2011 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1127

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1127
January 17, 2011
12956

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution: Health carrier external review, utilization review and grievance procedures; limitation of health insurance company risks, utilization review and independent external reviews.

Minutes:

Chairman Keiser: Opened the hearing on HB1127.

Adam Hamm~North Dakota Insurance Commissioner: (see attached testimony).

Chairman Keiser:

Representative Ruby: I understand the mechanics of what you are trying to do; couldn't a lot of this be preempted by prior authorization of some of these services? Wouldn't it be simpler to get approval prior to the process starting?

Adam Hamm: I don't disagree with what you are saying but the reality under PPAC, they have set forth this requirement that has to take place regardless or not whether there has been prior approval. Once the claim has been given, submitted and once you start working your way through utilization review grievance process and external review, under PPACA and under the previous rules from DOL and HHS, their promulgation of the rules, this is the requirement we have.

Representative N Johnson: Two questions I have, when they talk on page 24-26, the independent review organizations and that you are to certify them, what are independent organizations?

Adam Hamm: These are folks that are used currently both in North Dakota and around the country as independent 3rd parties for external review. There are certain requirements that have to be met to be an IRO Independent Review organization. Yes, they have to be an independent third party.

Representative N Johnson: The department selects who will be that independent reviewer.

Adam Hamm: From a list that we would maintain.

Representative N Johnson: The claimant wouldn't have any control over who would review it?

Adam Hamm: Correct.

Representative N Johnson: The days, is it business or calendar days.

Adam Hamm: We will clear it.

Representative Nathe: Are we under a time line with this bill like HB 1126 or can we wait until special session?

Adam Hamm: Yes, we are under a time line and this summer the HHS will be going state to state.

Representative Vigesaa: Is this bill an entirely NAIC model?

Adam Hamm: Yes, is NAIC model, it harmonizes those 3 models, the external review, the grievance procedure and utilization review. We are willing to work to make sure we are in compliance with federal law so we don't lose control over this issue.

Representative Vigesaa: Are states are all submitting legislation with model act?

Adam Hamm: We can get you that exact list of that.

Representative Clark: This process is going to apply to all health insurance claims, not just those involved employers of ERISA?

Adam Hamm: Yes, but there is a difference between grandfather and non-grandfathered plans, but if you take that out of the mix, then yes.

Chairman Keiser: How will the definition of essential health care benefits impact these review process? Once they are defined then, those are primary in subject to review or even the non essential are open to review?

Adam Hamm: My understanding is, this will apply regardless of the essential health care benefits, which will be base line offered exchange.

Chairman Keiser: Has there been any form of analysis for requests from the various health care insurance providers as to what this will cost and the subsequent impact on premium rates will be?

Adam Hamm: I'm not sure.

Chairman Keiser: It may add to costs for providers?

Adam Hamm: From what I've heard, it may.

Chairman Keiser: Anyone else to testify in support of HB1127?

Rob St Aubyn~Blue Cross Blue Shield of North Dakota: (see attached testimony).

Chairman Keiser: Questions from the committee?

Representative Clark: Do I understand that you and other insurance companies in North Dakota already meeting the requirement of PPACA and the ERISA without this particular bill?

Rob St Aubyn: Not in all phases, we do not have an external review bill in North Dakota law.

Representative Clark: Why will this cost you so much money if you are already meeting these requirements?

Rob St Aubyn: Part of it is the difference in the appeals process.

Jane Nephew~Medical Management Department-BCBS: We have a corporate project and any new changes, we estimate number of hours and staff. This will require system and we include those fees as well.

Chairman Keiser: How much discussion did you have prior with them today in trying to address your position?

Rob St Aubyn: This is a short time, we received this on Thursday and we were to send comments on Friday and it was 160 pages and it was impossible to do.

Representative Boe: Would we be running into trouble when we reference the federal law with transferring our power to them. Is that constitutional?

Rob St Aubyn: I'm not a constitutional lawyer, but this has happened may times.

Chairman Keiser: Anyone else here to testify in support of HB 1127, in opposition, neutral? Closes the hearing on HB 1127.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1127
February, 1, 2011
13765

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Health carrier external review, utilization review and grievance procedures; limitation of health insurance company risks, utilization review and independent external reviews.

Work Committee Session Minutes:

Chairman Keiser: Opens the work committee session on HB 1127. Representative Clark what does this bill do?

Representative Clark: It implemented 3 model NCOILs acts into one bill that give the insurance commissioner the authority to regulate the federal PPACA as it was passed in July.

Chairman Keiser: You have 2 amendments before you. One is similar to the amendment that we have placed on the other bill simply delaying the regulation components of PPACA until November or the following general session. The second amendment, if we look through the 96 pages, in adopting the NAIC models, the NAIC went further in many areas than PPACA required. PPACA rules are being written daily and we don't have a majority of them. Of the rules and regulations that we do have, some of these regulation standards goes beyond what is required in the federal law. What the 2nd amendment does and it is a hog house amendment, this 2 pages replaces all this and all it says that it shall not go beyond the minimal requirements of PPACA relative to regulation.

Chairman Keiser: Committee, what are your wishes?

Representative Ruby: To be consistent with the other amendments, we need to remain in control of what happens and to what extent the regulations are.

Representative Ruby: Moves to adopt amendment 01001.

Representative Clark: Second.

Voice vote, motion carried.

Chairman Keiser: Further discussion?

Representative Ruby: Moves to adopt amendment 01002.

Representative Frantsvog: Second.

Chairman Keiser: Further discussion?

Voice vote, motion carried.

Chairman Keiser: Further discussion? What are the wishes of the committee?

Representative Frantsvog: Moves a Do Pass as Amended.

Representative Clark: Second.

Chairman Keiser: Further discussion?

Roll call vote on HB 1127 for a Do Pass as Amended with 12 yeas, 0 nays, 2 absent and Representative Clark is the carrier.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1127
February 8, 2011
14191

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Health carrier external review, utilization review and grievance procedures; limitation of health insurance company risks, utilization review and independent external reviews.

Committee Work Session Minutes:

Chairman Keiser: I've been holding the bill at the request of the Insurance Department. This is an extensive bill that incorporated 3 different NAIC model acts into 1 bill. We hog housed that bill with a 2 page amendment suggested by BCBS which said that the state will apply and meet any of the standards of the federal law but not exceed them in any way. We have a significant disagreement between the department & providers. The department believes and has had some verbal communication with HHS and they can't get it in writing that that's unacceptable, they want more. Some of the providers have argued that can't be because the ARRISA market, the self market, all they have to do is apply the standards. So, why have dual standards, one for the group market and one for the self insured market. The department is working on a set of amendments, which no one has seen and they will have them tomorrow afternoon. We want to do the right thing. The department feels we should provide guidance on the regulation of complaints by consumers on health care and they have already consented through their amendments, which I have not seen, some accommodating of those concerns expressed by the insurance providers.

Vice Chairman Kasper: Are there any providers here that can share their concerns?

Rod St Aubyn~BCBS of ND: It adopts 3 model acts to incorporate provision of the appeal process. Our amendments that you adopted, basically say that the state regulations, rules and the law will be the same as federal regulations as the PPACA law relates to that. I think that the insurance department feels it needs to be more specific because of their discussions with HHS. Our argument and one of the concerns we have is the discussions about changing some of the standards that already have been adopted by HHS. HHS has indicated a willingness to back off on some of these provisions. The fear we have is if you adopt a set state law, then we will potentially have 2 appeal processes, the self funded and fully insured. If you adopt some standard, whatever that may be, that is what we have to live with for the fully insured market and if they relax anything between now and July 1, we have to be in compliance with all of this. Then we have 2 different appeal processes. If there is going to be significant differences, we don't know what those changes are. If you

adopt our amendments then we are assured that if they do make changes to federal law, in effect our state law will change accordingly.

Vice Chairman Kasper: What if federal standards are such, if we are not in session, the insurance commissioner would object to and to abide by the federal standards. What would the bill allow in the circumstance then?

Rod St Auybn: It wouldn't make any difference because insurance companies have to abide by the federal law. That is the minimum standard requirement and you could make state law that's more stringent than the federal law but you can't make state law less stringent. We still have to abide by the law.

Vice Chairman Kasper: Have you been in discussion with the insurance department about coming to these amendments to make it workable from the insurance's company's perspective or are the amendments going to be something brand new that you are not aware of where it's going?

Rod St Auybn: We are not sure what their amendments are. The fear is we are not going to have enough time to review them. You ask "what are some of the differences in the proposed bill and amendments". One of the things is PPACA is an appeals for the consumer. What the proposed bill does is it extends appeal for providers as well. It also provides a provision in federal law, a deal at the option of the insurer, you can actually extend another level of appeal and it's a voluntary appeal process by the insurer. This also have a provision that requires for emergency room services. If insurance has a requirement for a pre-authorization, which we don't, I don't know why you would need a pre-authorization for emergency services. If you do or don't, this current bill requires that you have to have medical staff available for those types of appeals 24-7. The Insurance Department has indicated their amendments will take care of most of these. If still does not take into account the fear that we have, if HHS makes changes, it's still the state law.

Chairman Keiser: Two things committee members, we don't have to deal with this today. We are going to take it up tomorrow. There is a big a big appropriation associated with this bill, but it is in the insurance department budget, not in the bill.

Rod St Auybn: I just thought of one other component that is different, under current law, unless the state has specified and under the NAIC model act, for independent external review, the federal law says the insurance company must hire independent external reviewers. They have to have 3 different external reviewers that rotate, so it's not the same reviewer. The difference in this law is that the Insurance Department must establish this. One of the issues in the current bill where it affords extends it to providers. All the appeal processes have to be paid by the insurer. The consumer never has to pay for an appeal which is somewhat understandable. From the provider standpoint, if they extend there, there is no disincentive to not appeal any changes between the provider and the insurer.

Representative Clark: If the bill passes in current form, does the 27 million dollars in the Insurance Commissioner's budget go away?

Rod St Auybn: I think most of the expense in the Insurance Department appropriation really doesn't have to do so much with the appeal process. It has more to do with the exchange.

Chairman Keiser: It doesn't go away.

Rod St Auybn: Part of it goes because the commissioner wouldn't have to hire an appeals reviewer.

Chairman Keiser: The reason this is critical is that there is a July 2011 time line on the appeals requirements. This is one bill that we have to deal with and cannot put off into special session.

Rod St Auybn: Actually the law is already in effect where we are suppose to be complying. What HHS did is they delayed and said that they were not going to do any enforcement action because this is evolving and they are trying to get the state to figure out what they are going to do on the appeal process, so they will delay until July 1, 2011.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1127
February 9, 2011
14241

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution: External :

Health carrier external review, utilization review and grievance procedures; limitation of health insurance company risks, utilization review and independent external reviews.

Committee Work Session Minutes:

Chairman Keiser: I'm the prime sponsor. This bill deals with the external utilization review and was a computation of 3 NAIC model bills. It did put into law, several extensions of PPACA as we currently know it. We put the amendment on that to say, "don't take any action if the action can be delayed until the next special or general session". We also hog housed the amendments that said in effect, don't exceed any of the requirements that PPACA might implement as you develop the state law as to external utilization review and etc. The Insurance Department indicated that they had verbal conversations with HHS and HHS won't send a letter saying that that is unacceptable but verbally said we would like the states to do more. The Insurance Department has developed a set of amendments and they became available yesterday at 4:43. I have not had a chance to review them. We will not have any time to work on it today.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1127
February 14, 2011
14472

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Health carrier external review, utilization review and grievance procedures; limitation of health insurance company risks, utilization review and independent external reviews.

Committee Work Session Minutes:

Chairman Keiser: Opened the work session on HB 1127. I did request that we bring back HB 1127 and reconsider our action. It's one of the 3 bills that the tax department developed in response to PPACA. We hogged housed this bill with an amendment and the Insurance Department didn't catch it. They asked if they could come back and appear before the committee and explain 2 things. One, why they would suggest that we need to put back the original language with amendment and two to put the amendments on it.

Rebecca Ternes~Deputiy Commissioner for the North Dakota Insurance Department: (See attached testimony).

Vice Chairman Kasper: Can you explain what the guts of the bill with the internal and external audits and appeals so we can get our minds back on what the issue is we are trying to address?

Rebecca Ternes: Basically if you get denied a procedure from an insurance carrier, this covers more than just a simple procedure; you have the ability to ask the insurance company to be reconsidered. There is an internal process that the carrier has to go through internally, both by utilization and grievance and then when the carrier says no, you get a another chance at an external appeal. In this case, with this bill, what the federal law requires is that they would come to the insurance department to assign an external appeal entity, which would not be us. What it is that is significantly different than what we have not now is it lays out very specific time frames for all of these things to happen. Right now those details do not exist in our law. This makes it consistent and makes it comply with federal law. Really, it's what they are already doing in much of their business in the state of North Dakota.

Vice Chairman Kasper: Can you give us the difference between self insured reviews are different compared to fully insured and how this bill would address that if all?

Rebecca Ternes: I not exactly what the statement was. This does bring it closer to what is happening in the self insured business.

Vice Chairman Kasper: We are told under the self insured plans that the Insurance Department has no authority because that's an ARISSA plan. So we are dealing with the fully insured only and what you are proposing isn't going to be similar to how self insured plans are doing anyway, is that what we are going to see?

Rebecca Ternes: Yes, that true.

Chairman Keiser: Who pays for the external review when they come to the Insurance Department?

Rebecca Ternes: The company will pay for the external review.

Chairman Keiser: Although there is no fiscal note on this bill, is there in the Insurance Department a fiscal impact from this bill?

Rebecca Ternes: We think we can absorb this because it becomes an assignment out to an external company. What we would do is create a RFP a list of companies that want to provide these services in North Dakota. Then we would randomly assign as these come in. They don't have that many that get to this point and won't be that big of an impact and we are going to absorb it.

Melissa Hauer~General Counsel for the Insurance Department: We have an amendment written and it would revise the original bill. Basically what it would do is to incorporate one of the changes that BCBS recommended which were to allow grandfathered plans the choice, whether to stick with the appeal they have right now or to incorporate this new process. What it would do is also remove 2 sections that BCBS expressed some concerns about and other companies did as well. It would take out section 26.1-36.8-06, which is on page 84 of original bill and that will take out the whole section that deals with standard reviews of grievances that don't involve an adverse determination. It would also take out the next section which is 26.1-26.8-07, which would have incorporated what was call the voluntary level of review of grievances. That would have added another layer of review at the company level and we agreed to that change. The federal PPACA was to say let's piggy back on what the self insured plans are already doing and let's adopt a process for the fully insured. One other change that a different company asked for was companies have to have somebody on staff 24 hours a day, 7 days a week for these emergencies type claims that come in.

Vice Chairman Kasper: Can you give us a bottom line comparison, what your amendment is as to the Blue Cross'.

Melissa Hauer: Our bill with the amendments that I just went through, would satisfy the Department of Labor regulations to lay out this process for how you appeal a decision of an insurance company, the internal process that the company has to use and then the external process. Comparing the Insurance Department and the BCBS amendment is difficult to do because their amendment basically cites to federal law and to code of federal regulations,

but it doesn't say which sections it referring to. My answer is that I don't know because we don't have citations to the regulations.

Vice Chairman Kasper: Under the BCBS amendments as we have them, it does not provide specifically for an internal and external review process. It simply cites federal code to which is not germane to the health insurance side of things or you couldn't find where it's germane, is that correct?

Melissa Hauer: That correct. I think I understand what they intended but their citations isn't clear because they don't say what sections. I googled the code federal regulations and came up with 4 pages of sections of federal regulations. The consumer is going to have to figure out what is the appeals section.

Vice Chairman Kasper: With the BCBS amendments, it appears that our consumers would be to appeal would be going to some federal entity and not have a clear way to have state oversight and appeal process because it's becoming eliminated the way you understand.

Melissa Hauer: That's the danger; I'm not saying that is what is going to happen. When we talked with HHS we were comfortable with the process that was laid out under the original bill. You will be able to control your own external review process. We also asked them "what happens if we take everything out and refer to the federal law and regulations"? They didn't like that but they said that they would not disapprove that. They were uncomfortable with that.

Representative Ruby: We heard this set of amendments basically the goal was to keep the regulation within the state but to limit the scope to minimum requirements of federal government. You referenced to the codes that are not so easy to the consumer to search the federal level but if you are required to maintain the minimal requirements at that point, can't you extract that and that is our policy for the state at this time. Is that what conveyed to the public through the Insurance Department.

