-09.1, 26.1-36-09.3, 26.1-36-09.6, 26.1-36-09.7, 26.1-36-09.9, 26.1-36-09.10, 26.1-36-12.1, and 43-13-31. However, the insurance company, nonprofit health service corporation, or health maintenance organization shall make the coverage required under these sections available at the option of the individual or employer and may charge an additional premium for each coverage provided.

3. Any law that becomes effective after January 1, 2001, which provides for an accident and health insurance coverage mandate does not apply to a basic health insurance policy issued under this section unless the law specifically identifies application to a basic health insurance coverage policy.

26.1-36-13. Applicability of accident and health policy simplification standards.

1. Except as provided in subsection 3, sections 26.1-36-13 through 26.1-36-16 apply to all individual and group accident and health insurance contracts, policies, plans, or agreements, insurance certificates under group accident and health insurance policies, and disability benefit certificates issued by fraternal benefit societies filed after June 30, 1982. No policy may be delivered or issued for delivery in this state after June 30, 1986, unless approved by the commissioner or permitted to be issued under sections 26.1-36-13 through 26.1-36-16. Any policy form that has been approved or permitted to be issued prior to July 1, 1986, and that meets the standards set by sections 26.1-36-13 through 26.1-36-16 need not be refiled for approval, but may continue to be delivered or issued for delivery in this state upon the filing with the commissioner of a list of the forms identified by form number and accompanied by a certificate as to each such form in the manner provided in subsection 6 of section 26.1-36-14.

2. The commissioner may extend the dates in subsection 1.

3. Sections 26.1-36-13 through 26.1-36-16 do not apply to:

   a. A policy that is a security subject to federal jurisdiction.

   b. Any group policy covering a group of one thousand or more lives at date of issue. However, this does not except any certificate issued pursuant to a group policy delivered or issued for delivery in this state.

   c. A form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under sections 26.1-36-13 through 26.1-36-16.

   d. The renewal of a policy delivered or issued for delivery prior to the dates the forms must be approved under sections 26.1-36-13 through 26.1-36-16.

4. No other state law setting language simplification standards applies to a policy form.

26.1-36-14. Minimum accident and health policy language simplification standards.

1. No policy form may be delivered or issued for delivery in this state unless:

   a. The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3.

   b. It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded.

   c. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or rider.

   d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed or three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

2. The commissioner may authorize a lower score than the Flesch reading ease score required in subdivision a of subsection 1 whenever the commissioner finds that a lower score:

   a. Will provide a more accurate reflection of the readability of a policy form.

   b. Is warranted by the nature of a particular policy form or type or class of policy forms.

   c. Is caused by certain policy language which is drafted to conform to the requirements of any state law or rule, or agency interpretation.

3. A Flesch reading ease test score is measured by the following method:

   a. For policy forms containing ten thousand words or less of text, the entire form must be analyzed. For policy forms containing more than ten thousand words, the readability of two 2-hundred word samples per page may be analyzed instead of the entire form. The samples must be separated by at least twenty printed lines.

   b. The number of words and sentences in the text must be counted and the total number of words divided by the total number of sentences. The figure obtained must be multiplied by a factor of one and fifteen thousandths.

   c. The total number of syllables must be counted and divided by the total number of words. The figure obtained must be multiplied by a factor of eighty-four and six-tenths.

   d. The sum of the figures computed under subdivisions b and c subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.

   e. For purposes of subdivisions b, c, and d, the following procedures must be used:

      (1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word.

      (2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

      (3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. When the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

4. As used in this section, "text" includes all printed matter except:

   a. The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, and tables.

   b. Any policy language drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words defined in the policy, and any policy language required by law or rule, provided, however, the insurer identifies the language or terminology excepted by this subdivision and certifies, in writing, that the language or terminology is entitled to be excepted by this subdivision.

5. The commissioner may approve any other reading test for use as an alternative to the Flesch reading ease test if the other test is comparable in result to the Flesch reading ease test.

6. Filings subject to this section must provide the minimum reading ease score or a statement that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any statement, the commissioner may require the submission of further information to verify the certification in question.

7. At the option of the insurance company, nonprofit health service corporation, fraternal benefit society, or health maintenance organization, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

26.1-36-15. Approval of accident and health policy forms. A policy form meeting the requirements of subsection 1 of section 26.1-36-14 must be approved notwithstanding any other law which specifies the contents of a policy, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

26.1-36-16. Effect of accident and health policy simplification standards on filed policies. Sections 26.1-36-13 through 26.1-36-15 do not negate any law of this state permitting the issuance of a policy form after it has been on file for the required time period and has not been disapproved by the commissioner.

26.1-36-17. Application for accident and health policy.

1. The insured is not bound by any statement made in an application for an accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy. If any policy delivered or issued for delivery to any person in this state is to be reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for reinstatement or renewal, the insurer, within fifteen days after the receipt of the request at its home office or any branch office of the insurer, shall deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed, the insurer is precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

2. No alteration of any written application for an accident and health insurance policy may be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

3. The falsity of any statement in the application for an accident and health insurance policy may not bar the right to recovery under the policy unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

26.1-36-18. Notice under accident and health policy - Waiver. The acknowledgment by any insurer of the receipt of notice given under an accident or health insurance policy, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim does not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy.

26.1-36-19. Age limit in accident and health policy. If an accident and health insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if the date falls within a period for

which premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer is limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

26.1-36-20. Juvenile's accident and health coverage to continue - Conditions. Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a juvenile insured under an accident and health insurance policy or a health service contract while the legal custody of the juvenile has been given by a court, under chapter 27-20, to any public institution or agency, to the same extent as the general public is covered as long as the juvenile meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A juvenile's incarceration may not be a basis for cancellation of the juvenile's accident and health insurance policy or health service contract.

26.1-36-21. Prisoner's accident and health coverage to continue - Conditions. Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a prisoner insured under an accident and health insurance policy or a health service contract while the prisoner is incarcerated and under state supervision to the same extent as the general public is covered as long as the prisoner meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A prisoner's incarceration may not be a basis for cancellation of the prisoner's accident and health insurance policy or health service contract.

26.1-36-22. Individual and group health insurance for dependents. An individual or group health insurance policy may be extended to insure the individuals, employees, or members with respect to their family members or dependents, including dependents of dependents, or any class or classes thereof, subject to the following:

1. The premium for the insurance must be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both. A policy on which no part of the premium for the family members or dependents coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

2. An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

3. A policy that provides coverage for a dependent child of an employee or other member of the covered group must provide such coverage up to a limiting age of twenty-two years of age, if the dependent child physically resides with the employee or other member and is chiefly dependent upon the employee or member for support and maintenance.

4. A policy that provides that coverage for a dependent child of an employee or other member of the covered group terminates upon attainment of the limiting age for dependent children specified in the policy does not operate to terminate the coverage of a dependent child: while the child is a full-time student and has not attained the age of twenty-six years; or while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of limiting age and subsequently as may be required by the insurer but not more

frequently than annually after the two-year period following the child's attainment of the limiting age.