Melissa Hauer: I'm not sure what you are totally asking.

Representative Ruby: If we are asking if minimum requirements required for appeals is to be what the federal government is required at a minimum level, you could extract that and have that written in rules to address that so the public can use the insurance department to gain information as to how the appeals process works.

Melissa Hauer: The federal law, PPACA, says that the state has to have a process in its state law. HHS did indicate that they thought if we would put into rule in our state that would muster. We can certainly extract and refer to our state law what the federal law says. We can do that, but part of the problem is the amendments don't make clear which federal regulations they are referring to and if they change in the future, we are stuck with what is in our state law. State law cannot adopt future amendments in federal law.

Chairman Keiser: We have heard the other side of the discussion said that is just is the reason we have to reference PPACA if we adopt this. If we had passed this bill out the way

it was, it went beyond what PPACA required, you have amendments that theoretically take it back to the current level of PPACA's requiring and so what happens if we pass this into law and they now reduce the standards significantly at the federal level, where are we then?

Melissa Hauer: We have a process that says what our appeal process is.

Chairman Keiser: We are stuck with it for 2 years. That's the committee's dilemma. Are there other places in the code where we make reference to the state standard that will meet federal law?

Melissa Hauer: Yes, in our insurance title specifically, there is a reference to HEPA and Public Service Act as well.

Vice Chairman Kasper: If we do adopt your amendments, we have at least procedures in statue which satisfy HHS according to your best understanding now and our citizens will be able to have an appeal process in North Dakota, compared to going through the federal channel, is that correct?

Melissa Hauer: Yes, that's correct.

Chairman Keiser: I don't believe that's correct. If we adopt the bill as it is, the department has full authority to implement PPACA and whatever standards they have, the state will control. We don't require people; based on this amendment to go to the federal government, we are saying in law the North Dakota's law will be the minimum standards requirement of PPACA and therefore we are retaining the authority.

Melissa Hauer: Maybe I'm misunderstanding the questions, are you saying under the original bill or the hogged housed bill?

Chairman Keiser: As hog housed.

Melissa Hauer: That we would maintain state control under that? Based on our conversations with HHS, I can't guarantee that, they were very concerned with a state law that just references a federal law. They did not like the idea that the process was not laid out somewhere in a rule or law.

Chairman Keiser: But they can't circumvent our state law if our law says we will meet their standards. They don't want to set up for one state a review process.

Melissa Hauer: That may be, I don't know.

Vice Chairman Kasper: Could we state that we will set up the internal and external review according to what the department is proposing and in addition to that state that PPACA changes state guidelines, then the department could modify?

Melissa Hauer: The legislature can delegate authority as long as you give sufficient guidelines to an agency as to what you want done in that situation, yes, you could delegate that authority.

Chairman Keiser: Couldn't we delegate that authority with the amendment?

Melissa Hauer: Yes, you mean something that would say that the federal law changed. Our current amendment would not go there and their amendment doesn't address that either.

Rod St Aubyn~Blue Cross Blue Shield of North Dakota: (See attached testimony).

Representative Clark: Is your amendment that's under attack, is your opinion that your amendment is superior the one we were just offered.

Rod St Austyn: Yes, it is because that way we have assurances. At least it's going to be the minimum of the PPACA and it won't go beyond. Even with the amendments where they have taken off a few things, the department still takes us beyond PPACA. The other option and it would be a simple amendment, would be to take all the components of PPACA and lay them out in state statue. I can assure you that the provision in HB 1127 with their amendments does go beyond the minimum requirements of PPACA.

Representative Clark: Does it concern you that the amendment that we voted on last week, doesn't allow us to do it?

Rod St Austyn: This is the first that I heard this and I will have to check with our attorneys.

Representative Clark: I do believe the amendment, the way we voted on it, does allow the Insurance Department to do their regulation, it's just that they don't want to go there.

Chairman Keiser: They don't need all those references because they are writing a bill with all of the specific details in it.

Rod St Austyn: It is our contention that with the amendments the department will have the authority to regulate the PPACA provisions of the appeals, utilizations and all the issues. They will have the authority, the same as they do not have authority in all examples that I gave you before.

Chairman Keiser: Other questions?

Rod St Austyn: Our concern is the consumer is going to see such a rate shock the way it is if PPACA does go into effect the way it is and we are trying to minimize costs. We don't object at all to complying with federal requirements, we just object to going beyond that.

Chairman Keiser: The department raised one of the concerns that the amendment that is on the bill currently, does not adequately reference it. The department would have the authority to generate the rules based on the final resolution of the rules by HHS. Do you have any problem adding any language giving them specific authority?

Rod St Austyn: I reference you to HB 1125 and that is the enforcement piece. I would argue that alone gives the commissioner the authority to do this. We are talking about the appeals provisions under PPACA.

Vice Chairman Kasper: Is BCBS supporting HB 1125?

Rod St Austyn: Yes.

Vice Chairman Kasper: Then you are supporting it so there would be no problem putting the same language in here.

Rod St Austyn: We wouldn't have any problem with that. We think the state should regulate this provision versus the federal government.

Chairman Keiser: What is the July date that we as a state have to have our rules in effect? Do we need the emergency clause?

Rod St Austyn: By July 1, all insurers must comply. Actually, the law went into effect to comply but they are in the process of making changes and they are delaying enforcement until of July 1, 2011.

Chairman Keiser: If it was left as it is, do we need the emergency clause?

Rod St Austyn: That would be a question for the department. It's immaterial what the state does, as a health plan we have to comply with the federal law.

Chairman Keiser: The state has had conversations with HHS and HHS has expressed some concern that North Dakota is not developing its own model. Do you think HHS has some concerns of our hog housed amendment approach, do you think that is a legitimate concern of HHS?

Rod St Austyn: No I don't. If they say it's detailed enough, how can the federal government enforce those same laws for the self funded? It is already detailed in federal law what is required.

Chairman Keiser: But Rod it isn't, you just said that they are changing them.

Rod St Austyn: They are changing them but the existing regulations and the laws are out there. Our self funded, we are going to have to comply no matter what and federal government is the one that enforces that. You have to understand, the Department of Labor, they have come to do some audits of some of our self funded plans before.

Chairman Keiser: We are not talking about self-funded.

Rod St Austyn: I don't see that's an issue because if they feel this isn't clear enough, then how can it be enough for what they are going to have to enforce? The same law applies to both.

Rebecca Ternes: I will have Melissa speak to the lack of detail in PPACA. We are talking about three areas, utilization review, grievance and external appeals. On external appeals, they specifically refer to a model in NAIC in the law. In talking to them, they also referred us to the other two models. They assure us that if we go down that road in the state of North Dakota, we will retain that state control. We would not have brought this to you but we thought it was necessary to make sure we do not risk losing state control. That is why we reached all of the companies on this bill. Three of the four companies are completely fine with this bill. One in particular worked with us on very detailed amendments where they did identify that it went beyond PPACA where there would be costs. Most said we could live with it the way it is. We went back and forth with HHS on the detailed amendments, maintaining state control is important. With the BCBS amendments that risk arises tremendously. We can't guarantee one way or the other where it lands because HHS will not determine this until closer to July 1. This bill is not what PPACA says because PPACA doesn't have any details; it's setting up a system that will pass muster with HHS.

Chairman Keiser: Committee members might want to know what rules they have established.

Melissa Hauer: PPACA leaves us in a strange place because what it does is, it doesn't give us any details. PPACA says that state law has to have a sufficient internal and external review process. To say let's do what PPACA requires, it doesn't give any detail, that's the problem. HHS is responsible for enforcing this law and what do they do? They make regulations to try to give some detail and those regulations say "we know there is already this is process out that self funded plans use, let's piggyback and incorporate that here". You have federal and all of these regulations. If you say that we are just going to incorporate the PPACA, I think we are talking about something that doesn't exist. To maintain state control, we must pass federal muster to do that. There is a federal agency that is going to look at our process and say, yes or no that it protect our consumers. If the federal agency says no it doesn't, when the consumer wants to appeal to an external review, you will have to send them to the federal government. We have heard concern from HHS that just referring to a federal law that refers to federal regulations of three federal agencies' treasuries, have all adopted regulations on this and that that's not sufficient. They say that what concerns them. Then there is the idea that if those regulations changed, relaxed, struck down or repealed whatever you put in our state law is what you get on the day you enact it. You don't get to incorporate future changes. Our Supreme Court has already said that's not allowed. To use that for a reason for doing it that way, I don't understand.

Chairman Keiser: Whatever we pass is effective on that date. PPACA is over 2000 pages and it contains nothing other than bad information but it does indicate and delegate authority to develop rules. HHS, Department of Labor and other departments, HHS has a full time staff on developing rules. They have come up with some and they are under review and possibly will be modified, those rules they develop will become our minimum standards that must be met regardless of what we do here. Even if we pass a law that didn't meet those, they would supersede on July 1 our state law. What they identify will be the minimum law and we can go beyond that. Why wouldn't it be the case recognizing that if we were to pass the amended version that we have before us and it become law, that

any addition standards that were implemented by HHS they would become part of the law. Their current standards do require you to have utilization, external and internal review, they just maybe haven't defined those things are, is that the issue?

Melissa Hauer: In my opinion, the rules are already there. I have not heard from HHS that they are intending to change or relax rules, that is something we have not heard.

Chairman Keiser: So if we adopt those rules that are there with our amended version, we are in compliance.

Melissa Hauer: Which amended version?

Chairman Keiser: The BCBS amendment.

Melissa Hauer: Then the one concern that I have is that their citations to the code of federal regulations may not be correct and don't cite to anything. That's one problem.

Chairman Keiser: That's a legitimate issue.

Melissa Hauer: If the federal regulations would change, our law is still stuck on the day that it was enacted.

Chairman Keiser: If they became less restrictive, our law would be in effect but if they got more restrictive the federal law would supersede.

Melissa Hauer: What is going to happen on July 1, the federal government is going to look at what whatever our process is in state law.

Chairman Keiser: If we say you have you're final rules and those are the rules we will adopt, nothing more, what can be the problem?

Melissa Hauer: I don't think there is a problem if you are clear on which rules you are talking about.

Representative Ruby: If the insurance company has to provide that to their insured, you can have that on hand to notify people if they call you instead? You have approval of what the insurance policies are and you have that on record. They could call you and you could provide that information for them couldn't you.

Melissa Hauer: Yes, that won't influence the federal government when it looks at our state law and decides whether we have an appropriate process or not.

Representative Ruby: But that's what the chairman is talking about. The process is approved because it is the requirement of the self-insured, we are referencing the correct areas of the code and the other area part is notifying the people about the appeals process, correct?

Melissa Hauer: Again, there is a question about if whether that will pass muster with HHS.

any addition standards that were implemented by HHS they would become part of the law. Their current standards do require you to have utilization, external and internal review, they just maybe haven't defined those things are, is that the issue?

Melissa Hauer: In my opinion, the rules are already there. I have not heard from HHS that they are intending to change or relax rules, that is something we have not heard.

Chairman Keiser: So if we adopt those rules that are there with our amended version, we are in compliance.

Melissa Hauer: Which amended version?

Chairman Keiser: The BCBS amendment.

Melissa Hauer: Then the one concern that I have is that their citations to the code of federal regulations may not be correct and don't cite to anything. That's one problem.

Chairman Keiser: That's a legitimate issue.

Melissa Hauer: If the federal regulations would change, our law is still stuck on the day that it was enacted.

Chairman Keiser: If they became less restrictive, our law would be in effect but if they got more restrictive the federal law would supersede.

Melissa Hauer: What is going to happen on July 1, the federal government is going to look at what whatever our process is in state law.

Chairman Keiser: If we say you have you're final rules and those are the rules we will adopt, nothing more, what can be the problem?

Melissa Hauer: I don't think there is a problem if you are clear on which rules you are talking about.

Representative Ruby: If the insurance company has to provide that to their insured, you can have that on hand to notify people if they call you instead? You have approval of what the insurance policies are and you have that on record. They could call you and you could provide that information for them couldn't you.

Melissa Hauer: Yes, that won't influence the federal government when it looks at our state law and decides whether we have an appropriate process or not.

Representative Ruby: But that's what the chairman is talking about. The process is approved because it is the requirement of the self-insured, we are referencing the correct areas of the code and the other area part is notifying the people about the appeals process, correct?

Melissa Hauer: Again, there is a question about if whether that will pass muster with HHS.

Representative Ruby: That' a different issue than the notification of the process.

Melissa Hauer: Correct.

Chairman Keiser: Further questions?

Vice Chairman Kasper: I would like clarification on the citation on the federal law that the department has expressed their concerns and perhaps the department should sit down and try to come to an agreement. There appears to be conflicting positions, that is a key part to what this bill is about, and it has to be done.

Chairman Keiser: If we stay with the amendment, I concur. We need the parties and your attorneys involved. We will ask the department and BC to work on that. We will give you until Wednesday morning. The Department, if we need a declarative statement to the current bill saying not only do the current date it becomes law, we are adopting the standard identified by PPACA, HHS and everyone else, but the insurance department will be responsible for implemention our plan.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1127
February 16, 2011
14600

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Health carrier external review, utilization review and grievance procedures; limitation of health insurance company risks, utilization review and independent external reviews.

Committee Work Session Minutes:

Chairman Keiser: Opens the work session on HB 1127.

Rebecca Ternes~North Dakota Insurance Department: (See attached testimony).

Vice Chairman Kasper: A comment more than a question. I'm disappointed that the department and the BCBS didn't sit down and talk.

Rebecca Ternes: We met in the parking lot and we did discuss again. The department made several amendments to meet the needs of BCBS and the other three companies. I again, why isn't that enough and there's no harm here, there was no willingness to move.

Vice Chairman Kasper: A meeting in the parking was poor judgment on your part.

Representative Ruby: Could you explain to me how the provisions in the amended bill are less vague than the language we have in HB 1125.

Rebecca Ternes: HB 1125 is the enforcement piece. Those amendments were not in our original language in HB 1125. Our original language refers to enforcing the entire law of PPACA. If you recall that on Monday we discussed the citations that BCBS put in, cited to several different code of federal regulation that are much larger than this. In areas of the code that have only a little to do with health care reform, not in total and that was part of our problem with those citations. It makes it difficult for someone who isn't an attorney or someone who is just reading those regulations to be able to figure out what is the law in the state of North Dakota.

Representative Ruby: If the laws that deals with self-insured plans is in place and understood, the intention of this is to mirror them as much as possible, how is it less vague than all of PPACA which is completely vague?

Rebecca Ternes: The reference to PPACA is to the specific law and to the language within the law. Whatever exists that day is the law, that's the intent. If you had to follow these regulations as a layperson, it's extremely difficult. We thought the better approach would be to lay it out in law and make it simple for industry and consumers. We only have one opponent in this issue.

Chairman Keiser: Because they didn't meet, this is not necessarily what I'm supporting, I did request Legislative Council what we had discussed last time in the form of the amendment. It's an expansion on page two of citing to the CFR and USC code. (see attached amendment). Reads section three that was added. This amendment is a slight expansion and we have before you the two positions. The question is before the committee, we have to take additional action, that is to take this amendment or we need to bring it back, restore it to its original condition and place the Insurance Department's amendments on the bill.

Vice Chairman Kasper: Would it help strengthen our position with HHS, if in front of the amendments starting with "if federal laws" if we said something like it is the intent of North Dakota or the Legislature to total comply with the rules of HHS so that we maintain state control, would that mean anything?

Chairman Keiser: I have no objection for Legislative Council to add an additions language to make it clear as possible what we are trying to achieve.

Rod St Aubyn: There is a typo on page three. Vice Chairman Kasper suggestion maybe covered in the previous sentence.

Vice Chairman Kasper: I understand that part, but if we can even state in the bill that it is the intent that we will, I thought it might strengthen it even more.

Chairman Keiser: It is the legislative intent of the 2011 session to ...

Vice Chairman Kasper: comply with HHS so the state of North Dakota is totally in control of the regulation of the internal and external review process.

Representative Ruby: Do we put the words "intent" language in the bill?

Chairman Keiser: North Dakota shall comply with. The minute we say that, the intent is imputed. We have two options here, what are your wishes.

Representative M Nelson: Looking at the two different ways of doing things, I think the real problem with the amendment you handed out and what we currently have is that it's trying to write to some vaporous standard. I like what the department had, it's straight forward and I don't think it goes too far beyond. There I know what we are doing; here I don't know what we are doing. Maybe if we passed this, we are just moving this over into the rules. I would support the department's position with the amendments because it's straight forward.

Representative M Nelson: Moves that we return to the original form of the bill and adopt the amendments purposed by the insurance department.

Chairman Keiser: Further discussion?

Representative Frantsvog: There are already some amendments that have been adopted, are we talking about something else?

Representative Ruby: This would replace them.

Chairman Keiser: We would go back to the original bill, the 90 pages, then adopt the amendments distributed by the Insurance Department today. That is the motion before the committee. The amendment currently on the bill was a hog housed amendment taking the 90 pages to a two or three page bill.

Representative Ruby: I'm going to resist the motion. We accomplished our goal the first time and we don't want to adopt any further than what PPACA is putting in place. The intent was to put the authority at the state level and I think we should go with it. I'm going to resist the motion.

Representative Boe: My question is this, the amendment that was handed out, your amendment that you have drafted out, when we talk about having the meeting of the standards as they come up with them. Are we illegally transferring the power to someone else?

Chairman Keiser: Representative M Nelson and Representative Boe have raised the two big issues on this bill. One, the standards have not been developed but when the standards are finalized, they are the minimum standards that every state must meet regardless of what you have done. If our standards we are adopting in our bill were not restrictive enough when the federal law is adopted, we would have to meet them. Representative M Nelson point, the standards are not developed so are these standards more restrictive or not restrictive enough. They are going to have to change up or down once the final standards are developed but regardless of which bill you pass, it will become effective on the day it becomes effective and the standards in place that day if you were to adopt this amendment, will become North Dakota standards. There is a time issue. We are shooting in the dark because HHS has not finalized all their standards. We have a proposal that will attempt to in a reasonable way, look at the standards of what might be coming down. The second approach is to say and I do firmly believe, the federal government is not going to take over the regulation in our state, we are meeting standards, we are meeting the standards. If we are exceeding the standards, they are not going to take it over.

Representative Amerman: Second the motion.

Chairman Keiser: Further discussion?

Representative Vigesaa: Could we have Melissa go over the amendments dated February 8?

Melissa Hauer~General Counsel for the Insurance Department: The purposed amendments are dated February 8. (See attached amendments on back of original testimony)

Chairman Keiser: Further discussion?

Roll call was taken on returning to the original form of the bill, the 90 plus pages, and adopting the Insurance Department amendments on HB 1127 with 5 yeas, 9 nays, 0 absent and the motion fails.

Vice Chairman Kasper: Move that we adopted the amendments 11.8111.01005 and the clarification of the typo and the addition of the sentence.

Representative Ruby: Second.

Chairman Keiser: Further discussion?

Representative M Nelson: We have to do something and I ask that we support the bill as it stands before us with the amendments.

Voice vote, motion carried.

Vice Chairman Kasper: Moves a Do Pass as Amended.

Representative Ruby: Second.

Chairman Keiser: Further discussion.

Roll call was taken for a Do Pass as Amended on HB 1127 with 13 yeas, 1 nay, 0 absent and Representative Clark is the carrier.

FISCAL NOTE

Requested by Legislative Council
12/29/2010

Bill/Resolution No.: HB 1127

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill is to ensure that the state's appeals process meets the requirements of 2010 federal legislation.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Any additional work required by the Department will be absorbed using existing resources.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

This bill will not affect revenues.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

See Section 2B.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

This bill will not affect appropriations.

Name:	Larry Martin	**Agency:**	Insurance Department
Phone Number:	701-328-2930	**Date Prepared:**	01/10/2011

Prepared by the Legislative Council staff for
Representative Keiser
January 13, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1127

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 26.1-36 of the North Dakota Century Code, relating to health carrier external appeals and internal claims and appeals procedures; and to amend and reenact sections 26.1-03-01, 26.1-26.4-01, and 26.1-36-44 of the North Dakota Century Code, relating to limitation on health insurance company risks, utilization review, and independent external reviews.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-01. Limitation on risks acceptable by company.

An insurance company transacting an insurance business in this state may not expose itself to loss on any one risk or hazard to an amount exceeding ten percent of its paid-up capital and surplus if a stock company, or ten percent of its surplus if a mutual company, unless the excess is reinsured. An insurance company offering group or individual insurance that is subject to the lifetime or annual benefit limit restrictions of the Patient Protection and Affordable Care Act [Pub. L.111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] is not subject to this section.

SECTION 2. AMENDMENT. Section 26.1-26.4-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-01. Purpose and scope.

This chapter applies to grandfathered health plans unless a health care insurer or utilization review agent determines to extend the protections of section 5 of this Act to a grandfathered plan. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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.

SECTION 3. AMENDMENT. Section 26.1-36-44 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-44. Independent external review.

This section applies to grandfathered health plans. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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. A provider may not use an independent external review under this section unless the provider first has exhausted all internal appeal processes offered by the insurance company, nonprofit health service corporation, or health maintenance organization.

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

External appeals procedures.

An insurance company, nonprofit health services corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage meets the minimum requirements of 42 U.S.C. 300gg-19 and complies with 26 CFR 54 and 602, 29 CFR 2590, and 45 CFR 147.

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

Internal claims and appeals procedures.

An insurance company, nonprofit health services corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage meets the minimum requirements of 42 U.S.C. 300gg-19 and complies with 26 CFR 54 and 602, 29 CFR 2590, and 45 CFR 147."

Renumber accordingly

Date: Feb 1, 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .01001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Ruby Seconded By Rep Clark

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote, motion carries

Total Yes _____ No _____

Absent _____

Floor Assignment _____

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

2 page

11.8111.01002
Title.

Prepared by the Legislative Council staff for
Representative Keiser
January 27, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1127

Page 1, line 5, remove the second "and"

Page 1, line 5, after "penalty" insert "; to provide for application; and to declare an emergency"

Page 95, after line 2, insert:

"**SECTION 7. APPLICATION.** In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. The commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to implement any program or requirement before January 1, 2013. For any program or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012.

SECTION 8. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: Feb 1, 2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 01002

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Ruby Seconded By Rep Frantsvog

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote, motion carries

Total Yes _____ No _____

Absent _____

Floor Assignment _____

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

Date: Feb 1, 2011

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	AB		Representative Boe	✓	
Representative Clark	✓		Representative Gruchalla	✓	
Representative Frantsvog	✓		Representative M Nelson	AB	
Representative N Johnson	✓				
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 12 No 0

Absent 2

Floor Assignment Rep Clark

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

Date: Feb 16, 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep M Nelson Seconded By Rep Amerman

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser		✓	Representative Amerman	✓	
Vice Chairman Kasper		✓	Representative Boe	✓	
Representative Clark		✓	Representative Gruchalla	✓	
Representative Frantsvog		✓	Representative M Nelson	✓	
Representative N Johnson	✓				
Representative Kreun		✓			
Representative Nathe		✓			
Representative Ruby		✓			
Representative Sukut		✓			
Representative Vigesaa		✓			

Total Yes 5 No 9

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent: Go back of original form of the bill & to adopt Ins. Dept Amendments.

1

motion fails

Prepared by the Legislative Council staff for
Representative Keiser
February 15, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1127

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 26.1-36 of the North Dakota Century Code, relating to health carrier external appeals and internal claims and appeals procedures; to amend and reenact sections 26.1-03-01, 26.1-26.4-01, and 26.1-36-44 of the North Dakota Century Code, relating to limitation on health insurance company risks, utilization review, and independent external reviews; to provide for application; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-01. Limitation on risks acceptable by company.

An insurance company transacting an insurance business in this state may not expose itself to loss on any one risk or hazard to an amount exceeding ten percent of its paid-up capital and surplus if a stock company, or ten percent of its surplus if a mutual company, unless the excess is reinsured. An insurance company offering group or individual insurance that is subject to the lifetime or annual benefit limit restrictions of the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], is not subject to this section.

SECTION 2. AMENDMENT. Section 26.1-26.4-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-01. Purpose and scope.

This chapter applies to grandfathered health plans unless a health care insurer or utilization review agent determines to extend the protections of section 5 of this Act to a grandfathered plan. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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.

SECTION 3. AMENDMENT. Section 26.1-36-44 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-44. Independent external review.

This section applies to grandfathered health plans. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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. A provider may not use an independent external review under this section unless the provider first has exhausted all internal appeal processes offered by the insurance company, nonprofit health service corporation, or health maintenance organization. If federal laws or rules relating to independent external review are amended, repealed, or otherwise changed, the insurance commissioner shall adopt rules to ensure the independent external review procedure is in compliance with and substantively equivalent to the federal requirements.

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

External appeals procedures.

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

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

Internal claims and appeals procedures.

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

SECTION 6. APPLICATION. In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. The commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to implement any program or requirement before January 1, 2013. For any program or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012.

SECTION 7. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: Feb 16, 2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8111.01005

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Kasper Seconded By Rep Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote - motion carried

Total Yes _____ No _____

Absent _____

Floor Assignment _____

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

typo & added sentence and 11.8111.01005

Adopted by the Industry, Business and Labor Committee

February 15, 2011

VR 2/17/11 #3

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1127

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 26.1-36 of the North Dakota Century Code, relating to health carrier external appeals and internal claims and appeals procedures; to amend and reenact sections 26.1-03-01, 26.1-26.4-01, and 26.1-36-44 of the North Dakota Century Code, relating to limitation on health insurance company risks, utilization review, and independent external reviews; to provide for application; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-01. Limitation on risks acceptable by company.

An insurance company transacting an insurance business in this state may not expose itself to loss on any one risk or hazard to an amount exceeding ten percent of its paid-up capital and surplus if a stock company, or ten percent of its surplus if a mutual company, unless the excess is reinsured. An insurance company offering group or individual insurance that is subject to the lifetime or annual benefit limit restrictions of the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], is not subject to this section.

SECTION 2. AMENDMENT. Section 26.1-26.4-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-01. Purpose and scope.

This chapter applies to grandfathered health plans unless a health care insurer or utilization review agent determines to extend the protections of section 5 of this Act to a grandfathered plan. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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.

SECTION 3. AMENDMENT. Section 26.1-36-44 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-44. Independent external review.

This section applies to grandfathered health plans. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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. A provider may not use an independent external review under this section unless the provider first has exhausted all internal appeal processes offered by the insurance company, nonprofit health service corporation, or health maintenance organization. The insurance commissioner shall take steps necessary to ensure compliance with this section. If federal laws or rules relating to independent external review are amended, repealed, or otherwise changed, the insurance commissioner shall adopt rules to ensure the independent external review procedure is in compliance with and substantively equivalent to the federal requirements.

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

External appeals procedures.

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

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

Internal claims and appeals procedures.

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

SECTION 6. APPLICATION. In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. The commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to implement any program or requirement before January 1, 2013. For any program or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012.

SECTION 7. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: Feb 16, 2011

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Rep Kasper Seconded By Rep Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	✓		Representative Boe		✓
Representative Clark	✓		Representative Gruchalla	✓	
Representative Frantsvog	✓		Representative M Nelson	✓	
Representative N Johnson	✓				
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 13 No 1

Absent 0

Floor Assignment Rep Clark

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

REPORT OF STANDING COMMITTEE

HB 1127: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). HB 1127 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact two new sections to chapter 26.1-36 of the North Dakota Century Code, relating to health carrier external appeals and internal claims and appeals procedures; to amend and reenact sections 26.1-03-01, 26.1-26.4-01, and 26.1-36-44 of the North Dakota Century Code, relating to limitation on health insurance company risks, utilization review, and independent external reviews; to provide for application; and to declare an emergency.

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SECTION 7. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

2011 SENATE HUMAN SERVICES

HB 1127

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1127
3-16-2011
Job Number 15549

☐ Conference Committee

Committee Clerk Signature AMouson

Explanation or reason for introduction of bill/resolution:

Relating to health carrier external appeals and internal claims and appeals procedures.

Minutes: Attachments

Senator Judy Lee opened the hearing on **Engrossed HB 1127**.

Representative George Keiser (Dist. 47) explained the bill. Attachment #1 He also submitted an amendment for a simple correction. Attachment #1a.

Senator Tim Mathern was a little concerned with leaving the department in a lurch. He wondered if they thought of the possibility to proceed with the greater elaboration of the processes in the 95 page bill but with more of an escape clause to move out of it if the federal requirements weren't that restrictive versus not developing them.

Rep. Keiser answered that they did think about that issue but didn't choose that option.
There are currently federal laws on the books that seem to be working. They saw the bill as extending beyond the limitations that they knew were, at that time, in PPACA. They weren't comfortable with that. There were two options: 1. The default option – adopting those standards that went beyond PPACA and if it is ruled unconstitutional reverting back to our current standards, or 2. They felt it was a more positive approach to stay with the current standards and maybe change them, upgrade them, in the special session.

Dan Ulmer, BC of North Dakota, testified in support of the bill as sent by the House. Attachment #2

Senator Tim Mathern said one of his concerns was kind of like a back end loading. Without these changes being considered or reviewed or tested in rule making and some need to be put in place he wondered if there would be some scrambling at the end that would be tough.

Bob Stroup, Deputy General Counsel for BC/BS of ND, didn't feel it puts anyone in a box because, for the most part, the internal appeals have been in place and they are following the changes and the time frames. The problem with the external appeals is they don't have the final rules yet. In the short term he didn't think this would cause the kinds of concerns Sen. Mathern was asking about.

Adam Hamm, ND Insurance Commissioner, appeared in opposition to HB 1127. He asked the committee to restore the language of the bill as introduced and to adopt amendments the Insurance Department prepared in February. Attachment #3 and #3a

Senator Tim Mathern asked who the sponsor of the bill was.

Commissioner Hamm responded that the original bill was prepared by the Insurance Department but it was sponsored by Chairman Keiser, Chairman of IBL.

Senator Tim Mathern asked why he didn't introduce it.

Commissioner Hamm replied that there were several discussions about that and it was decided by all parties that the three pieces of legislation 1125, 1126, and 1127 would all be introduced or sponsored by Chairman Keiser. At the end all sides could not work out an agreement on 1127.

After a short discussion, it was noted that the amendments prepared by the Dept. were for the original bill. To accomplish the objective of the Commissioner a different set of amendments would be needed.

Senator Dick Dever asked if he would like to see the bill go away if the changes are not adopted.

Commissioner Hamm replied that was not what he was saying. The engrossed bill is still a potential answer to what HHS is looking for but is less likely to be given the stamp of approval.

Attachment # 4 – Written testimony submitted from Lisa Carlson, Sanford Health.

The hearing on HB 1127 was closed.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1127
3-22-2011
Job Number 15853

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened committee discussion.

Senator Tim Mathern presented amendment .03002 dated 3-21-2011. Attachment #5 This is taking 1127 back to how it was introduced in the House with the specifics that were laid out in the department's original bill. His concern was that they are piling up too many things for the special session. The special session dealing with redistricting can often be real contentious. In the context of that contention, he is concerned with what they are doing in health care reform so he is asking to put more detail into the bill which reflects the work of the interim committees.
This bill, as he understood it, is more oriented towards the consumers, the rights of providers, the rights of health care users, in and around federal health care reform and should have the highest level of scrutiny. He felt 1127 was an attempt to understand people's rights about appeal, changes, and demands of services that are available. It is a lot of material but he thought not knowing and dealing with the material is essentially turning over control to the federal government.

Senator Judy Lee responded that by what they were told, the original longer bill spelled out what the current potential federal circumstances were. There was knowledge of the possibility of change. Her understanding of 1127 is that instead of being specific it directs the insurance department to make sure that whatever requirements are in place are the minimum that the feds establish as things go along. It allows them and insurance carriers to be adaptable to whatever is determined by the federal rule to be the restrictions at the time. She felt there was an advantage to that.

Senator Tim Mathern was concerned about how long they are keeping it flexible.

Senator Dick Dever said that Rep. Keiser's explanation satisfied his own concerns about the rationale for reducing the bill to what they did.

Senator Spencer Berry felt the same.

The effective date and emergency clause were discussed. They are both needed.

Rod St. Aubyn, BC of North Dakota, informed the committee that if Sen. Mathern's amendments are considered a fiscal note may be needed.
He pointed out that the interim committee might not have to do anything. The federal law already exists in quite a bit of detail. In addition, the appeals process has to be identified in detail by the insurers in the members benefit book.