26.1-36-23. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership. A group policy or certificate of insurance or certificate on a master policy of a group as defined by subsection 6 of section 26.1-02-05 delivered or issued for delivery in this state issued by any insurance company, nonprofit health service corporation, health maintenance organization, or any other insurer that provides hospital, surgical, or major medical expense insurance or any accommodation of these coverages on an expense incurred basis, but not a policy that provides benefits for specific diseases or for accidental injuries only, must provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership are entitled to continue their hospital, surgical, and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation is only available to an employee or member who has been continuously insured under the group policy, and for similar benefits under any group policy which it replaced, during the entire three-month period ending with the termination.

2. Continuation is not available for any person who is covered by medicare. Neither is continuation available for any person who is covered by any other insured or uninsured arrangement which provides hospital, surgical, or medical coverages for individuals in a group and under which the person was not covered immediately prior to the termination.

3. Continuation need not include dental, vision care, or prescription drug benefits or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits.

4. An employee or member who wishes continuation of coverage must request the continuation in writing within the ten-day period following the later of the date of termination, or the day the employee is given notice of the right of continuation by either the employer or the group policyholder. The employee or member may not elect continuation more than thirty-one days after the date of termination.

5. An employee or member electing continuation shall pay to the group policyholder or the employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's insurance would otherwise terminate.

6. Continuation of insurance under the group policy for any person terminates when the person fails to satisfy subsection 2 or, if earlier, at the first to occur of the following:

    a. The date thirty-nine weeks after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

    b. If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

    c. The date on which the group policy is terminated or, in the case of an employee, the date the employer terminates participation under the group policy. However, if this subdivision applies and the coverage ceasing by reason

of such termination is replaced by similar coverage under another group policy, the following apply:

(1) The employee or member may become covered under that other group policy for the balance of the period that the employee or member would have remained covered under the prior group policy in accordance with this subsection had a termination described in this subdivision not occurred.

(2) The minimum level of benefits to be provided by the other group policy is the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy.

(3) The prior group policy must continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege must be included in each certificate of coverage.

8. Upon termination of the continuation period, the member, surviving spouse, or dependent is entitled to exercise any option which is provided in the group plan to elect a conversion policy. The member electing a conversion policy shall notify the carrier of the election and pay the required premium within thirty-one days of the termination of the continued coverage under the group contract.

26.1-36-23.1. Former spouse's and dependent children's accident and health coverage to continue - Conditions.

1. No group accident and health insurance policy, including a policy issued under a self-insured plan, group health service contract issued under chapter 26.1-17, or evidence of coverage issued under chapter 26.1-18.1, providing coverage for hospital or medical expenses, delivered, issued for delivery, renewed, or amended after July 1, 1987, which in addition to covering the insured also provides coverage to the spouse of the insured, may contain a provision for termination of coverage for a spouse covered under the policy, contract, or evidence of coverage solely as a result of a break in the marital relationship except by reason of an entry of a decree of annulment of marriage or divorce.

2. Every policy, contract, or evidence of coverage described in subsection 1 must contain a provision that permits continuation of coverage of the insured's former spouse and dependent children upon entry of a decree of annulment of marriage or divorce, if the decree requires the insured to provide continued coverage for those persons. The coverage may be continued until the date of remarriage of the insured's former spouse or the date coverage would otherwise terminate, whichever occurs first, but not to exceed thirty-six months. The insured shall pay any required premium contributions for the coverage not to exceed one hundred two percent of the premium for the group coverage.

3. Every policy, contract, or evidence of coverage described in subsection 1 must contain a provision allowing a former spouse and dependent children, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage under subsection 2 or upon termination of coverage by reason of an entry of a decree of annulment or divorce which does not require the insured to provide continued coverage for the former spouse and dependent children, conversion coverage providing comparable benefits of the group policy, contract, or evidence of coverage, if an application is made to the insurer within thirty days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. A policy, contract, or evidence of coverage providing

reduced benefits at a reduced premium rate may be accepted by the former spouse and dependent children in lieu of the existing coverage. The policy, contract, or evidence of coverage must be renewable at the option of the former spouse as long as the former spouse is not covered under another accident and health insurance plan, policy, or contract, up to age sixty-five or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act [42 U.S.C. 1305 et seq.], as amended.

26.1-36-24. Health policy transferable. A health insurance policy may pass by transfer, will, or succession to any person, whether that person has an insurable interest or not, and that person may recover any benefit payable under the policy in accordance with the terms of the policy, but in no event shall such transfer or succession operate to change the named insured or insureds covered under the policy. An insured under a group health insurance policy, pursuant to agreement among the insured, the group policyholder and the insurer, may make an assignment of all or any part of the incidents of ownership held by the insured under the policy, including any right to designate a beneficiary and any right to have an individual policy issued in case of termination of employment. An assignment, whether made prior to or subsequent to July 1, 1971, is valid for the purpose of vesting in the assignee all the incidents of ownership assigned, and entitles the insurer to deal with the assignee as the owner in accordance with the policy, but without prejudice to the insurer on account of any payment made or individual policy issued prior to receipt by the insurer of such notice as may be required by the policy.

26.1-36-25. Notice of transfer of health policy unnecessary - Exception. Notice to an insurer of a transfer or bequest of a health insurance policy is not necessary to preserve the validity of the policy unless notice is required by the policy.

26.1-36-26. Dual choice option on group health coverage - Minimum conditions - Transfer of coverage. If an existing or prospective employer group desires a dual choice option between a nonprofit health service corporation or an insurance company and a health maintenance organization, the dual choice option may be made available to the employees in the group only if all of the following conditions are met:

1. There are at least fifteen employees in the group.

2. The group shall maintain the highest enrollment percentage as specified in the underwriting manual of the nonprofit health service corporation, the insurance company, or the health maintenance organization, and the health maintenance organization enrollees must be combined with subscribers of nonprofit health service corporations or insureds of insurance companies in meeting the percentage requirements.

3. An employee must be allowed to transfer between coverage offered by a health maintenance organization and coverage offered by a nonprofit health service organization or insurance company on the group's anniversary date as specified in the master contract with the group, except a special opening must be offered at the group's request for the following reasons:

    a. Upon a group's initial offering of a dual choice plan in addition to existing coverages offered by a nonprofit health service corporation or an insurance company.

    b. When a group discontinues offering a dual choice plan with a health maintenance organization to request open enrollment into the group offered by the nonprofit health service corporation or the insurance company.

    c. If the group offers both coverage by a nonprofit health service corporation or an insurance company and a health maintenance organization and an individual employee enrolled in the health maintenance organization transfers within the same company but leaves the service area of the health maintenance

organization, the employee must be allowed to enroll in the plan offered by the nonprofit health service corporation or the insurance company at the time of transfer.

d. Any group that offers health coverage to its retired employees by a nonprofit health service corporation or an insurance company and a health maintenance organization must advise the employees who are enrolled under their present coverage that they may change to other coverage offered at the time of retirement, and if the employees who retire elect to retain or change their present coverage, the employees will no longer be eligible to change coverage after retirement.