Senator Tim Mathern addressed two points. 1. If the bill isn't structured to clarify the costs then they aren't clear about the message. 2. Why not work with the last set of changes that were announced and put them in an amendment where it is appropriate so more people become informed.

Rod St. Aubyn said that theoretically if this is passed there shouldn't be a need at the special session for anything as it relates to appeals. There won't be a need because the law is in effect with this. There isn't any need for additional legislation as it relates to the appeal process of 1127. There is going to be a need in terms of the exchange and if the federal government makes changes between now and then on other provisions of PPACA.
He emphasized that this only deals with the appeals process and doesn't have anything to do with the other provisions of PPACA.
To answer the question posed by Sen. Mathern in #2 above about including the changes that happened from the Dept. of Labor he said part of the reason is that they haven't formulated the formal response. This was supposed to go into effect on July 1 and now four or five issues have been identified and significant changes will be made to the interim final rules – one being a change to an appeal time frame.

Senator Spencer Berry asked for a response to the testimony by the Insurance Commissioner who opposed this and felt that reinstating to the original form would give a better chance of keeping local control.

Rod St. Aubyn responded that he didn't think it was a valid concern to be more detailed.
The federal law ends up being the threshold. Rules or state laws can be adopted that go beyond the minimum threshold but it would only apply to fully insured products. The lower level of the threshold would apply to the self funded. Then there would be two different appeal processes.

Dan Ulmer, BC of ND, said the other thing that needed to be understood was how the process works. First, they are in motion now in terms of complying. Secondly, he said they need to appreciate that the commissioner has the authority. This bill entitles him to basically enforce the PPACA appellate process. He explained how that works.

Senator Tim Mathern said that he hadn't shared his amendments with the Ins. Commissioner but was willing to do so and felt he would also have some amendments.

Discussion: The original bill is three NAIC model acts. They are not PPACA requirements and it goes beyond PPACA.

Senator Gerald Uglem moved to **accept the amendment proposed by Rep. Keiser**.

Seconded by **Senator Spencer Berry**.

Roll call vote 5-0-0. **Amendment adopted.**

Senator Judy Lee was comfortable with the bill after the attachment of the amendment by Rep. Keiser. She had concerns with the larger bill because it was three National Association Insurance Commissioner Bills put together to get the detail. It was not the PPACA details.

Further action was set aside so Sen. Mathern could visit with the Insurance Commissioner about the larger amendments.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1127
3-23-2011
Job Number 15888

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened committee work.

Senator Tim Mathern reported that he had a copy of what the Insurance Commissioner recommended – an amendment of 94 pages. Attachment #6 This is an alternative to the amendment by Sen. Mathern from 3-21-11.
He summarized the Commissioner's amendments (Attachment #7) and provided an e-mail from Melissa Hauer, Attorney who works with the Insurance Commissioner. (Attachment #8)
Sen. Mathern believes that potentially between now and the next legislative session the federal government is going to assess whether or not North Dakota is properly prepared to be the regulator in this area. We have the greatest chance of the federal government approving ND remaining in charge of the insurance regulation aspect if we were to adopt these amendments now.
He understood that this puts them in a different place than the House but that the Senate would have strength in its position with the Insurance Commissioner supporting the position. It would have to be negotiated out with the House probably in a conference committee.

Senator Judy Lee didn't remember the $10,000 penalty for each violation before.

Senator Tim Mathern thought that had been part of the bill from the beginning.

Melissa Hauer, Insurance Department, explained that the penalty provisions were in the bill as introduced. The three models have penalty provisions in them. The insurance code has a number of different penalty provisions. Some are $10,000 and some are higher.

Senator Dick Dever was curious if all of the amendments flow from PPACA and are necessary to satisfy the requirements.

Ms. Hauer replied that was difficult to answer because PPACA has a very small section on what states have to do with their appeals. For the external review it basically says, if the state has the minimum protection that the NAIC model has, that will be deemed sufficient. The federal law does not have any detail about what is required.

Senator Dick Dever asked if there was a time frame.

Ms. Hauer – July 1- it was effective right away but the federal government promulgated regulations and gave a grace period until July 1. There are different level of requirements that are going on whether you are an employer sponsored plan or a fully insured individual plan. Dept. of Labor rules apply to some plans. The HHS rules apply to other insurance coverage.

Senator Judy Lee asked if the 95 page bill or amendment, which includes merging three NAIC bills, includes provisions in addition to the minimum requirements for PPACA.

Ms. Hauer replied that the bill takes the NAIC models. For external review they have what the NAIC models require. In some areas they go beyond what the Dept. of Labor rules require. Those rules only apply to certain kinds of coverage. They don't apply to fully insured, what you would think of as an individual policy.

Senator Tim Mathern asked how these amendments have responded to the insurance industries concerns or requests.

Ms. Hauer replied that Sanford Health Plan was ok with the bill as introduced but asked for modification in a couple of areas. Those modifications were made along with the grandfathering change that Blue Cross asked for.

Senator Tim Mathern asked what she believed the outcome to the state would be if the amendments were not adopted.

Ms. Hauer said the risk that the federal government will look at the review process and say it doesn't meet muster is greater with the way the bill is right now. Referring to the federal law and regulations might not be enough.

Rod St. Aubyn (BC/BS of ND) addressed the guidance issued by the Dept. of Labor and the effective dates. There are changes coming on board and part of the problem is that there are so many significant changes they are looking at and it's taking longer than they thought to finalize all of them.
A concern they had from the original bill was that there is no definition of a post evaluation and he explained the problem with it.
He pointed out that they are going to have to comply to PPACA but they don't think it is appropriate to go beyond PPACA minimum requirements.

Senator Spencer Berry asked if he saw this as an all or nothing. Adopt this now to increase the chances of leaving it within the state or going with this and there's no chance for ongoing conversation and change.

Rod St. Aubyn found it hard to believe that the federal government would even attempt to tell a state that it is not specific enough if the state says their requirement is going to be the same as the federal requirement. The federal government has to regulate the self funded right now.

Ms. Hauer, talked about the amendment on page 53 concerning post evaluation or post stabilization services. She explained the changes made that were requested by Sanford and discussion followed.

Senator Dick Dever asked if not for PPACA would they consider all of the provisions of this bill to be good public policy.

Ms. Hauer said it was a matter of opinion. In the Commissioner's view this is good for the consumers.

Senator Judy Lee didn't see that all the detail needed to be in statute.

Discussion continued on who the detail might be needed for and why it is needed. Also more discussion followed on the post stabilization services and definitions.

Senator Tim Mathern moved to accept the amendments, dated 3-22-11, which reflect his summary also dated 3-22-11. They would restore the original bill and make the additional changes that have come to the attention of the Insurance Commissioner and that he agrees should be changed from the original bill.

Seconded by **Senator Spencer Berry.**

Senator Gerald Uglem was conflicted between doing what the Insurance Commissioner recommends or what the legislators have decided is the best way to go. For that reason he opposed the amendment.

Senator Spencer Berry was also conflicted but wanted the second for the purpose of discussion.

Senator Dick Dever said that the House took a position on this and he wasn't sure what their rationale was for that position. This seems to him to some extent to be more about insurance than health care. He would probably vote yes.

Senator Tim Mathern hoped the amendment would be passed. He felt this gives them the best shot to keeping ND in charge while still realizing that they will have to revisit it.

Senator Judy Lee planned to oppose the amendments. The House committee worked judiciously to go through this much more thoroughly than this committee has had a chance to do at this point. She agreed with what Rep. Keiser said in his presentation. This bill that has combined three NAIC model bills together into one has way more in it than PPACA requires and she felt it was burdensome.

Roll call vote 3-2-0. **Amendment adopted**.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1127
3-24-2011
Job Number 15912

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes:

Senator Judy Lee reopened committee work on Engrossed HB 1127.

Senator Spencer Berry moved to reconsider actions on 1127.

Seconded by **Senator Gerald Uglem**.

Senator Tim Mathern thought the amendments they adopted were appropriate. Essentially, they recognize interim committee work of the last interim, the work of the Insurance Commissioner in putting together consumer protections, meet muster with federal requirements, and they have a reflection of the feedback that the Insurance Commissioner has received. They have the changes the Insurance Commissioner suggested since the bill was introduced and the additional wording that direct the Insurance Commissioner to come to the special session if there are things that need to be addressed. He felt the amendments also reflect the needs of the committee to prepare for negotiations with the House.
He opposed the motion and asked the rest of the committee to vote no on the motion.

Senator Dick Dever pointed out that the prime sponsor of the bill is the Chairman of the House IBL Committee and was the Chairman of the Interim IBL Committee and also serves on the National Council of Insurance Legislators. Sen. Dever originally supported the amendment for the purpose of having a conversation in Conference Committee to hear their rationale of why they adjusted the bill from 95 pages to 4. In further conversations, he said he is comfortable with Rep. Keiser's position. The bill as amended would be largely about insurance and those people are the ones that deal with it all the time. He felt our focus should be on federal health care reform. To the extent it exceeds that, it detracts from that focus. He supported the motion.

Senator Judy Lee asked for a vote of the reconsideration.

Voice vote 4-1 (Senator Tim Mathern). **The amendment will be reconsidered**.

Senator Spencer Berry moved to reverse the action by which they adopted the amendment dated 3-22-2011.

Seconded by **Senator Dick Dever**.

Senator Tim Mathern suggested that those amendments reflect the greatest opportunity for the state of ND to continue to be in charge of regulation of health care in terms of consumer rights. He believed it's the intent of most of the legislature and probably most of the citizens that the state of ND retain jurisdiction of that effort. He felt this amendment is the best effort to demonstrate to the federal government that we can stay in charge of this area of commerce and regulation. He said it would be in our interest to pass the amendment and continue working on it. Then have the federal government make its decision and if we have to make other changes we can do it in November.

Senator Spencer Berry agreed with Senator Tim Mathern as far as the intent. He wants to see North Dakota stay in control of it as much as possible. That is his #1 intent. Rep. Keiser is very knowledgeable about this and the fact that he is comfortable with the situation as it is right now is very impressive – that he comes to it with that idea and with his background and depth of involvement. That is the reason Sen. Berry feels ND will be able to stay in charge and control. He supported the removal of the amendments.

Senator Tim Mathern commented further that this bill represents the best effort of a statewide elected official, Commissioner Adam Hamm. That is the greatest portion of the amendments. That department has every bit as much expertise as Rep. Keiser. He did echo some of the concerns of the committee and felt that all of them needed to attain that same level of expertise. It would bring forth the best product for North Dakota if more legislators get into the detail of heath care reform. He believed that is what the amendment suggested they do. He opposed the motion.

Senator Judy Lee replied that everybody wants North Dakota to be in control of what's going on. She was no more comfortable because it is a department bill than because it would have any involvement with Rep. Keiser. She was part of some of those interim committee meetings and spent a lot of time looking into this also. Trying to do everything that is beyond what just deals with the Affordable Health Care Act in this bill is a concern to her. She is comfortable having it in sync with what the federal minimums are for PPACA.

For clarification, a yes vote is to remove the amendment.

Roll call vote 4-1-0. **Amendment dated 3-22-2011 was removed.**

Senator Judy Lee pointed out that it is their intent that the State and the Insurance Dept. work together but make sure there similar grace periods to insurers and group health plans as the recent Dept. of Labor technical release has mentioned.

The bill before the committee now is the bill as it came from the House with the Keiser amendment (.03001) on it.

Senator Spencer Berry moved a **Do Pass as Amended with .03001**.

Seconded by **Senator Gerald Uglem**.

Senator Tim Mathern believed the bill is now in a format that puts our state at great risk to losing the ability to stay in charge of the regulation in this area. It also makes it unclear to consumers what our position is in terms of their rights with health care reform as expressed by the ND Legislature.

Senator Spencer Berry asked Sen. Mathern what specifically concerned him that we would lose control if, in fact, we are staying in sync with guidelines from PPACA.

Senator Tim Mathern responded his concern was that the federal government will look to see what we have in place in the detail sometime around July. Passing of the bill without the amendments doesn't demonstrate to the federal government that we have the detail in place that demonstrates we are prepared to regulate this area.

Senator Dick Dever didn't think they should construe the passage or defeat of this bill as a concession to the federal government of the authority to assume control of the regulation of our insurance industry.

Roll call vote 4-1-0. **Motion carried**.

Carrier is **Senator Judy Lee**.

Date: 3-22-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .03001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Uglem Seconded By **Sen.** Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

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

#7

March 22, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1127

Page 1, line 1, replace "two new sections to chapter 26.1-36" with "chapters 26.1-36.6, 26.1-36.7, and 26.1-26.8"

Page 1, line 2, replace "appeals and internal claims and appeals" with "review, utilization review, and grievance"

Page 1, line 5, after the first semicolon and before "to" insert "and" and replace "for application; and to declare an" with "a penalty"

Page 1, line 6, remove "emergency"

Page 2, line 30, remove "The insurance commissioner shall take steps"

Page 2, remove line 31

Page 3, remove lines 1 through 31

Page 4, remove lines 1 through 9

Page 4, after line 9, insert the following:

"**SECTION 4.** Chapter 26.1-36.6 of the North Dakota Century Code is created and enacted as follows:

26.1-36.6-01. Definitions. For purposes of this chapter:

26.1-36.6-02. Applicability and scope.

26.1-36.6-03. Notice of right to external review.

26.1-36.6-04. Request for external review.
26.1-36.6-05. Exhaustion of internal grievance process.

26.1-36.6-07. Expedited external review.

26.1-36.6-08. External review of experimental or investigational treatment adverse determinations.

26.1-36.6-09. Binding nature of external review decision.

26.1-36.6-10. Approval of independent review organizations.

26.1-36.6-11. Minimum qualifications for independent review organizations.

26.1-36.6-12. Hold harmless for independent review organizations. No
26.1-36.6-13. External review reporting requirements.

26.1-36.6-14. Funding of external review.
26.1-36.6-15. Disclosure requirements.

26.1-36.6-16. Rulemaking. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.6-17. Confidentiality. Any protected health information that the commissioner receives pursuant to this chapter is confidential.

SECTION 5. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36.7-01. Definitions. As used in this chapter:

(1

26.1-36.7-02. Applicability and scope.

26.1-36.7-03. Corporate oversight of utilization review program.

26.1-36.7-04. Contracting.

26.1-36.7-05. Scope and content of utilization review program.

26.1-36.7-06. Operational requirements.

26.1-36.7-07. Procedures for standard utilization review and benefit determinations.

26.1-36.7-08. Procedures for expedited utilization review and benefit determinations.

26.1-36.7-09. Emergency services.
26.1-36.7-10. Confidentiality requirements. **26.1-36.7-11. Disclosure requirements.**

26.1-36.7-12. Rules.
26.1-36.7-13. Penalties.
SECTION 6.
26.1-36.8-01. Definitions. As used in this chapter:

26.1-36.8-02. Applicability and scope.

26.1-36.8-03. Grievance reporting and recordkeeping requirements.

26.1-36.8-04. Grievance review procedures.

26.1-36.8-05. First-level reviews of grievances involving an adverse determination.

26.1-36.8-06. Expedited reviews of grievances involving an adverse determination.

26.1-36.8-07. Rulemaking. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.8-08. Penalties. The commissioner may assess a penalty against a health carrier that violates this chapter of not more than ten thousand dollars for each violation.The fine may be recovered in an action brought in the name of the state.In addition to imposing a monetary penalty, the commissioner may also cancel, revoke, or refuse to renew the certificate of authority of a health carrier that has violated this chapter."

The commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the federal government adopts standards regarding internal claims and appeals and external review that are less stringent than the standards contained in this Act.

Renumber accordingly

Date: 3-23-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 3-22-2011

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment Further Amend

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Mathern Seconded By Sen. Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman		✓	Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair		✓			
Sen. Spencer Berry	✓				

Total (Yes) 3 No 2

Absent 0

Floor Assignment

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

Date: 3-24-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☒ Reconsider

Motion Made By **Sen.** Berry Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern		✓
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Voice Vote

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Date: 3-24-2011

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number remove amendment dated 3-22-11

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Berry Seconded By **Sen.** Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern		✓
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment

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

11.8111.03001
Title.04000

Prepared by the Legislative Council staff for
Representative Keiser
March 9, 2011

3-24-11

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1127

Page 1, line 5, after the second semicolon insert "to provide an effective date;"

Page 4, line 1, after the second boldfaced period insert "The citations to federal laws and rules in this Act refer to the versions in effect on the effective date of this Act."

Page 4, after line 8, insert:

"**SECTION 7. EFFECTIVE DATE.** This Act becomes effective on July 1, 2011."

Renumber accordingly

Date: 3-24-2011

Roll Call Vote # 3

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1127

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8111.03001 Title 04000

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Berry Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern		✓
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen. J. Lee

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

REPORT OF STANDING COMMITTEE

HB 1127, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1127 was placed on the Sixth order on the calendar.

Page 1, line 5, after the second semicolon insert "to provide an effective date;"

Page 4, line 1, after the second boldfaced period insert "The citations to federal laws and rules in this Act refer to the versions in effect on the effective date of this Act."

Page 4, after line 8, insert:

"**SECTION 7. EFFECTIVE DATE.** This Act becomes effective on July 1, 2011."

Renumber accordingly

2011 TESTIMONY

HB 1127

HOUSE BILL NO. 1127

Presented by: **Adam Hamm**
Commissioner
North Dakota Insurance Department

Before: **House Industry, Business and Labor Committee**
Representative George Keiser, Chairman

Date: **January 17, 2011**

TESTIMONY

Good morning, Chairman Keiser and members of the committee. My name is Adam Hamm, the North Dakota Insurance Commissioner. I appear before you today in support of House Bill No. 1127.

This bill was brought due to the federal health care reform law that was signed into law on March 23, 2010. The law, known as the Patient Protection and Affordable Care Act, was followed one week later by the enactment of the Health Care and Education Reconciliation Act of 2010. These laws are sometimes referred to as "federal health care reform", or "PPACA". I will refer to them as "PPACA".

PPACA is lengthy and deals with many topics related to health care reform. This bill deals only with the requirement that group health plans and health insurers implement an "effective" process for appeals of coverage determinations and claims, including an internal claims appeal process (meaning an appeal within the company) and an external review process (meaning asking an independent third party to review an appeal).

BACKGROUND

Some background information will be helpful in understanding the bill. PPACA provides that plans and issuers must initially incorporate the internal claims and appeals

processes set forth in regulations issued in 2000 by the U.S. Department of Labor for plans covered by the Employee Retirement Income Security Act (ERISA). Those regulations require that every employee benefit plan establish and maintain reasonable claims procedures governing the filing of benefit claims, notification of benefit determinations and appeal of adverse determinations.

An "adverse determination" means a determination by a health insurance company that a request for payment of a benefit does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational. The requested benefit is, therefore, denied, reduced, or terminated by the health insurer. It also includes the health insurer's rescission of a health insurance policy due to fraud or misrepresentation by the insured. Essentially, an adverse benefit determination occurs when someone with health insurance received a health care service or treatment and the health insurer declines to pay, either in whole or in part. This bill deals with the procedures that the health insurance consumer can use to appeal the insurer's decision.

PPACA recognized that the 2000 Department of Labor regulations contained an existing standard for this appeals process in those plans governed by ERISA and that process could be used as the basic model to be applied to all health insurance issuers. PPACA also added some additional requirements to the claims appeals procedures which were explained in regulations issued on July 22, 2010, by the Departments of Treasury, Labor, and Health and Human Services (HHS). The regulations contained the requirements for the internal claims and appeals procedures for group health plans and a new requirement for an external appeals process. The new requirements generally apply to insured and self-insured group health plans beginning with the first plan year commencing on or after September 23, 2010, but do not apply to group health plans that are treated as "grandfathered plans."

It is important to note that most of the health insurers doing business in North Dakota today also administer some self-insured, ERISA plans in and out of our state and, therefore, are already required to use these appeals processes.

Changes to Internal Claims and Appeals Procedures

A group health plan and a health insurer must implement an effective process for appeals of coverage determination and claims. This appeals process must include, at a minimum, the following[1]:

- An established internal claims appeal process;
- A notice to participants, in a "culturally and linguistically appropriate manner", of available internal and external appeals processes, including the availability of assistance with the appeals processes; and
- A provision allowing an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeal process.

Health insurers offering individual coverage and any issuers that were not initially subject to existing Department of Labor claims appeals rules may initially use claims and appeals procedures under any other applicable law, such as individual state insurance requirements. Insurers are now required, however, to update these procedures specified in the 2010 HHS regulations. The 2010 regulations create the following six new requirements that supplement the existing ERISA claims and appeals procedures:

[1] Act Sec. 1001(5) of the Patient Protection and Affordable Care Act, as amended by Act Sec. 10101(g), adding Public Health Service Act Sec. 2719(a)(1)).

- First, the definition of an "adverse benefit determination" that is subject to the new internal appeals procedures has been expanded to include a "rescission of coverage."

- Second, the maximum time period within which a plan must notify a claimant of the determination of an urgent care claims is reduced from 72 hours to 24 hours after receipt of such claim, unless the claimant fails to provide sufficient information for the plan to determine whether, or to what extent, benefits are covered or payable.

- Third, claimants must be allowed to review the claim file and present "evidence and testimony" as part of the internal claim and appeal process. Upon review of a denial of a claim, plans must now provide to the claimant, free of charge:

    - Any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim, and

    - Any new or additional rationale that will be used as a basis for the denial of the claim on appeal or review. Plans must provide such information in advance of any final internal adverse benefit determination so that the claimant has a reasonable opportunity to respond prior to the determination.

- Fourth, plans must take additional steps to avoid conflicts of interest and ensure independence and impartiality in the appeals process.

- Fifth, a notice of an adverse benefit determination must include significantly more disclosures, including diagnosis, treatment, and denial codes and an explanation of those terms.

- Finally, if a plan fails to comply with all requirements of the internal claims and appeals process, a claimant will be deemed to have exhausted the process and, therefore, will be eligible to seek external review or judicial review of the claim. This remedy is available even if the plan has substantially complied with these requirements or the error was de minimis.

In addition to these six requirements, the 2010 regulations require group health plans to continue coverage pending the outcome of an internal appeal of an adverse benefit determination. Plans are generally prohibited from reducing or terminating an ongoing course of treatment without notice and an opportunity to review, and individuals in urgent care situations and those receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

New Process for External Review of Appeals

The 2010 regulations also provide details of the new external review process for appeals of final internal adverse benefit determinations and rules determining whether a state or federal external review process applies.

Under the new regulations, an insured group health plan that is already subject to an existing state external review process must continue to comply with the applicable state process if such process includes, at a minimum, the consumer protections set forth in the National Association of Insurance Commissioners' Uniform Model Act as in effect on July 23, 2010 (the "NAIC Model Act"). However, the regulations provide for a transition period, such that all existing state external review processes are deemed to be in compliance with the requirements until the first day of the first plan year beginning on or after July 1, 2011, after which time the Department of Health and Human Services will determine whether a state's external review process complies with the requirements of the NAIC Model Act.

Plans that do not meet the minimum standards of the NAIC Model Act must comply with a federal external review process which will follow the NAIC Model Act as well.

SUMMARY OF THE BILL'S PROVISIONS

Since the bill is lengthy, I will not endeavor to explain every provision but rather will provide an overview of what it will accomplish. If you have questions as to any specifics in the bill, I would be happy to try to answer them. As the background section of my testimony states, the bill is designed to ensure that the state's appeals process is found to be an "effective" process by the federal government so that our health care consumers and insurers will have available to them an appeals process overseen by the state rather than a federal agency. To accomplish this goal, the bill would incorporate the NAIC Model External Review Act. If HHS determines our state law is not an effective external review process, health plans issued here will have to comply with a federal external review process. In other words, North Dakotans will have to deal with a federal agency when they want to invoke the external review process.

The bill would also incorporate the NAIC Model Utilization Review Act and the Model Grievance Procedures Act. These two models work in tandem with the NAIC Model External Review Act, to provide to consumers the full process of appeals anticipated by PPACA. Each of these three model acts are designed to work together and they refer to the others often as they describe the process of utilization review (the health insurer's initial review of a claim), grievance procedure (internal appeals process), and external review (review by an outside independent entity). In other words, each of the three model acts assumes the existence of the others in state law. Without each of the models, the state's appeals process would lack one of these three levels of review of adverse benefit determinations.

These three models are similar to the levels of review given by our court system, with a trial court giving the first level, the appellate court giving the second level and the Supreme Court giving the final level of review. They work together to ensure a

hierarchical system of review that offers every consumer the exact same process to reach a final determination within expressly stated timelines.

The purpose of each model is:

- Health Carrier External Review Model Act – To provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination. The Insurance Commissioner would be responsible for accepting requests for external review and forwarding them to independent review organizations for a decision.

- Health Carrier Grievance Procedure Model Act – To provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of grievances.

- Utilization Review and Benefit Determination Model Act – To establish standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.

Any process used by a plan to resolve a claim dispute must be conducted without imposing fees on the claimant. The bill also preserves the existing utilization review and external review processes in state law for grandfathered plans. The new law would only apply to nongrandfathered plans.

In summary, plans and insurers must have an effective and fair claims and appeals process. As noted, HHS will determine if the state's process meets the minimum consumer protections. HHS has indicated that the details of the claims and appeal

processes must be codified so we will likely not meet federal requirements if we simply refer to a separate piece of federal law or regulation. I believe that it is important to North Dakotans to ensure these processes are overseen at the state level and not the federal level.

Before this bill was filed, I shared a draft with all the major health insurance companies doing business in North Dakota. Two companies responded with comments. There are a couple of areas where the models used to craft the bill vary from the requirements of the DOL rules which are in the definition of a "grievance" and the voluntary level of review. In conversations we have had with HHS, we were informed that if our state's process follows at least the minimum protections contained in the DOL rules, the state will be allowed to oversee the claims appeal process. If our state process does not have those minimum protections, however, the federal government will almost certainly take over the administration of the external review process. Given that information, we are willing to work with these insurers on amendments that would address these areas to align the requirements of the bill with those of the DOL rules. If the proposed amendments do not, however, follow at least the requirements of the DOL rules, it would be difficult to see how I could support them due to the likely loss of state control.

I do also want to mention that this bill is not an endorsement of PPACA or the wisdom or effectiveness of its provisions. It is merely the means by which the issue of whether the state or federal government should enforce the law is brought before you.

Lastly, the final section of the bill was added to take care of another PPACA consequence. It amends existing N.D.C.C. § 26.1-03-01 to provide an exception for health insurers to the limitation on risks acceptable by insurers. The existing section provides that an insurance company may not expose itself to loss on any one risk or hazard to an amount exceeding 10 percent of its paid-up capital and surplus if a stock company, or 10 percent of its surplus if a mutual company, unless the excess is reinsured.

The amendment provides that an insurance company offering group or individual insurance that is subject to the lifetime or annual benefit limit restrictions of PPACA is not subject to this section. Insurers can no longer impose lifetime or annual benefit limit restrictions on most group or individual health insurance plans. The amendment is being sought because, although in practice it is unlikely that the payouts under any one health insurance policy could exceed 10 percent of a health insurer's surplus, the elimination of the benefit caps by PPACA could result in a conflict with current state law and would mean a company would be out of compliance with surplus or capital requirements.

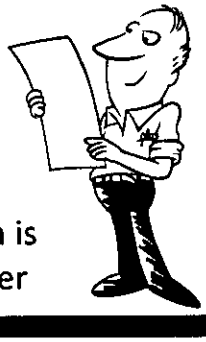
This concludes my testimony. I would be happy to try to answer any questions you may have. Thank you.

HB 1127

Health care claims, grievance, external review process

Step 1. Health care service is rendered to insured

Step 2. Claim is sent to insurer



Step 3. Insurer performs utilization review to determine if claim should be paid

Denied

Approved

Step 4. Insured can invoke grievance procedure: first level review.

Insured can invoke additional voluntary review (optional)

Approved

Denial upheld

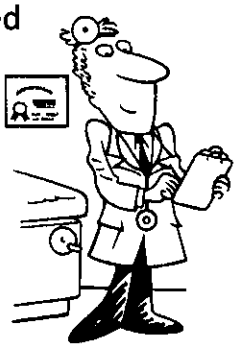
Step 5. Insured can:
- Request external review;
- File a civil suit;
- Ask the Insurance Commissioner for assistance;
- Or all three.

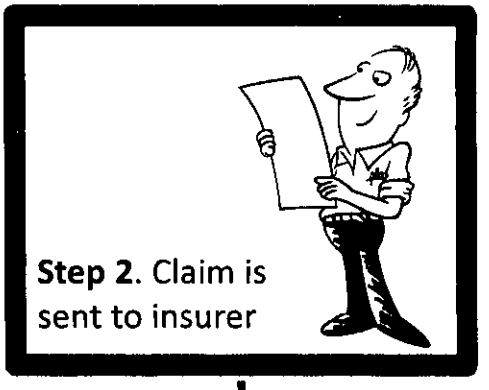
North Dakota INSURANCE DEPARTMENT
PROTECTING THE PUBLIC GOOD

Without HB 1127

Health care claims, grievance, external review process

Step 1. Health care service is rendered to insured





Step 2. Claim is sent to insurer

Step 3. Insurer performs utilization review to determine if claim should be paid

Denied

Approved

Step 4. Insured can invoke grievance procedure: first level review

Approved

Denial upheld

Step 5. Insured can file external review with the federal government

North Dakota INSURANCE

Testimony on House Bill 1127
House Industry Business and Labor Committee
January 17, 2011

Chairman Keiser and members of the House Industry Business and Labor Committee, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota. Because this bill is so complicated and detailed we have representatives from our Legal Department and Medical Management Division here today to answer any technical or operational questions. We support the concept of HB 1127, but are quite concerned about many details within this proposed bill and would like to offer amendments to address these concerns. Our staff have spent extensive time reviewing the 3 original bills and now the combined HB 1127. I think BCBSND and the Insurance Department are after the same goal – to extend jurisdiction to the Insurance Department and incorporate provisions of PPACA regarding External Review, Utilization Review, and the specified grievance procedures. At the same time, we do not think it is in the public's best interest to go beyond what is required by PPACA and the associated regulations which will add costs to already increasing health insurance premiums.

The following includes a comparative analysis between those provisions included in the legislation proposed by the North Dakota Insurance Department through House Bill 1127 related to required claims and appeals procedures that are now mandated for health plans with the requirements in the Patient Protection and Affordable Care Act, PL 111-148, enacted March 23, 2010, and the Health Care and Education Reconciliation Act, PL 111-152, enacted on March 30, 2010, which are referred to in this analysis as PPACA.

BACKGROUND

In the most simplified terms, PPACA extended current *internal* federal claims and appeals requirements adopted during the Clinton Administration in 2001. On July 1, 2002, the U.S. Department of Labor, under authority granted by the Employee Retirement Income Security Act of 1974 (ERISA), put into effect new regulations covering claims procedures for employer-based health plans. These regulations were the first updated claims procedures regulations issued by the federal government since 1977 and had been under development since 1998. The regulations were originally published in the Federal Register in November 2000 to become effective on January 1, 2001, however, after the Bush Administration took office, the applicability date of these regulations was delayed until July 1, 2002. These initial regulations created standards for claims procedures, required greater disclosure of information by insurers, outlined requirements for insurers' appeals processes, and established set timelines for insurers in responding to customer claims and appeals.

INTERNAL CLAIMS AND APPEALS PROCESSES

PPACA establishes two major changes to the current *internal* claims and appeals requirements. The first is to extend these requirements from only group health plans to individual insurance policies and other group health plans not included in the previous requirements. The second was to amend or impose changes to several aspects of the existing regulatory requirements. These changes include expanding the definition of adverse benefit determination to include rescissions, amending the response time for claims for urgent care from 72 hours to 24 hours, implementing new information disclosure requirements providing for "full and fair" review, expanding limitations on "conflicts of interests" for

reviewers, expanding the requirements for notifications to customers, creating guidelines for culturally and linguistically appropriate standards, revising the strict compliance requirements in the previous regulations, and clarifying continuing coverage requirements throughout the appeal process.