26.1-36-27. Dual choice option on group health coverage - Continuous coverage - Payment of benefits. If an employee, or an eligible dependent of the employee, transfers from coverage provided by a nonprofit health service corporation or an insurance company to coverage offered by a health maintenance organization or transfers from coverage offered by a health maintenance organization to coverage offered by a nonprofit health service corporation or an insurance company and is an inpatient of a hospital or alcoholism treatment center on the day the coverage becomes effective, then the benefits for confinement on an inpatient basis of a hospital or alcoholism treatment center must be provided by the nonprofit health service corporation, insurance company, or health maintenance organization providing coverage on the date the employee or the eligible dependent of the employee was confined as an inpatient of a hospital or alcoholism treatment center so long as coverage is uninterrupted, medically necessary, and directly related to the inpatient's stay.

26.1-36-28. Measure of indemnity in health policy. Unless the interest of a person insured is susceptible of exact pecuniary measurement, the measure of indemnity under a health insurance policy is the sum fixed in the policy.

26.1-36-29. Coordination of benefits in individual and group accident and health policies - Limitations. An insurer or health service corporation may not issue or renew any individual or group accident and health insurance policy that excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued contract or plan of insurance which provides exclusively for specific disease, hospital indemnity, and other limited benefits, irrespective of the mode or channel of premium payment, with or without payroll deduction, to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of the insured's status as an employee. This section does not affect the practice of coordination of benefits as provided in section 26.1-36-10.

26.1-36-30. Individual or group accident and health insurer or nonprofit health service corporation responsibility - Release of information to department of human services.

1. Any individual or group accident and health insurer or nonprofit health service corporation, upon request of the department of human services, shall provide any information contained in its records pertaining to an individual who is an applicant for or recipient of medical assistance under chapter 50-24.1, and who is covered under an accident and health insurance policy or a health service contract issued by the insurer or nonprofit health service corporation or the medical benefits paid by or claims paid to the insured or subscriber under a policy or contract. The insurer or nonprofit health service corporation shall make the requested records or information available upon receipt of a certification by the department of human services that the individual is an applicant for or recipient of medical assistance under chapter 50-24.1, or is a person who is legally responsible for the applicant or recipient.

2. The information required to be made available pursuant to this section is limited to information necessary to determine whether benefits under the policy or contract have been or should have been claimed and paid pursuant to an accident and health

insurance policy or health service contract with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.

3. The department of human services shall, in consultation with the commissioner, establish guidelines:

   a. For the method of requesting and furnishing appropriate information, the time in which the information is to be provided, and method of reimbursing insurance companies and nonprofit health service corporations for necessary costs incurred in furnishing the requested information.

   b. To assure that information relating to an individual certified to be an applicant for or recipient of medical assistance under chapter 50-24.1, furnished to an insurer or subscriber pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate section 50-06-15.

26.1-36-31. Medicare supplement policies - Definitions. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-32. Standards for medicare supplement policies. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-33. Medicare supplement policy benefit standards. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-34. Medicare supplement policy loss ratio standards. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-35. Medicare supplement policy disclosure standards. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-36. Medicare supplement policies - Notice of free examination. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-36.1. Filing requirements for advertising. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-36.2. Noncustodial care coverage. An insurer offering convalescent nursing home, extended care facility, or skilled nursing facility coverage under chapter 26.1-36.1 or 26.1-45 shall cover intermediate care confinements in the same manner as skilled care confinements.

26.1-36-37. Nursing home policy - Guaranteed renewable for life - Limitation on preexisting conditions. Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-37.1. Standard health insurance proof of loss form - Claim payment time limits. The commissioner shall prescribe by rule a standard health insurance proof of loss and claim form for use in filing proof of loss and a claim for all health care services. For purposes of this section, "health care service" means any service included in providing an individual with medical, dental, or hospital care or any service incident to providing medical, dental, or hospital care as well as any service provided to prevent, alleviate, care, or heal human illness or injury. After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim or that portion of the claim that is not contested, deny the claim, or make an initial request for additional information. If a claim or a portion of a claim is contested, the insured or the insured's assignee must be notified in writing that the claim is contested and the reasons for the contest. Nothing in this notification precludes the insurer from denying the claim in whole

or in part, for other reasons at a later date. Within fifteen business days of the receipt of the information initially requested, the insurer shall pay or deny the claim.

26.1-36-37.2. Loss ratios - Rules. For all policies providing hospital, surgical, medical, or major medical benefit, an insurance company, a nonprofit health service corporation, a fraternal benefit society, and any other entity providing a plan of health insurance or health benefit subject to state insurance regulation shall return benefits to group policyholders in the aggregate of not less than seventy percent of premium received and to individual policyholders in the aggregate of not less than fifty-five percent of premium received. The commissioner shall adopt rules to establish these minimum standards on the basis of incurred claims experienced and earned premiums for the entire period for which rates are computed to provide coverage in accordance with accepted actuarial principles and practices. This section does not apply to any contract or plan of insurance that provides exclusively for accident, disability income insurance, specified disease, hospital confinement indemnity, or other limited benefit health insurance.

26.1-36-38. Rulemaking authority. The commissioner may adopt reasonable rules necessary, proper, or advisable to administer this chapter.

26.1-36-39. Effect of policy not conforming to chapter. A policy delivered or issued for delivery to any person in this state in violation of this chapter is valid but must be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary are governed by this chapter.

26.1-36-40. General penalty - License suspension or revocation. Any person willfully violating any provision of this chapter or order of the commissioner made in accordance with this chapter is guilty of a class A misdemeanor. The commissioner may also suspend or revoke the license of an insurer or insurance producer for any such willful violation.

26.1-36-41. 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 subject to state insurance regulation may not terminate a practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose sanctions on any practitioner solely for an excessive or inappropriate practice pattern unless the requirements of this section are met. If a practitioner engages in an excessive or inappropriate practice pattern for the practitioner's specialty, the entity shall inform the practitioner, in writing, as to the manner in which the practitioner's practice is excessive or inappropriate. The entity shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the practitioner's practice pattern. If the excessive or inappropriate practice pattern continues, the entity may impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable. If considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner 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 practitioner 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. Nonpayable status under this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section "practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice in this state.

2. If the entity uses a practice profile as a factor to evaluate a practitioner's practice pattern, the entity shall provide upon request of the practitioner at any time, a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the practitioner and the manner in which the practice profile is used to evaluate the practitioner. An entity may not sanction a practitioner, terminate a practitioner's participating contract, or designate a practitioner as nonpayable on the basis of a practice profile without informing the practitioner 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 practitioner, group of practitioners, or preferred provider. In addition, an entity in developing practice profiles or otherwise measuring practitioner 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 practitioners 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 practitioner at any time to examine the accuracy, completeness, or validity of any practice profile concerning the practitioner and to prepare a written response to the profile. The entity shall negotiate in good faith with the practitioner to correct any inaccuracies or to make the profile complete. If the inaccuracies or deficiencies are not corrected to the satisfaction of the practitioner, the entity shall submit the written response prepared by the practitioner along with the profile at the time the profile is used pursuant to subsection 1 or provided to any third party consistent with section 26.1-36-12.4.

26.1-36-42. 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 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 procedure must include a system to record and document all grievances since the date of its last examination of the grievances.

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

26.1-36-43. Uniform prescription drug information card.

1. An insurance company, a nonprofit health service corporation, or a health maintenance organization that provides coverage for prescription drugs and that issues a card or other technology for prescription drug claims processing and an administrator of such coverage, including a third-party administrator for a self-insurance plan, a pharmacy benefits manager, and a state-administered plan 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 insured is also issued a uniform card or other

technology containing uniform prescription drug information as provided under this section.

2. The uniform prescription drug information card or other technology must be in the format approved by the national council for prescription drug programs and must include all of the fields the issuer determines necessary to submit a claim and all the fields necessary to conform to the most recent pharmacy information card or technology implementation guide produced by the national council for prescription drug programs, or must include all the fields necessary to conform to a national format acceptable to the commissioner. All information the issuer determines necessary for claims submission of prescription drug benefits, exclusive of information provided on the prescription as required by law or rule, must be included on the card or other technology in a clear, readable, and understandable manner. All information on the card or other technology which is required under this section and which is not specified by the national council for prescription drug programs must be formatted and arranged in a manner that corresponds in content and format acceptable to the commissioner. All information on the card must be formatted and arranged in a manner that corresponds in content and format to the current content and format required by the issuer to process the claim. If an issuer requires a conditional or situation field as defined by the national council for prescription drug programs, the field must conform to the pharmacy information card or technology implementation guide produced by the national council for prescription drug programs or conform to the national format acceptable to the commissioner.

3. An issuer shall issue a new uniform prescription drug information card or other technology upon enrollment and reissue upon any change in the cardholder's coverage which impacts data in content or format as contained on the card or which affects the data content or format required to be on the card or other technology as required by this section. Newly issued cards or other technology must be updated with the latest coverage information and must conform to the national council for prescription drug programs standards and to the implementation guide or must conform to the format specified by the commissioner. However, the issuer may issue to the insured stickers or other methodologies to temporarily update cards as may be acceptable to the commissioner.

4. The card or other technology may be used for any health insurance coverage. This section does not require any person issuing the card or other technology to issue a separate card for prescription coverage, provided the card or other technology can accommodate the information necessary to process the claim as required by this section.

26.1-36-44. Independent external review. Every insurance company, nonprofit health service corporation, and health maintenance organization that offers an accident and health line of insurance shall establish and implement an independent external review mechanism to review and determine whether medical care rendered under the line of insurance was medically necessary and appropriate to the claim as submitted by the provider. For purposes of this section, "independent external review" means a review conducted by the North Dakota health care review, inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the commissioner to conduct an independent external review. A determination made by the independent external reviewer is binding on the parties. Costs associated with the independent external review are the responsibility of the nonprevailing party.

CHAPTER 26.1-26.4
HEALTH CARE SERVICE UTILIZATION REVIEW

26.1-26.4-01. Purpose. The purpose of this chapter is to:

1. Promote the delivery of quality health care in a cost-effective manner;
2. Assure that utilization review agents adhere to reasonable standards for conducting utilization review;
3. Foster greater coordination and cooperation between health care providers and utilization review agents;
4. Improve communications and knowledge of benefits among all parties concerned before expenses are incurred; and
5. Ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable laws.

26.1-26.4-02. Definitions. For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the insurance commissioner.
2. "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.
3. "Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.
4. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.
5. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.
6. "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.
7. "Retrospective" means utilization review of medical necessity which is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.
8. "Utilization review" means a system for prospective, retrospective, and concurrent review of the necessity and appropriateness in the allocation of health care

resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

9. "Utilization review agent" means any 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.

26.1-26.4-03. Certification. 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. The name, address, telephone number, and normal business hours of the utilization review agent.

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

3. A description of the appeal procedures for utilization review determinations.

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

A provider may request that a utilization review agent furnish the provider with the medical review criteria to be used in evaluating proposed or delivered health care services. Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

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

1. Notification of a determination by the utilization review agent must be provided to the enrollee or other appropriate individual in accordance with 29 U.S.C. 1133 and the timeframes set forth in 29 CFR 2560.503-1.

2. Any 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. Any notification of a determination not to certify an admission or service or procedure must include the information required by 29 U.S.C. 1133 and 29 CFR 2560.503-1.

4. 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 of determinations by the utilization review agent. The 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 must be made by a physician or, if appropriate, a licensed psychologist.

b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures in accordance with 29 U.S.C. 1133 and the timeframes for appeals set forth in 29 CFR 2560.503-1.

c. Utilization review agents shall provide for an expedited appeals process complying with 29 U.S.C. 1133 and 29 CFR 2560.503-1.

5. 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. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.

8. Psychologists making utilization review determinations shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

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

10. When an initial appeal to reverse a 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 must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate.

However, the commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.

26.1-26.4-04.1. Utilization review in this state - Conditions of employment. 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 when compensation of the review agent is contingent upon a denial or reduction in the payment for hospital, medical, or other health care services.

26.1-26.4-04.2. Utilization review - Duty of health care insurers. A health care insurer that contracts with another entity to perform utilization review on its behalf remains responsible to ensure that all the requirements of this chapter are met to the same extent the health care insurer would be if it performed the utilization review itself.

26.1-26.4-05. Utilization review agent violations - Penalty. Whenever the commissioner has reason to believe that a utilization review agent subject to this chapter has

been or is engaged in conduct that violates section 26.1-26.4-03 or 26.1-26.4-04, the commissioner shall notify the utilization review agent of the alleged violation. The utilization review agent has thirty days from the date the notice is received to respond to the alleged violation.

If the commissioner believes that the utilization review agent has violated this chapter, or is not satisfied that the alleged violation has been corrected, the commissioner shall conduct a hearing on the alleged violation in accordance with chapter 28-32.

If, after the hearing, the commissioner determines that the utilization review agent has engaged in violations of this chapter, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the utilization review agent a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

1. Payment of a penalty of not more than ten thousand dollars for a violation that occurred with such frequency as to indicate a general business practice; or

2. Suspension or revocation of the authority to do business in this state as a utilization review agent if the utilization review agent knew that the act was in violation of this chapter.