The original claims and appeals requirements included specific definitions established by the federal government when implementing these regulations, which were implemented and have been in place and followed by all insurance companies and third party administrators since July 1, 2002. BCBSND implemented these requirements beginning in 2001 effective for its group health insurance business upon the anniversary of any group health plan through July 1, 2002, and BCBSND has been compliant with these requirements since that time. Moreover, because it was not cost-effective to administer two separate claims and appeals processes, BCBSND extended its federally mandated claims and appeals requirements to its fully insured individual book of business as well. In other words, BCBSND has developed timeframes and implemented processes based on the original *internal* claims and appeals requirements for both its fully insured group and individual lines of business that have been in place and followed for over 10 years as of this moment in time.

Critical to the administration of these original *internal* claim and appeals regulations are the definitions included in the federal regulation, which not only defined what constituted a claim for benefits and adverse benefit determination, but also established specific timeframes for claims and appeals reviews dependent upon whether these claims for benefits were *pre-service claims* or *post-service claims*. Again, BCBSND has developed timeframes and implemented processes based on the definitions set forth in the original claims and appeals requirements that have been in place and followed for over 10 years at this moment in time.

Although the state of North Dakota did not enact any legislation in 2001 setting forth mandated claims and appeals requirements available to customers of insurance companies, in 2003 the legislature did enact legislation that applied to all *pre-service claims* that were submitted by health care providers to health insurance companies on behalf of their patients with health insurance. This legislation amended §26.1-26.4-04, N.D.C.C., to track the federal *internal* claims and appeals requirements by specifically referencing the federal laws containing these requirements. *See, e.g.*, §26.1-26.4-04(10), N.D.C.C., "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" *see also* S.L. 2003, ch. 248, §1 (Senate Bill number 2184).

As a result, in regard to the *internal* claims and appeals requirements, all insurance companies in North Dakota were required to comply with these requirements, develop administrative processes, and extend the protections contained with the federal regulations by July 1, 2002, and BCBSND has been providing the protections of these federal laws since that time. Similarly, for all *pre-service claims* (claims involving prior approval or preauthorization for benefits), all insurance companies in North Dakota have been required by state law to meet the *internal* claims and appeals requirements required under federal law. This includes BCBSND.

Proposed House Bill 1127 includes separate legislative requirements that incorporate new definitions and expanded administrative requirements that apply to the *internal* claims and appeals processes that have applied to and have been and administered by insurance companies since 2001, and that expand beyond those amended and new requirements than are required under PPACA. BCBSND proposes to delete those provisions of House Bill 1127 that alter the definitions and administrative processes that apply to *internal* claims and appeals procedures to track the requirements imposed under the original

regulations as now amended by PPACA and recognize the processes that have been in place since 2001. The amended federal *internal* claims and appeals requirements already anticipate a costly administrative burden. Our staff has calculated the additional added costs already anticipated for these new requirements of PPACA. We have estimated that these provisions required by PPACA will increase our costs by approximately $275,000 per year plus $300,000 in one-time implementation costs. BCBSND currently is in the process of developing and implementing these new requirements. But to impose additional layers of administrative requirements, including changing definitions and expanding certain requirements that impact processes already established that are fully compliant with the federal regulations as proposed in House Bill 1127 is unduly burdensome. Our staff has projected that the costs to implement the changes within HB 1127 that go beyond what PPACA will cost **our members and your constituents**, approximately an additional $600,000 annually in addition to the costs we will incur with the PPACA requirements. In addition it is estimated that one-time implementation cost of $50,000. Keep in mind, other provisions within PPACA will have a significant impact on premiums in the future. We need to keep this in mind and try to avoid any unnecessary increases that go beyond the minimal requirements of PPACA.

EXTERNAL APPEALS PROCESS.

PPACA included a new requirement related to health insurance companies and third party administrators that was never before required under federal or North Dakota state law, and this involves an independent external appeals process that was available to members. BCBSND is currently required to meet the federal guidelines as contained in two technical releases issued by the United States Department of Labor. However, these external appeal processes are exceedingly different from the provisions offered by the Department in Section 4 of House Bill 1127. As a result, BCBSND proposes amendments to refer to PPACA legislation and associated rules and regulations.

OTHER PROBLEMATIC PROVISIONS

House Bill 1127 contains an amendment to §26.1-26.4-01, N.D.C.C., that will restrict the ability of insurance companies that want to extend the federal claims and appeals requirements across all company lines of business from doing so and prohibits insurance companies from providing these protections to "grandfathered" health plans, as these plans are defined under PPACA. There may be valid reasons for insurance companies to desire expanding the claims and appeals requirements across all company lines including economies of scale and costs involved with administering two separate claims and appeals processes.

The amendment in Section 3, page 2, lines 12-14, does not comply with the new external review requirements contained in PPACA and does not extend any external appeal protections to consumers (except, perhaps tangentially in the case of pre-service claims). It will permit an avenue of external review to health care providers, which was not contemplated under the federal law, where external appeals were restricted to consumers only. This is one area of great discrepancy between the NAIC model laws and the PPACA requirements, which limit external appeals only to consumers. HB 1127 expands these claims and appeal rights to health care providers, which was never contemplated under the federal regulations or PPACA. Retaining this provision will certainly lead to confusion in regard to the external appeals process required under PPACA and added cost.

Several provisions of the proposed bills contain requirements related to utilization review that conflict with chapter 26.1-26.4, N.D.C.C.

The external review requirements contained in §26.1-36-44, N.D.C.C., remain intact but only for grandfathered plans. This could result in numerous administrative processes and confusion.

Section 6 of House Bill 1127 contains a grievance process but there are no amendments or consideration given to §26.1-36-42, N.D.C.C., a statute entitled, "Grievance procedures". Again, this will require two separate administrative processes and cause confusion.

On page 86, Section 26.1-36.8-07, establishes a "mandatory" voluntary level of reviews of grievances. Not only is such a process not contemplated under the federal claims and appeals requirements adding a costly and unnecessary level of administration not included within PPACA, but it imposes as a mandate a voluntary level of review that is permissive to the insurance company under PPACA. The voluntary hearing process imposes a fiduciary responsibility onto the review committee not contemplated under federal law and usually unwanted by the health plan.

One more example of discrepancies of this bill that is not only problematic, but ultimately very costly deals with page 67, lines 21-23. There is no definition or reference to this in PPACA for "postevaluation or poststabilization services" and the insurer must maintain a designated representative 24/7, which is also not a requirement of PPACA. Because of the nature of the requirement, it would mean that we would have to have a physician available 24/7 even though we don't have preauthorization or prior approval requirements for emergency services.

CONCLUSION

As our staff was going through the bill there were so many proposed amendments and notations of differences between PPACA requirements and the proposed bill, it became apparent that there was a much simpler process to achieve the same goal that we thought both the Insurance Department and BCBSND wanted to achieve - establish a state standard that would be exactly the same as the federal PPACA law and associated regulations. Our proposed solution would be to reference the applicable federal laws instead of adopting the bill offered by the Department. The advantages are:

No unwarranted and not-required administrative process outside of those included in PPACA.

Insurance companies, and the North Dakota legislature, adopted the claims and appeals requirements and have offered these to consumers for over 10 years, and it is far easier and less expensive to just expand the "new" PPACA requirements to the current processes.

Our proposal is far less complicated, easier to understand and implement than the proposed bill.

Our proposal guarantees the same claims and appeals processes for members of both fully insured and self-funded plans (but perhaps not grandfathered and non-grandfathered plans as provided by PPACA).

Should the federal law or the regulations be changed in the future, ND's requirements would be up to date and not require a change during an upcoming legislative session. In addition, if that were to occur with passage of HB 1127, it would result in two different processes for fully insured and self-funded

plans until the legislature made the required changes. We are aware that the federal government is in fact already looking at some changes before the required July 1, 2011, implementation date.

This proposal (referencing the federal law) is common in the Insurance Code (ie NDCC 26.1-36-09.11, NDCC 26.1-36-12, NDCC 26.1-36-44, NDCC 26.1-36.5-05, NDCC 26.1-26.4-04, etc.)

The Department can extend its jurisdiction over the claims and appeals provisions of fully insured plans.

Mr. Chairman and Committee members, this is a very complicated and costly process. It is our hope that the ND Legislature will see the merit in assuring that ND's requirements do not go beyond what is required by PPACA and their regulations. We ask that you adopt our proposed amendments and approve this bill to ensure that the State of North Dakota and the Insurance Commissioner retains jurisdiction in this important aspect of insurance law. We would be willing to answer any questions that the committee may have.

HOUSE BILL NO. 1127

Presented by: **Rebecca Ternes**
Deputy Commissioner
North Dakota Insurance Department

Before: **House Industry, Business and Labor Committee**
Representative George Keiser, Chairman

Date: **February 14, 2011**

TESTIMONY

Good morning, Chairman Keiser and members of the committee. My name is Rebecca Ternes and I am Deputy Insurance Commissioner. I appear before you today to ask that you restore House Bill No. 1127 to the originally proposed bill and adopt an amendment based on extensive feedback from several insurance companies.

The intent of House Bill No. 1127 is to set forth requirements that health insurers must follow when consumers disagree with their determinations regarding coverage. The Patient Protection and Affordable Care Act (PPACA) and federal regulations lay out specifics for how a person might request a reconsideration of an insurer's decision to deny coverage including an insurer's failure to pay based on an individual's eligibility to participate in a plan; that a benefit is not covered or is limited; or that a benefit is experimental, investigational, or not medically necessary. These requirements closely follow procedures long used by companies on the self-insured side of their businesses. PPACA provides a system for either a state external review process or a federal external review process once all internal methods are exhausted.

As Commissioner Hamm stated in his original testimony, the reason the Insurance Department brought this lengthy bill with all of its detail to you is to ensure that the state's appeals process remains within the control of the State of North Dakota and not the federal government. Similar to how we have approached all of the healthcare reform legislation, our goal was to implement the minimum required by PPACA in order to maintain state control.

By July 1, 2011, the U.S. Department of Health and Human Services (HHS) will be reviewing North Dakota's internal claims appeal process and external review process to determine whether they pass muster with the federal requirements. After several lengthy conversations with HHS, we have been informed they do not favor the approach suggested by North Dakota Blue Cross Blue Shield (BCBS) in the amendment incorporated into the bill as it sits today. This approach will risk the state's ability to retain the authority over the handling of external review. This could lead to the possibility of consumers having to "phone a friend" in the federal government for assistance—something the Insurance Department adamantly opposes.

HHS has made it clear they will be very concerned with any states where the process is not clearly laid out for consumers. Without a process laid out clearly in law, how can it be enforced?

The amendments presented by BCBS refer to a federal law and federal regulations. While I realize that from time to time our state law will refer to federal laws or regulations, this trail of federal bureaucratic crumb dropping is not easy for consumers to follow and is not our preference for good, clean policymaking. Most importantly, it is not necessary. Additionally, it appears that the regulations cited in the BCBSND amendment do not deal with health insurance claims or appeals. Page 2 of the proposed amendments cites to "26 CFR 54", which deals with pension excise taxes. It is unclear what this citation intends to refer to—one section of the code or to a group of code sections. Consumers are going to have a difficult time knowing where to find appeal procedures in a regulation that deals with pension excise taxes. The citation to "26 CFR 602" is also unclear in that it does not refer to a particular section or chapter. 26 CFR Part 602 deals with OMB Control Numbers under the Paperwork Reduction Act. Similarly, the cites to "29 CFR 2590" and "45 CFR 147" are unclear as to whether they are intended to refer to one particular section of the code or to a group of code sections. How will consumers be able to go through tens of sections of the Code of Federal Regulations and determine which one applies? This is not consumer friendly nor does it bode well for enforcement.

As to the suggestion that the federal healthcare reform law may change, the amendments proposed will not incorporate any changes that may be made in the future. A bill may adopt by reference an existing law or regulation. But, except for federal income tax laws, a bill may not adopt future amendments. According to State v. Julson, 202 N.W.2d 145 (N.D. 1972); Weber v. Weber, 512 N.W.2d 723, 730-731 (N.D. 1994); McCabe v. N.D. Worker's Compensation Bureau, 567 N.W2d 201 (N.D. 1997); and Article X, Section 3 of the Constitution of North Dakota, once the state law is enacted, it will refer to the federal law and the regulations as they existed on that day. So, if the federal law would change, or the regulations would change, the state law would not change along with them. Courts have found that an attempt to adopt future laws, rules or regulations is an unlawful delegation of legislative power.

In the first hearing it was stated that the originally proposed bill might add to the expenses of insurance companies and, therefore, be passed on to consumers in the form of premiums. We have not been presented the specific costs of each of the processes suggested in this bill. In fact three of the insurers we spoke to about this bill indicated this does not change their business practices at all because all insurers already have this process in place for self-insured business and a number of them for efficiency purposes use it for fully insured business as well.

We have taken a further step with today's amendment to ensure requirements in the legislation that are not specifically required in PPACA are removed such as the ability to have an additional level of voluntary review and requiring a medical expert be on call 24/7 for appeals. We also incorporated BCBS's suggestion that they be given the option to apply this law to grandfathered plans at their discretion.

In enacting the original bill with the Department's amendments you will be assuring that North Dakotans will be able to ask their own Insurance Department for assistance with appeals and not take the risk that instead they will be passed on to a federal agency. They will also be able to go to one place—our state law—and know what their minimum appeal rights are no matter what insurer carries their coverage.

Melissa Hauer, the Department's General Counsel, will be walking through the specifics of the amendments and we will both be available for questions.

Thank you for your consideration.

HB 1127

Consideration of Insurance Department Amendments

February 14, 2011

Mr. Chairman and Committee Members, for the record I am Rod St. Aubyn representing Blue Cross Blue Shield of North Dakota.

We had our Medical Management and Legal staff review the proposed amendments offered by the Insurance Department. While some of the proposed amendments address a few of our concerns, there still remain many items within HB 1127 that go beyond the rules, regulations, and specific language of PPACA. I will address some of their concerns below:

The page 1 change to Section 2 of the bill kind of follows the proposed amendment requested by BCBSND to allow grandfathered plans to follow the federal claims and appeals requirements. However, as I understand this legislation from the Department, the proposed language change does not extend to the initial claim or "grievance", only to Section 5 of HB 1127, regarding appeals of "grievances" or the initial claim for benefits. I would argue that permitting "grandfathered" plans to follow the legislation proposed by the Department under HB 1127 extends administrative requirements significantly beyond PPACA, but to even meet the requirements of the federal law, the amendment proposed by the Department would need to extend to Section 6 of HB 1127, too, governing "grievances" or the initial claim and not just appeals as the proposed amendment does. This may be further evidence of how complicated the bill is. But at a minimum, the requirements included even with the proposed amendments extend way beyond PPACA.

The next significant amendment proposed by the Department, to page 67, line 23, amends language objected to by BCBSND and concerns regarding staffing nurse or doctors 24/7/365 to address post-stabilization or post-evaluation services. This is a requirement that does not currently exist under the federal claims and appeals requirements. Importantly, please note that the Department's solution, to exclude the requirement so long as the insurance company pays any claims incurred during this time period ("or otherwise provide coverage with no financial penalty to the covered person"), is not a satisfactory response to address the concern. The requirement still exceeds the requirements established by PPACA, which has no similar requirement by offering a choice, incur costs of staffing personnel to meet the requirement or incur costs by simply paying the claim. Additionally, to obligate a health plan or insurance company to extend coverage for services under a health plan where these services are not covered benefits or not medically necessary and appropriate is potentially a violation of the plan's fiduciary obligations to the plan participants at its worst, but simply paying claims as a result of expediency certainly is not a sign of being a good steward of member health care dollars. This requirement would also result in a violation of the administrative agreement in place between BCBSND and its employer groups.

The proposed changes on pages 84 through 91 appear to delete the requirements that insurance companies offer the full blown claims and appeals processes for claims NOT involving adverse benefit determinations (which is not required under PPACA), as well as the "voluntary" but mandatory appeals requirement contained in the initial bill (also not required under PPACA), through the removal of certain language. The first concession, eliminating the non-adverse benefit determination requirements, does

provide for some administrative savings from the initial bill, but this requirement was never included as a part of PPACA. Additionally, the mandatory "voluntary" requirements that the Department proposes to remove leave the remaining bill very confusing and maintain additional administrative requirements not included in PPACA that will add cost to administering fully insured health plans. The proposed HB 1127 still appears to require an insurance company to: provide a statement to a covered person that there is no voluntary level of review and a statement directing a covered person to contact the Department, requirements outside of any administrative directive contained in PPACA.

The remaining proposed amendments simply correct the section number changes brought about by the removal of the two provisions described above.

There still exist additional provisions that go beyond PPACA. There are numerous additional administrative reports and surveys that need to be submitted to the Department, extending the scope of the federal claims and appeals and external review requirements beyond PPACA to include, e.g., health care providers, and other costly administrative burdens not otherwise required under PPACA. Additionally, these bills as engrossed together are confusing and do not appear to flow freely together but in several instances contain repetitive and, worse, contradictory provisions. The bill also remains confusing in light of two existing North Dakota statutory requirements, and through the use of terms and concepts included in the NAIC model acts that do not appear in the federal claims and appeals requirements.

This bill also extends appeal rights to medical providers, not intended within PPACA. The bill as proposed also would extend jurisdiction by fiat to the Department over numerous reimbursement issues normally the subject of contract between BCBSND and its participating providers through the definitions included in the proposed HB 1127 and through the fact that many of the coding /bundling reimbursement issues are easily transposed over to the claims and appeals process. This is an aspect of the NAIC model acts verified and acknowledged by commentators addressing these model acts, as represented in HB 1127. And it results in a significant extension of the covered person's claims and appeal rights significantly beyond those contained in PPACA.

The only time the federal claims and appeals requirements refer to health care providers in acting on behalf of a claimant is in 29 CFR Section 2560.503-1(b)(4), wherein the regulations provides: "The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, . . . a health care professional . . ., with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative." What this language means is that a claimant may have any person act on their behalf as an authorized representative so long as the claimant follows the plan's reasonable procedure for becoming authorized, except in cases involving a claim for urgent care, in which case the health care provider may act so long as the provider is familiar with the claimant's medical condition. In other words, except in cases involving urgent care, the plan can require an authorization process before a provider can seek reimbursement for a claim.

In the definitions of "authorized representative" included throughout HB 1127, in particular in Section 5 and Section 6, the authorization process left up to the plan under federal law is changed by requiring

only consent by the claimant. None of these definitions appear under PPACA or other federal laws. This consent requirement undermines the concept of the federal regulations by allowing a claimant the authority to simply "consent" to the representation by a provider in these instances, where the federal requirements permit a process developed by the plan. As with claims for urgent care, which do not allow this authorization process, BCBSND is certain to see an increase in claims and appeals by providers, some of whom may simply include such "consent" in their intake and other registration forms presented to their patients. This will result in added administrative costs and additional claims paid, and more cost. It will also require changes to current BCBSND administrative processes that currently meet and follow the federal claims and appeals requirements. And through this simple "consent" process, it will be relatively easy for providers to turn normally reimbursement issues involving coding, as an example, into a denial of a benefit under the health plan, and implication of this entire review process, occasionally without even the covered person's knowledge.

Medical management staff also noted some areas of concern which are presented below:

I get a bit confused by their definition of "Grievance" and how they intend to regulate within the appeals process. On page 71 is the definition of Grievance which is a complaint related to 3 issues. One of the issues is a complaint about adverse benefit determinations (Letter a). Letters b and c seem to mean anything else a member wishes to appeal (reimbursement, claims payment, a non-covered benefit etc.). Since they are amending this section to remove 26.1-36.8-06 (pages 84, 85) how are we to apply a "grievance" procedure for issues b and c? Or doesn't it matter and their appeal process regulation doesn't have to include processes for the entire definition?

We previously proposed amendments that your committee adopted that would simply make ND law the same as required under PPACA. That way, you can be assured that ND standards are not more than that required by PPACA. This is not unusual. It has occurred in numerous locations of the Insurance laws within the ND Century Code. I referenced many of those in my previous testimony. I have included some of those highlighted sections for your benefit.

The requirements for these areas are clearly laid out or will soon be adopted by government agencies and are the minimal standard that must be applied to all self funded and fully insured products. States may adopt additional standards for fully insured products, but are precluded from doing so on self funded plans. About 50% of our market is covered by the self funded plans.

One final note that I want to emphasize for the committee is very important to understand. The rules and regulations for the appeals process within PPACA are still evolving. I wanted to share with you a memo that I received last Thursday. There was conference call with the BCBS Association and members of our Reform Task Force. Their discussions were a summary of meetings with Federal agencies adopting rules, regulations, and guidance for PPACA. You will note that several changes are expected to be made within the next two weeks. By simply adopting our amendments, we can be assured that these changes will be reflected in ND's law and will eliminate the need to have two appeal processes – one for fully insured plans and a different one for self-funded plans.

Mr. Chairman and committee members, we urge you to adopt the amendments you previously adopted and not include these amendments which will expand requirements beyond PPACA and will increase costs for our members.

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.

26.1-36.5-05. Authority and jurisdiction. This chapter is adopted pursuant to the requirements of sections 4301 and 13623 of Public Law 103-66 [107 Stat. 312; 29 U.S.C. 1161 et seq. and 42 U.S.C. 1396g-1]. The commissioner may take any action reasonably necessary to enforce this chapter and section 26.1-36-12. Any insurer subject to the provisions of this chapter or section 26.1-36-12 must submit to the jurisdiction of the commissioner and to the courts of this state to the greatest extent permitted under state or federal law.

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.

Rod St. Aubyn

[redacted]m: Tim Huckle
[redacted]nt: Thursday, February 10, 2011 3:00 PM
To: Mark Tschider; Paul von Ebers; Dan Ulmer; Rod St. Aubyn; Bob Stroup; Brad Bartle; Kimberly Myers; Judd Wagner; Denise Kolpack
Subject: Guidance Coming on Appeals Rule

On BCBSA Reform Task Force call.

Just heard that we are expecting guidance in the next two weeks that will:

- Eliminate the requirement for ICD codes on the EOB. It sounds like we may need to add a tag line indicating the code information is available upon request.
- There is also a softening on the linguistic translation thresholds for members. There are moving to a county by county 10% threshold. We may not have any counties that reach a 10% threshold for any one language so this change may not affect us. Kim, do we have any counties with 10% of higher population speaking a specific language other than English?
- Urgent Claims – Going back to the 72 hours requirement with some education and compliance required.
- Administration is asking if we can be compliant by 7/1/11.

[redacted]

Tim Huckle
Chief Operating Officer
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[redacted]

HOUSE BILL NO. 1127

Presented by: **Rebecca Ternes**
Deputy Commissioner
North Dakota Insurance Department

Before: **House Industry, Business and Labor Committee**
Representative George Keiser, Chairman

Date: **February 16, 2011**

TESTIMONY

Good morning, Chairman Keiser and members of the committee. My name is Rebecca Ternes. I am the Deputy Insurance Commissioner.

I stand before you on House Bill No. 1127 to reiterate the ultimate decision that you have to make with this bill. The choice is whether to have the state or federal government oversee health insurance appeals. If you want the state to oversee the process, the U.S. Department of Health and Human Services (HHS) has indicated that the bill as introduced or with the Department's amendments would almost certainly accomplish that goal.

Adopting the approach in the amendments written by Blue Cross Blue Shield (BCBS) substantially increases the risk of losing oversight of this process to the federal government. Again, this is a choice between one approach that has the best chance of maintaining state control and another approach where the risk of losing that control is increased.

Thank you and I would be happy to take any questions.

February 8, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1127

Page 1, line 20, after "plans" and before the period insert "unless a health care insurer or utilization review agent determines to extend the protections of section 5 of this Act to a grandfathered plan"

Page 9, line 26, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 13, line 10, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 13, line 16, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 13, line 30, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 14, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 20, line 23, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 20, line 28, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 63, line 23, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 67, line 23, after "review" and before the period insert "or otherwise provide coverage with no financial penalty to the covered person"

Page 71, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 76, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 76, remove lines 10 through 12

Page 76, line 13, replace "4." with "3."

Page 76, line 20, replace "5." with "4."

Page 76, line 22, replace "6." with "5."

Page 77, remove lines 2 through 4

Page 77, line 5, replace "(e)" with "(d)"

Page 77, line 6, replace "(f)" with "(e)"

Page 77, line 7, replace "(g)" with "(f)"

Page 77, line 8, replace "(h)" with "(g)"

Page 77, line 12, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 77, line 14, remove ", 26.1-36.8-06, and 26.1-36.8-07"

Page 77, line 16, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 77, line 21, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 77, line 31, remove ", 26.1-36.8-06, and 26.1-36.8-07"

Page 83, line 8, remove "the covered person wishes to request"

Page 83, line 9, replace "pursuant to section 26.1-36.8-07" with "is offered by the health carrier"

Page 84, remove lines 11 through 31

Page 85, remove lines 1 through 30

Page 86, remove lines 1 through 29

Page 87, remove lines 1 through 30

Page 88, remove lines 1 through 30

Page 89, remove lines 1 through 30

Page 90, remove lines 1 through 30

Page 91, remove lines 1 through 2

Page 91, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 94, line 26, replace "26.1-36.8-09" with "26.1-36.8-07"

Page 94, line 28, replace "26.1-36.8-10" with "26.1-36.8-08"

Renumber accordingly

#1

Testimony on Engrossed House Bill No. 1127
Senate Human Services Committee
Rep. George Keiser

Madam Chair and Committee members, I am Rep. George Keiser, representing District 47 in Bismarck.

I was asked to introduce this bill by the Insurance Department. The House Industry Business and Labor committee, which I chaired, originally heard this bill. The Patient Protection and Affordable Care Act, often referred as PPACA, established some minimum health insurance appeal processes. In order to give the Insurance Commissioner the authority to enforce these new federal requirements, it is necessary for the state to establish its own state law that is comparable or stricter than the federal law. The original bill included the components of three National Association of Insurance Commissioners (NAIC) model acts. These 3 components included model acts for Internal Appeals, External Appeals, and Utilization Review. It came to us as a 95 page bill. Testimony heard in our committee indicated that the proposed bill went beyond the minimum requirements of PPACA. In addition, we became aware that federal agencies were considering changes that were less stringent than those issued last year in the federal interim final regulations. These interim final regulations are scheduled to be finalized on July 1, 2011.

Our committee was concerned about all of the anticipated additional costs associated with PPACA. Amendments were offered by representatives from Blue Cross Blue Shield to basically say that ND's laws regarding Internal Appeals, External Appeals, and Utilization Review would be the same as the requirements of PPACA, but nothing more than that. We ultimately adopted those amendments. If there are changes in the future to the federal law or regulations, the engrossed bill makes it clear that the Insurance Commissioner is to adopt administrative rules to make sure the state law remains "substantively equivalent to the federal requirements". The insurance Department did not support the proposed amendments and felt that more specificity is needed in order for HHS to

certify that the state can enforce the minimum PPACA requirements. While we respect their opinion, we felt that if there are enough specifics in federal law and regulations for self-funded plans which the federal government must regulate, then those same specified federal law and regulations should be adequate for the Insurance Department to regulate for fully insured plans.

In addition, the Department thought that it was important to have all the regulations spelled out in the Century Code rather than a reference to the federal law and regulations in order for the consumer to be knowledgeable. However, our committee was informed that the new law requires that an insurer must specify the appeal process in their benefit books that each insurance policyholder gets. These benefit books must be approved by the Insurance Department. In addition, our committee felt that the Insurance Department staff would have the expertise to assist any consumer in explaining the appeal processes if needed.

Madam Chair and committee members, I will attempt to explain the different sections of the bill as approved by our committee and the full House.

Section 1 is language offered by the Insurance Department in the original bill to amend provisions of NDCC 26.1-03-01 regarding limitations on risks acceptable by company. I will let the Department describe that further in their testimony.

Section 2 adopts language to give flexibility to health insurers to decide if they wish to adopt internal appeals provisions to "grandfathered plans" under PPACA. Currently these "grandfathered plans" do not have to comply with the internal appeal provisions, but this section allows flexibility to health insurers to establish the same standard if they desire to for business reasons.

Section 3 is the section that clarifies that this section dealing with independent external reviews applies to "grandfathered" plans as defined by PPACA. It also states that if the federal rules or law change, the Insurance Commissioner must adopt rules to make sure ND's laws are "substantively" equivalent to the federal requirements.

Section 4 establishes that the ND law for **external appeal procedures** is the same as the federal requirement. It also contains the same language that if the federal

rules or law change, the Insurance Commissioner must adopt rules to make sure ND's laws are "substantively" equivalent to the federal requirements.

Section 5 establishes that the ND law for **internal appeal procedures** is the same as the federal requirement. It also contains the same language that if the federal rules or law change, the Insurance Commissioner must adopt rules to make sure ND's laws are "substantively" equivalent to the federal requirements.

Section 6 is application language that our committee amended in all of the PPACA bills that states that the Insurance Commissioner is to update our interim committees on issues regarding PPACA and any changes being made at the federal level. It directs the Insurance Commissioner to prepare any proposed legislation for an anticipated special legislative session this fall.

Section 7 includes the emergency clause because these new standards are supposed to go into effect on July 1, 2011.

Madam Chair and Committee Members, after our committee approved this bill and the full House approved Engrossed HB 1127, we discovered that we needed to make a simple correction. I have an amendment to make that correction. I will explain the amendment now.

Explanation of Proposed Amendments to Engrossed House Bill No 1127

The Engrossed Bill as amended in the House included the emergency clause. That means that the law would become effective at the time of signature of the Governor and filing by the Secretary of State.

According to the Legislative Council, when this bill references a federal law and regulations, it means that the state law would be the same as such reference **at the time of enactment**. Interim Final Regulations were initiated with an enforcement date of July 1, 2011. As a result, we need to clarify that that the effective date would be July 1, 2011.

In addition recent discussions between Insurers and the Department of Labor seem to indicate possible changes to their rules within the next few weeks that could lessen the requirements of the current regulations. If that was to occur between the time of passage of this bill and July 1, 2011, we need the first part of these amendments to make it clear that our state law is the same as PPACA with its regulations on the effective date – July, 2011.

I worked with the legal staff at the Legislative Council to address these issues which is what is reflected in these amendments.

As previously stated, after July 1, 2011, if there are future changes to PPACA or its associated regulations, then the Insurance Commissioner must adopt administrative rules to make sure the state law remains "substantively equivalent to the federal requirements". It was intention to never go beyond the minimal requirements of PPACA.

Madam Chair and Committee Members, I hope this fully explains the engrossed bill and my proposed amendments. There are others here that could probably answer the more technical nature of the bill, but I would attempt to answer questions related to the House IBL Committee's work on this very important bill. I would urge that you adopt my proposed amendment and that you give this bill as amended a Do Pass as Amended.

#1.a

11.8111.03001
Title.

Prepared by the Legislative Council staff for
Representative Keiser
March 9, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1127

Page 1, line 5, after the second semicolon insert "to provide an effective date;"

Page 4, line 1, after the second boldfaced period insert "The citations to federal laws and rules in this Act refer to the versions in effect on the effective date of this Act."

Page 4, after line 8, insert:

"**SECTION 7. EFFECTIVE DATE.** This Act becomes effective on July 1, 2011."

Renumber accordingly

#2

Testimony on HB 1127

Senate Human Services Committee 3/16/11

Madam Chair and members of the committee I'm Dan Ulmer representing Blue Cross Blue Shield of North Dakota and we support this bill as sent you from the House.

HB 1127 came in as a 95 page bill intended to allow North Dakota's Insurance Commissioner to implement and regulate the appeals rights explicated in the Patient Protection and Affordable Care Act (PPACA)by establishing those appeals in state law. The original bill included numerous sections from several model acts put forth by the National Association of Insurance Commissioners (NAIC).

As you can imagine we at BCBSND have spent a significant amount of time and effort attempting to comply with the various sections and ensuing requirements contained in PPACA. That process involves paying close attention to the federal rules promulgation process. As each rule has come forward we have done our best to implement it.

BCBSND has fully committed to complying with PPACA and doing that has required us to establish work groups composed of our experts along with outside counsels. These folks have exerted an incredible amount of vigilance in assuring that the solutions we implement not only meet PPACA's requirements but also serve our members in the best way we can.

As you know there are still many federal rules forthcoming, essential benefits, exchanges, and, amongst others, the appeals rules that are the topic of HB1127. The interim appeals rules have surfaced but they are still not fully promulgated and our sources in Washington DC that are working directly with the various departments charged with promulgation (the White House, Dept of Labor, Health and Human Services ,and the IRS) indicate that several significant changes are still forthcoming.