SECTION 6
CLAIMS FOR BENEFITS AND APPEALS

A Member may submit a Claim for Benefits by contacting BCBSND at the telephone number or address listed on the back of the Identification Card. The Member is responsible for providing BCBSND with a Claim for Benefits within 18 months after the date the benefits or services offered under this Benefit Plan were incurred. A Claim for Benefits must include the information necessary for BCBSND to determine benefits or services.

The Member may designate an Authorized Representative to pursue a Claim for Benefits or appeal an adverse determination from a Claim for Benefits. The designation of an Authorized Representative is limited in scope and not an assignment of benefits. It does not grant the Authorized Representative any of the Member's rights and privileges under the terms of this Benefit Plan. See Section 3, Managed Benefits.

Upon receipt of a Claim for Benefits under this Benefit Plan from a Member and/or the Member's Authorized Representative, the following claims review and appeals process applies:

Maximum Time Limits for Claims Processing

Type of Notice	Emergency Claim for Benefits	Pre-Service Claim for Benefits	Post-Service Claim for Benefits	Ongoing Course of Treatment Claim for Benefits
Initial Determinations (Plan) Extensions	72 Hours NONE	15 Days 15 Days	30 Days 15 Days	Notification "sufficiently in advance" of reduction or termination of benefits.*
Improperly Filed Claims (Plan)	24 Hours	5 Days	NONE	N/A
Additional Information Request (Plan)	24 Hours	15 Days	30 Days	N/A
Response to Request For Additional Information (Claimant)	48 Hours	45 Days	45 Days	N/A
Request for Appeal (Claimant)	180 Days	180 Days	180 Days	N/A
Appeal Determinations (Plan) Extensions	72 Hours NONE	30 Days NONE	60 Days NONE	As appropriate to the type of claim.

*If claim is made at least 24 hours before expiration of treatment and the claim involves an urgent care claim, BCBSND's decision must be made within 24 hours of receipt of the claim.

6.1 CLAIMS FOR BENEFITS INVOLVING PREAUTHORIZATION AND PRIOR APPROVAL (PRESERVICE CLAIMS FOR BENEFITS)

A. Claims for Benefits Requiring Preauthorization or Prior Approval.

1. Claims for Benefits Requiring Preauthorization or Prior Approval. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative that is conditioned on a Member obtaining approval in advance of obtaining the benefit or service, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days from receiving the claim. BCBSND may extend this initial time period an additional 15 days if BCBSND is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 15-day time period.

If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits, BCBSND will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 5 days after receipt of the Claim for Benefits and provide the Member and/or the Member's Authorized Representative with the proper procedures to be followed when filing a Claim for Benefits. BCBSND may also request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 15-day time period after receiving the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to properly file the Claim for Benefits and submit the requested information. After receiving the properly filed Claim for Benefits or additional or specified information, BCBSND shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days after receipt of the properly filed Claim for Benefits and additional information.

2. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, BCBSND will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

3. Appeals of Claims for Benefits Requiring Preauthorization and Prior Approval. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits requiring Preauthorization or Prior Approval benefits or services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

B. Claims for Benefits Involving Emergency Care or Treatment

1. Claims for Benefits for Emergency Services. Upon receipt of a Claim for Benefits for Emergency Services from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 72 hours after receiving the Claim for Benefits.

   If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits or the Claim for Benefits is incomplete and BCBSND requests additional or specified information, BCBSND will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 24 hours after receipt of the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or the request from BCBSND for additional or specified information, the Member and/or the Member's Authorized Representative has 48 hours to properly file the Claim for Benefits or to provide the requested information. After receiving the properly filed Claim for Benefits or requested information, BCBSND shall notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 48 hours after receipt of the additional or specified information requested by BCBSND or within 48 hours after expiration of the Member's time period to respond.

2. Appeals of Claims for Benefits for Emergency Services. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits for Emergency Services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination, whether adverse or not, as soon as possible but no later than 72 hours after receiving the Member's and/or the Member's Authorized Representative's request for review. A Member and/or a Member's Authorized Representative may request an appeal from a determination involving a Claim for Benefits for Emergency Services orally or in writing, and BCBSND will accept needed materials by telephone or facsimile.

6.2 ALL OTHER CLAIMS FOR BENEFITS (POST SERVICE CLAIM FOR BENEFITS)

A. Claims for Benefits for All Other Services or Benefits. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days from receiving the Claim for Benefits and only if the determination is adverse to the Member. BCBSND may extend this initial time period in reviewing a Claim for Benefits an additional 15 days if BCBSND is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 30-day time period.

   BCBSND may request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 30-day time period after receiving the Claim for Benefits. Upon receiving a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to submit the requested information. After receiving the additional or specified information, BCBSND shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receipt of the additional information.

B. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For a Claim for Benefits involving services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, BCBSND will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

C. Appeals from Initial Claims for Benefits Determinations for All Other Claims for Services or Benefits. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 60 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

To inquire on the Claims for Benefits and appeals process, please contact Member Services at the telephone number and address on the back of the Identification Card.

Appeal and Grievance Administrative Manual

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Section I: Introduction and Definitions

Introduction:

The purpose of this manual is to provide you with a source of information relating to the policies and procedures for Member and Health Care Provider Inquiries, Complaints, Grievances and Appeals.

Definitions:

This section defines the terms used by Blue Cross Blue Shield of North Dakota (BCBSND) throughout this Manual. These terms are capitalized throughout this Manual when referred to in the context defined. BCBSND shall determine the interpretation and application of the Definitions in each and every situation.

Appeal - Expedited
An Appeal (oral or written) in which the time frame for the standard process could seriously jeopardize the Member's life, health, or ability to regain maximum functioning.

Appeal - Standard
A statement (oral or written) expressing disagreement with a decision made by BCBSND and requesting a change in that decision.

Benefit Plan
The Subscriber's agreement with BCBSND, including, but not limited to, the membership application, identification card, a certificate of insurance, Benefit Plan agreement, the Benefit Plan attachment and any supplements, endorsements, attachments, addenda, or amendments.

Complaint
An expression (oral or written) of dissatisfaction that relates to terms of insurance or coverage.

Covered Service
Medically Appropriate and Necessary services and supplies for which benefits are available when provided by a Health Care Provider.

Explanation of Benefits (EOB)
A document sent to the Member by BCBSND after a claim for services has been processed. It includes the patient's name, claim number, type of service, Health Care Provider, date of service, charges submitted for the services, amounts covered by the Benefit Plan, noncovered services, Cost Sharing Amounts and the amount of the charges that are the Member's responsibility.

Health Care Provider
Institutional or professional health care providers providing Covered Services to Members. The Health Care Provider must be licensed, registered or certified by the appropriate state agency where the Covered Services are performed and provided in accordance with the Health Care Provider's scope of licensure as provided by law. Where there is no appropriate state agency, the Health Care Provider must be registered or certified by the appropriate professional body.

Grievance
A complaint about the manner in which the Member or service had been handled. It relates not to the terms of the insurance or coverage, but in the fashion in which the care is provided by the Health Care Provider (i.e., access to and availability of services, choice and accessibility of Health Care Providers, quality of care, quality of service, facility, network adequacy, conduct and/or behavior).

Inquiry
A request (oral or written) for information and/or education about products, services, benefits, systems, or Health Care Providers.

Medically Appropriate and Necessary

The services, supplies, or treatments provided by a Health Care Provider to treat an illness or injury that satisfy all the following criteria as determined by BCBSND:

a. The services, supplies, or treatments are medically required and appropriate for the diagnosis and treatment of the Member's illness or injury; and

b. The services, supplies, or treatments are consistent with professionally recognized standards of health care; and

c. The services, supplies, or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the Member's illness or injury.

Member

The Subscriber and eligible dependents of the Subscriber eligible for Covered Services pursuant to the terms of a Benefit Plan. Member shall also include those Subscribers and Members of any of the association of Independent Blue Cross Blue Shield Plans.

Subscriber

The individual whose application for membership has been accepted, whose coverage is in force with BCBSND and in whose name the identification card and benefit plan attachment is issued.

Section II: Inquiry Process

Inquiry

A request (oral or written) for information and/or education about products, services, benefits, systems, or Health Care Providers.

1. Service representative receives a request from a Member either via phone, walk in, email, or written correspondence. All Inquiries are documented on inquiry tracking system.
2. The service representative determines if the request is considered an Inquiry, Complaint, Grievance, or Appeal.
3. The requested information is communicated to the Member or is routed to the appropriate area for further research or review.
4. If the Inquiry is sent for further research and review, the Member is notified of the results either by phone, letter, or on their next EOB.

Section III: Complaint Procedure

Complaint

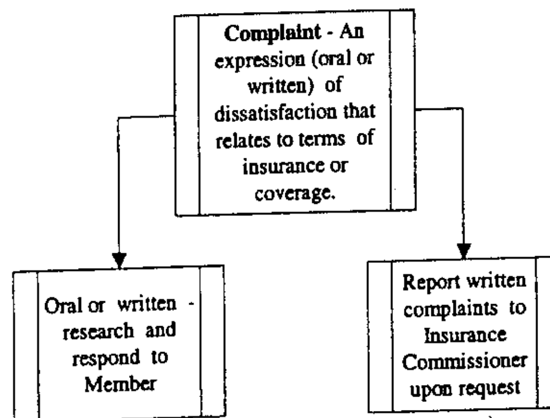
An expression (oral or written) of dissatisfaction that relates to terms of insurance or coverage.

1. Service representative receives a request from a Member either via phone, walk in, email, or written correspondence and determines if the request is considered an Inquiry, Complaint, Grievance, or Appeal.

2. For oral or written Complaints, the service representative records the Complaint on the inquiry tracking system, researches the information, and responds to the Member.

3. For written Complaints, a report is run each quarter, which details the number and types and is reviewed by the Manager of Member Services.

   - Documentation is kept in Member Services for easy access if requested by the Insurance Department.



Section IV: Grievance Procedure

Grievance

A complaint about the manner in which the patient or service had been handled. It relates not to the terms of the insurance or coverage, but in the fashion in which the care is provided by the Health Care Provider (i.e., access to and availability of services, choice and accessibility of Health Care Providers, quality of care, quality of service, facility, network adequacy, conduct and/or behavior).

1. Service representative receives a request from a Member either via phone, walk in, email, or written correspondence and determines if the request is considered an Inquiry, Complaint, Grievance, or Appeal.
2. Service representative asks the Member if action is to be taken, determines if this is a network product, and documents the Grievance on the inquiry tracking system. All such Grievances shall be recorded and documented.

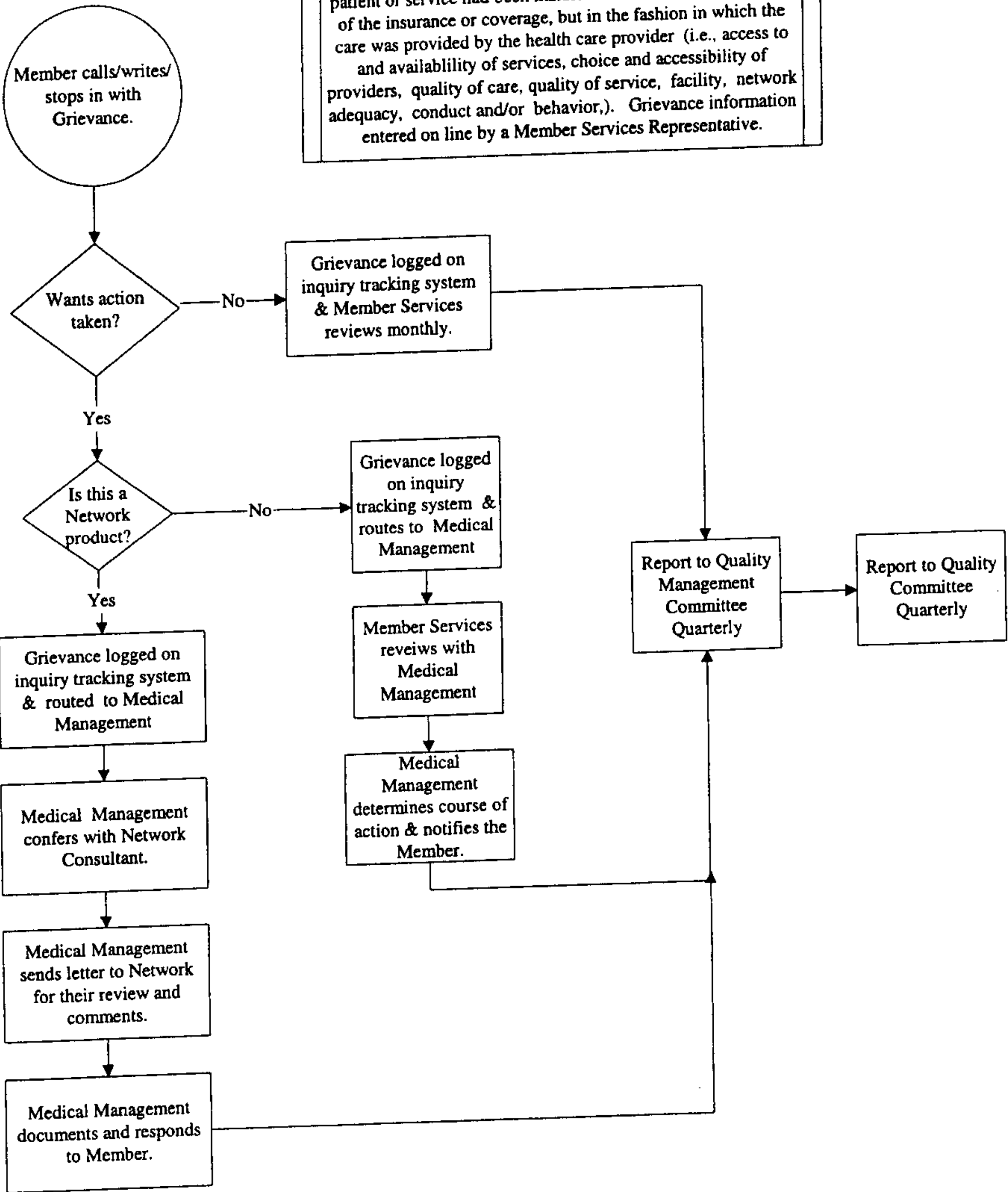
If the Member does not want action taken:

These inquiries are reviewed monthly by Member Services for accuracy in documentation.

If the Member wants action taken:

- Member Services reviews non-network grievances with Medical Management. Medical Management is responsible to determine the course of action, and notify the Member of the decision within 30 days of the receipt of the Grievance.
- Network Grievances are routed to Medical Management who confers with the appropriate Network Consultant. If grievance warrants notifying the network, Medical Management sends a letter to the network for their review and comments. Medical Management will document on inquiry tracking system and respond to Member within 30 days of the receipt of the Grievance.

All Grievances are reported to the BCBSND Quality Management Committee and Quality Committee of the BCBSND Board on a quarterly basis.


Grievance -A complaint about the manner in which the patient or service had been handled. It relates not to the terms of the insurance or coverage, but in the fashion in which the care was provided by the health care provider (i.e., access to and availablility of services, choice and accessibility of providers, quality of care, quality of service, facility, network adequacy, conduct and/or behavior,). Grievance information entered on line by a Member Services Representative.
Member calls/writes/ stops in with Grievance.
Wants action taken?
No
Grievance logged on inquiry tracking system & Member Services reviews monthly.
Yes
Is this a Network product?
No
Grievance logged on inquiry tracking system & routes to Medical Management
Yes
Grievance logged on inquiry tracking system & routed to Medical Management
Member Services reveiws with Medical Management
Medical Management determines course of action & notifies the Member.
Report to Quality Management Committee Quarterly
Report to Quality Committee Quarterly
Medical Management confers with Network Consultant.
Medical Management sends letter to Network for their review and comments.
Medical Management documents and responds to Member.

Section V: Appeal

Policy/Procedures for Appeal

The following is the BCBSND expedited and standard Appeal process.

Expedited Medical Appeal

Definition:
An Appeal (oral or written) in which the time frame for the standard process could seriously jeopardize the Member's life, health, or ability to regain maximum functioning.

EMERGENCY SERVICES

The Member and/or the Member's Health Care Provider has up to 180 days to Appeal BCBSND's benefit determination of a claim for Emergency Services. Upon receipt of an Appeal from a Member and/or a Member's Health Care Provider, BCBSND will notify the Member and/or the Member's Health Care Provider of its determination, whether adverse or not, as soon as possible but no later than 48 hours after receiving the Member's and/or the Member's Health Care Provider's request for review. A Member or a Member's Health Care Provider may request an Appeal from a determination involving Emergency Services orally or in writing, and BCBSND will accept needed materials by telephone or facsimile.

If BCBSND makes a determination which results in a partial authorization or denial of authorization (reduction or noncertification of benefits), an immediate or expedited Appeal may be made via telephone by the attending physician. Access to the Medical Director who made the initial determination will be available within 48 hours to discuss the expedited Appeal.

1. The attending Health Care Provider initiates an expedited Appeal by calling either the BCBSND Provider Service Department or the Medical Director.

2. The Medical Director reviews the documentation to see if additional medical documentation is needed. Additional information may be faxed from the attending Health Care Provider to the Medical Director.

3. If the determination is reversed, the attending physician is informed by telephone within 48 hours. A follow-up written notification is sent to the Health Care Provider and Member within 48 hours.

4. If the original determination is upheld, the Health Care Provider is informed by telephone 48 hours that he/she has the right to Appeal the determination through the standard Appeal process. Written notification is also sent to the Health Care Provider and Member within 48 hours of the decision. This letter includes the medical reason for the partial authorization or denial of authorization and an explanation of how to initiate a standard Appeal.

Standard Appeal

Definition:
A statement (oral or written) expressing disagreement with a decision made by BCBSND and requesting a change in that decision.

If BCBSND makes a determination that results in a reduction or denial of benefits, the Member and/or the Member's Health Care Provider may appeal the determination. The following Appeal process applies:

PREAUTHORIZATION OR PRIOR APPROVAL

The Member and/or the Member's Health Care Provider has up to 180 days to Appeal BCBSND's benefit determination of a claim for Preauthorization or Prior Approval of benefits or services. Upon receipt of an Appeal from a Member and/or a Member's Health Care Provider, BCBSND will notify the Member and/or the Member's Health Care Provider of its determination within a reasonable period of time but no later than 30 days after receiving the Member's and/or the Member's Health Care Provider's request for review.

OTHER CLAIMS

The Member and/or the Member's Health Care Provider has up to 180 days to Appeal BCBSND's benefit determination of a claim for benefits or services. Upon receipt of an Appeal from a Member and/or a Member's Health Care Provider, BCBSND will notify the Member and/or the Member's Health Care Provider of its determination within a reasonable period of time but no later than 60 days after receiving the Member's and/or the Member's Health Care Provider's request for review.

Upon receipt of an Appeal for a chiropractic service from a Member and/or a Member's Health Care Provider, BCBSND will notify the Member and/or the Member's Health Care Provider of its determination within a reasonable period of time but no later than 30 days after receiving the Member's and/or the Member's Health Care Provider's request for review.

Standard Appeal Process:

1. Service representative receives a request from a Health Care Provider or Member either via telephone, walk in, email, or written correspondence and determines if the request is considered an Inquiry, Complaint, Grievance, or Appeal.

2. If additional medical information is necessary to complete the review, this will be requested from the appropriate Health Care Provider. Medical information may include copies of part or all of the medical record and/or a written statement from the Health Care Provider.

3. For preauthorization or prior approval the member and/or the healthcare provider are notified in writing within 30 days of the date that all additional information was received or for other claims are notified in 60 days.

4. BCBSND identifies and documents all Appeal cases. A quarterly Appeals report is reviewed by the BCBSND Quality Management Committee and then reported to the Quality Committee of the BCBSND Board.

Standard Medical Appeal

Medical Appeal:

Introduction: Often a formal appeal process is avoided when additional documentation is submitted and reviewed for approval by the initial clinical review staff. If additional information does not support approval then the following appeal procedure is completed.

An active, unrestricted practicing Medical Doctor (Board Certified)/Medical Consultant, within the same specialty or similar specialty as the Health Care Provider, other than the Medical Director/Medical Consultant or subordinate of that individual who made the initial determination not to certify; reviews the information.

Examples of *medical* Appeals:

- Medically appropriate & necessary service, supplies, or treatments (e.g. cosmetic versus reconstructive procedure)

Blue Cross Blue Shield of North Dakota reserves the right to initiate a panel review at its discretion. A panel within the same specialty or similar specialty as the Health Care Provider meets upon request and reviews the information.

Panel Examples:

- Chiropractic Committee
- Licensed Registered Dieticians
- Medical Claims Advisory Committee (MCRAC)
- North Dakota Nurse's Association
- North Dakota Occupational Therapy Association
- North Dakota Physical Therapy Peer Review Committee
- Pharmacy and Therapeutics Committee
- Podiatry Committee
- Psychiatry/Psychology Review and Advisory Committee (PsychRAC)

Criteria for Medical Review

- Dollar amounts do not determine review level.
- Panel review is at the discretion of Blue Cross Blue Shield of North Dakota

Standard Non-Medical Appeal

Non-Medical Appeals are researched by the service representatives and documented. The service representatives determine a course of action and notify the Health Care Provider and/or Member.

Examples of *non-medical* Appeal:

- Affiliation changes
- Dates of service change with appropriate documentation.
- Claims processed incorrectly (e.g. cost share, keying errors)
- Diagnosis and procedure code changes
- Premium overdrafts
- Time and units changes with appropriate documentation.
- Incorrect/Incomplete information given to Member

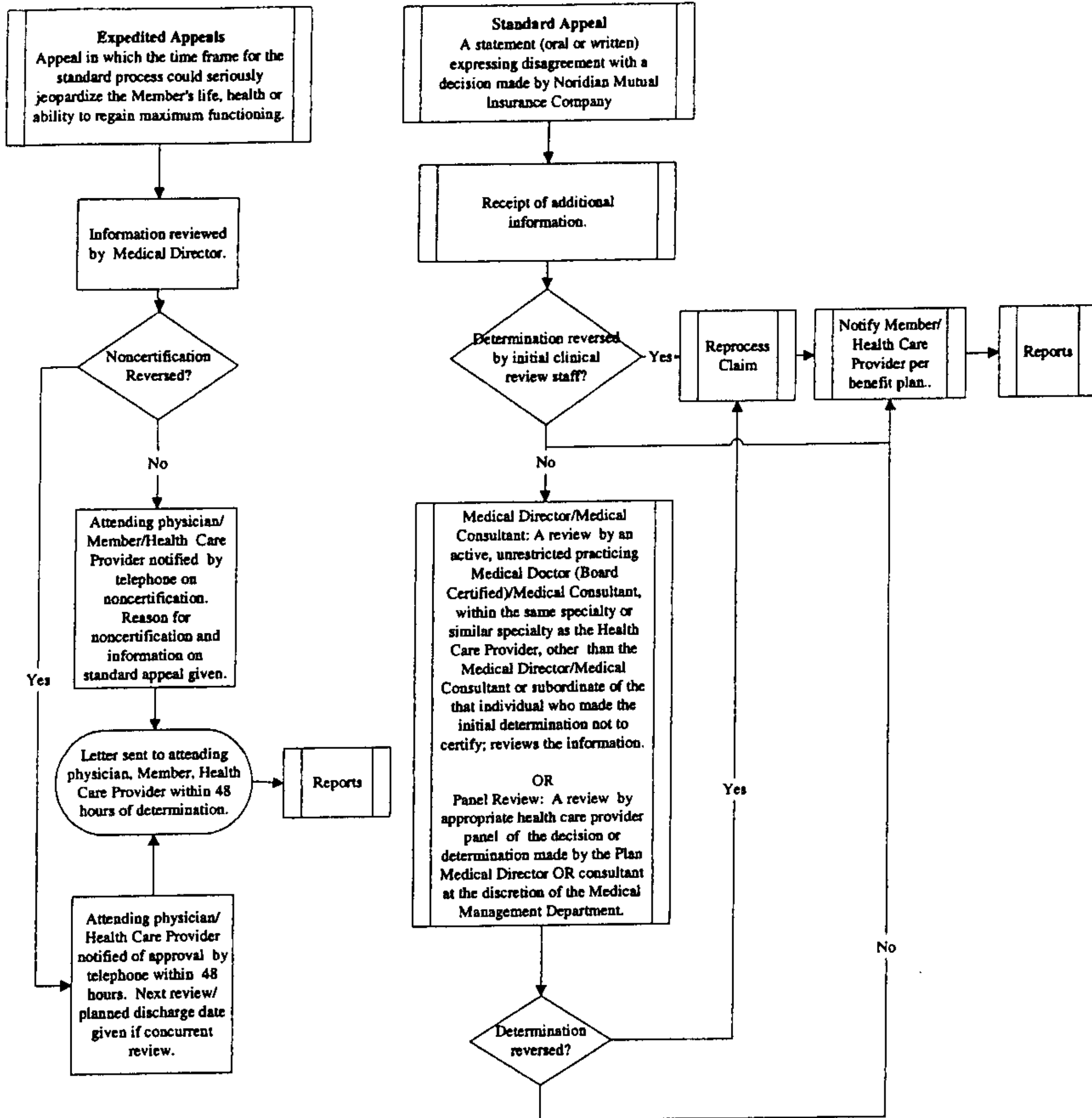
Appeal for Affiliation Changes

1. The service representative informs the Member that affiliation changes can only be made on anniversary date. If the Member wishes to Appeal this decision further, the request must be made in writing and sent to BCBSND.
2. Written Appeal for affiliation changes are documented on inquiry tracking system and routed to Medical Management. Medical Management researches the information and discusses the case with the appropriate Network Consultant. The following criteria are used to determine affiliation changes off anniversary:

   Appeals of affiliation changes are reviewed on an individual case by case basis.

   a) Subscribers/Members may be allowed to change affiliation if:
      - A Member is being seen for a chronic or disabling medical condition (e.g. pregnancy or cancer) and cannot receive satisfactory care or their Health Care Provider changes networks.
      - Member's Health Care Provider changed networks and there is no other Health Care Provider that could provide their care.
      - The Benefit Plan holder is changing his/her address, which places him/her closer to another network.
      - There is a significant change in the Health Care Provider network composition.

   b) If the Member does NOT meet the above criteria, we will ask the following questions of the Member:
      - Have you tried different Health Care Providers within the network?
      - Have you discussed your case with the network?
3. If the Member has met these criteria, the Network Consultant may research the case with the Network or group. If the determination is to allow the affiliation change, the Member will be notified by phone or in writing that they can change affiliation off anniversary. New Id cards with new affiliation name on them will be mailed to Member.
4. If the Member has not met these criteria, they will be notified by phone or in writing that they will only be able to change affiliation on anniversary.
5. If the Member wants to appeal this decision further, the information will be routed to the Product Development committee who will make a final determination. The Member and the network will then be notified of this decision within 30 days.



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