When HB1127 was introduced our internal workgroup examined it closely and discovered that many of the requirements in the bill went far beyond the minimum requirements in PPACA and promulgated rules. So given that the rules are not fully promulgated and the fact that HB1127 went far beyond what we knew about the existing requirements we asked the House to amend the bill to not go beyond what PPACA requires and they did so.

In particular we are very concerned that if the original HB1127 passed without our amendments we insurers would end up with two differing appeals procedures.

As you know self funded plans are only subject to federal law (regulated by the Dept. of Labor) and fully insured are subject to state regulation (regulated by the ND Insurance Dept.). So if the original 1127 had passed unamended we would have ended up with two different appeals procedures depending on who gets to regulate the plan. It makes sense to us and will be much simpler for patients and their families, as well as providers, to only have to navigate their concerns through one set of appeal rights and that would be one of the more important reasons we asked for HB1127 to be amended and as you can see the House agreed.

Thus HB 1127 as amended will assure that North Dakota will have the same appeals process for both the fully insured and self funded plans. Should federal regulations change in the future amendments in the house provide that the Insurance Commissioner must adopt administration rules to replicate and not exceed the minimum requirements of PPACA.

Madam Chair and members of the committee this was not an easy task for us or the insurance department or the House IBL committee. The House IBL committee held several hearings on this issue as they attempted to understand the nuances and details involved in assuring that patients were treated fairly when they feel their health claims are unfairly denied and such.

However, as Representative Keiser said in his testimony to you, the committee came to the same conclusion that our internal work group did and that is North Dakota law should not expand beyond what PPACA requires.

Madam Chair in an attempt to be brief and to the point I have been scant on describing the details of the appeals process. I am not an expert in this arena , however I do have two of our experts in the room today that came in from Fargo to assist you in this area if you so desire.

Thank you for your time and we will attempt to answer any questions you might have.

Dan Ulmer

AVP Government Relations BCBSND

ENGROSSED HOUSE BILL NO. 1127

#3

Presented by: **Adam Hamm**
Insurance Commissioner
North Dakota Insurance Department

Before: **Senate Human Services Committee**
Senator Judy Lee, Chairman

Date: **March 16, 2011**

TESTIMONY

Good morning, Chairman Lee and members of the committee. My name is Adam Hamm, North Dakota's Insurance Commissioner. I appear before you today in opposition to Engrossed House Bill No. 1127 and ask that you restore the language of the bill as introduced and adopt amendments that the Insurance Department prepared in February following extensive feedback from several insurance companies.

The intent of the original bill was to set forth requirements that health insurers must follow when consumers disagree with their determinations regarding coverage. The Patient Protection and Affordable Care Act (PPACA) and federal regulations lay out specifics for how a person might request a reconsideration of an insurer's decision to deny coverage including an insurer's failure to pay based on an individual's eligibility to participate in a plan; that a benefit is not covered or is limited; or that a benefit is experimental, investigational, or not medically necessary. These requirements closely follow procedures long used by companies on the self-insured side of their businesses. PPACA provides a system for either a state external review process or a federal external review process once all internal methods are exhausted.

As I stated in my original testimony on this bill in the House (which is attached to this document), the reason the Insurance Department originally supported House Bill No. 1127 was to ensure that the state's appeals process remains within the control of the State of North Dakota and not the federal government. Similar to how we have

approached all of the health care reform legislation, our goal was to implement the minimum required by PPACA in order to maintain state control.

By July 1, 2011, the U.S. Department of Health and Human Services (HHS) will review North Dakota's internal claims appeal process and external review process to determine whether they pass muster with the federal requirements. HHS has made it clear it will be very concerned with any states where the process is not clearly laid out for consumers. After several lengthy conversations with HHS, we have been informed they do not favor the approach included in Engrossed House Bill No. 1127. This approach will risk the state's ability to retain the authority over the handling of external review. This could lead to the possibility of consumers having to go to the federal government for assistance—something that the Insurance Department opposes.

In the House, it was suggested that Engrossed House Bill No. 1127, which basically just refers to a federal law and regulations, was the proper course of action because PPACA may change, but it is important to understand that Engrossed House Bill No. 1127 will not incorporate any changes that may be made in the future. A bill may adopt by reference an existing law or regulation. But, except for federal income tax laws, a bill may not adopt future amendments. According to State v. Julson, 202 N.W.2d 145 (N.D. 1972); Weber v. Weber, 512 N.W.2d 723, 730-731 (N.D. 1994); McCabe v. N.D. Worker's Compensation Bureau, 567 N.W2d 201 (N.D. 1997); and Article X, Section 3 of the Constitution of North Dakota, once the state law is enacted, it will refer to the federal law and the regulations as they existed on that day. So, if the federal law would change, or the regulations would change, the state law would not change along with them. Courts have found that an attempt to adopt future laws, rules or regulations is an unlawful delegation of legislative power.

Also, in the House it was stated that the original proposed bill might add to the expenses of insurance companies and, therefore, be passed on to consumers in the form of premiums. We have not been presented the specific costs of each of the processes suggested. In fact three of the insurers we spoke to about this bill indicated this does not change their business practices at all because all insurers already have

this process in place for self-insured business and a number of them for efficiency purposes use it for fully insured business as well.

We have taken a further step with the amendments we prepared over the last few weeks in consultation with numerous insurance companies to ensure requirements in the legislation that are not specifically required in PPACA are removed such as the ability to have an additional level of voluntary review and requiring a medical expert be on call 24 hours a day, 7 days a week for appeals. We also incorporated Blue Cross Blue Shield of North Dakota's suggestion that insurers be given the option to apply this law to grandfathered plans at their discretion.

By enacting the original bill with the Department's amendments you will be assuring that North Dakotans will be able to ask their own Insurance Department for assistance with appeals and not take the risk that instead they will be passed on to a federal agency. They will also be able to go to one place—our state law—and know what their minimum appeal rights are no matter which insurer carries their coverage.

The bottom line here is that this is a choice between one approach that has the best chance of maintaining state control and not losing oversight of this process to the federal government (original House Bill No. 1127 with amendments we have prepared) and another approach where the risk of losing that control is substantially increased (Engrossed House Bill No. 1127).

Thank you and I would be happy to attempt to answer any questions you may have.

HOUSE BILL NO. 1127

Presented by: **Adam Hamm**
Commissioner
North Dakota Insurance Department

Before: **House Industry, Business and Labor Committee**
Representative George Keiser, Chairman

Date: **January 17, 2011**

TESTIMONY

Good morning, Chairman Keiser and members of the committee. My name is Adam Hamm, the North Dakota Insurance Commissioner. I appear before you today in support of House Bill No. 1127.

This bill was brought due to the federal health care reform law that was signed into law on March 23, 2010. The law, known as the Patient Protection and Affordable Care Act, was followed one week later by the enactment of the Health Care and Education Reconciliation Act of 2010. These laws are sometimes referred to as "federal health care reform", or "PPACA". I will refer to them as "PPACA".

PPACA is lengthy and deals with many topics related to health care reform. This bill deals only with the requirement that group health plans and health insurers implement an "effective" process for appeals of coverage determinations and claims, including an internal claims appeal process (meaning an appeal within the company) and an external review process (meaning asking an independent third party to review an appeal).

BACKGROUND

Some background information will be helpful in understanding the bill. PPACA provides that plans and issuers must initially incorporate the internal claims and appeals

processes set forth in regulations issued in 2000 by the U.S. Department of Labor for plans covered by the Employee Retirement Income Security Act (ERISA). Those regulations require that every employee benefit plan establish and maintain reasonable claims procedures governing the filing of benefit claims, notification of benefit determinations and appeal of adverse determinations.

An "adverse determination" means a determination by a health insurance company that a request for payment of a benefit does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational. The requested benefit is, therefore, denied, reduced, or terminated by the health insurer. It also includes the health insurer's rescission of a health insurance policy due to fraud or misrepresentation by the insured. Essentially, an adverse benefit determination occurs when someone with health insurance received a health care service or treatment and the health insurer declines to pay, either in whole or in part. This bill deals with the procedures that the health insurance consumer can use to appeal the insurer's decision.

PPACA recognized that the 2000 Department of Labor regulations contained an existing standard for this appeals process in those plans governed by ERISA and that process could be used as the basic model to be applied to all health insurance issuers. PPACA also added some additional requirements to the claims appeals procedures which were explained in regulations issued on July 22, 2010, by the Departments of Treasury, Labor, and Health and Human Services (HHS). The regulations contained the requirements for the internal claims and appeals procedures for group health plans and a new requirement for an external appeals process. The new requirements generally apply to insured and self-insured group health plans beginning with the first plan year commencing on or after September 23, 2010, but do not apply to group health plans that are treated as "grandfathered plans."

It is important to note that most of the health insurers doing business in North Dakota today also administer some self-insured, ERISA plans in and out of our state and, therefore, are already required to use these appeals processes.

Changes to Internal Claims and Appeals Procedures

A group health plan and a health insurer must implement an effective process for appeals of coverage determination and claims. This appeals process must include, at a minimum, the following[1]:

- An established internal claims appeal process;
- A notice to participants, in a "culturally and linguistically appropriate manner", of available internal and external appeals processes, including the availability of assistance with the appeals processes; and
- A provision allowing an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeal process.

Health insurers offering individual coverage and any issuers that were not initially subject to existing Department of Labor claims appeals rules may initially use claims and appeals procedures under any other applicable law, such as individual state insurance requirements. Insurers are now required, however, to update these procedures specified in the 2010 HHS regulations. The 2010 regulations create the following six new requirements that supplement the existing ERISA claims and appeals procedures:

[1] Act Sec. 1001(5) of the Patient Protection and Affordable Care Act, as amended by Act Sec. 10101(g), adding Public Health Service Act Sec. 2719(a)(1)).

- First, the definition of an "adverse benefit determination" that is subject to the new internal appeals procedures has been expanded to include a "rescission of coverage."

- Second, the maximum time period within which a plan must notify a claimant of the determination of an urgent care claims is reduced from 72 hours to 24 hours after receipt of such claim, unless the claimant fails to provide sufficient information for the plan to determine whether, or to what extent, benefits are covered or payable.

- Third, claimants must be allowed to review the claim file and present "evidence and testimony" as part of the internal claim and appeal process. Upon review of a denial of a claim, plans must now provide to the claimant, free of charge:

    - Any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim, and

    - Any new or additional rationale that will be used as a basis for the denial of the claim on appeal or review. Plans must provide such information in advance of any final internal adverse benefit determination so that the claimant has a reasonable opportunity to respond prior to the determination.

- Fourth, plans must take additional steps to avoid conflicts of interest and ensure independence and impartiality in the appeals process.

- Fifth, a notice of an adverse benefit determination must include significantly more disclosures, including diagnosis, treatment, and denial codes and an explanation of those terms.

- Finally, if a plan fails to comply with all requirements of the internal claims and appeals process, a claimant will be deemed to have exhausted the process and, therefore, will be eligible to seek external review or judicial review of the claim. This remedy is available even if the plan has substantially complied with these requirements or the error was de minimis.

In addition to these six requirements, the 2010 regulations require group health plans to continue coverage pending the outcome of an internal appeal of an adverse benefit determination. Plans are generally prohibited from reducing or terminating an ongoing course of treatment without notice and an opportunity to review, and individuals in urgent care situations and those receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

New Process for External Review of Appeals

The 2010 regulations also provide details of the new external review process for appeals of final internal adverse benefit determinations and rules determining whether a state or federal external review process applies.

Under the new regulations, an insured group health plan that is already subject to an existing state external review process must continue to comply with the applicable state process if such process includes, at a minimum, the consumer protections set forth in the National Association of Insurance Commissioners' Uniform Model Act as in effect on July 23, 2010 (the "NAIC Model Act"). However, the regulations provide for a transition period, such that all existing state external review processes are deemed to be in compliance with the requirements until the first day of the first plan year beginning on or after July 1, 2011, after which time the Department of Health and Human Services will determine whether a state's external review process complies with the requirements of the NAIC Model Act.

Plans that do not meet the minimum standards of the NAIC Model Act must comply with a federal external review process which will follow the NAIC Model Act as well.

SUMMARY OF THE BILL'S PROVISIONS

Since the bill is lengthy, I will not endeavor to explain every provision but rather will provide an overview of what it will accomplish. If you have questions as to any specifics in the bill, I would be happy to try to answer them. As the background section of my testimony states, the bill is designed to ensure that the state's appeals process is found to be an "effective" process by the federal government so that our health care consumers and insurers will have available to them an appeals process overseen by the state rather than a federal agency. To accomplish this goal, the bill would incorporate the NAIC Model External Review Act. If HHS determines our state law is not an effective external review process, health plans issued here will have to comply with a federal external review process. In other words, North Dakotans will have to deal with a federal agency when they want to invoke the external review process.

The bill would also incorporate the NAIC Model Utilization Review Act and the Model Grievance Procedures Act. These two models work in tandem with the NAIC Model External Review Act, to provide to consumers the full process of appeals anticipated by PPACA. Each of these three model acts are designed to work together and they refer to the others often as they describe the process of utilization review (the health insurer's initial review of a claim), grievance procedure (internal appeals process), and external review (review by an outside independent entity). In other words, each of the three model acts assumes the existence of the others in state law. Without each of the models, the state's appeals process would lack one of these three levels of review of adverse benefit determinations.

These three models are similar to the levels of review given by our court system, with a trial court giving the first level, the appellate court giving the second level and the Supreme Court giving the final level of review. They work together to ensure a

hierarchical system of review that offers every consumer the exact same process to reach a final determination within expressly stated timelines.

The purpose of each model is:

- Health Carrier External Review Model Act – To provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination. The Insurance Commissioner would be responsible for accepting requests for external review and forwarding them to independent review organizations for a decision.

- Health Carrier Grievance Procedure Model Act – To provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of grievances.

- Utilization Review and Benefit Determination Model Act – To establish standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.

Any process used by a plan to resolve a claim dispute must be conducted without imposing fees on the claimant. The bill also preserves the existing utilization review and external review processes in state law for grandfathered plans. The new law would only apply to nongrandfathered plans.

In summary, plans and insurers must have an effective and fair claims and appeals process. As noted, HHS will determine if the state's process meets the minimum consumer protections. HHS has indicated that the details of the claims and appeal

processes must be codified so we will likely not meet federal requirements if we simply refer to a separate piece of federal law or regulation. I believe that it is important to North Dakotans to ensure these processes are overseen at the state level and not the federal level.

Before this bill was filed, I shared a draft with all the major health insurance companies doing business in North Dakota. Two companies responded with comments. There are a couple of areas where the models used to craft the bill vary from the requirements of the DOL rules which are in the definition of a "grievance" and the voluntary level of review. In conversations we have had with HHS, we were informed that if our state's process follows at least the minimum protections contained in the DOL rules, the state will be allowed to oversee the claims appeal process. If our state process does not have those minimum protections, however, the federal government will almost certainly take over the administration of the external review process. Given that information, we are willing to work with these insurers on amendments that would address these areas to align the requirements of the bill with those of the DOL rules. If the proposed amendments do not, however, follow at least the requirements of the DOL rules, it would be difficult to see how I could support them due to the likely loss of state control.

I do also want to mention that this bill is not an endorsement of PPACA or the wisdom or effectiveness of its provisions. It is merely the means by which the issue of whether the state or federal government should enforce the law is brought before you.

Lastly, the final section of the bill was added to take care of another PPACA consequence. It amends existing N.D.C.C. § 26.1-03-01 to provide an exception for health insurers to the limitation on risks acceptable by insurers. The existing section provides that an insurance company may not expose itself to loss on any one risk or hazard to an amount exceeding 10 percent of its paid-up capital and surplus if a stock company, or 10 percent of its surplus if a mutual company, unless the excess is reinsured.

The amendment provides that an insurance company offering group or individual insurance that is subject to the lifetime or annual benefit limit restrictions of PPACA is not subject to this section. Insurers can no longer impose lifetime or annual benefit limit restrictions on most group or individual health insurance plans. The amendment is being sought because, although in practice it is unlikely that the payouts under any one health insurance policy could exceed 10 percent of a health insurer's surplus, the elimination of the benefit caps by PPACA could result in a conflict with current state law and would mean a company would be out of compliance with surplus or capital requirements.

This concludes my testimony. I would be happy to try to answer any questions you may have. Thank you.

3(04)

February 8, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1127

Page 1, line 20, after "plans" and before the period insert "unless a health care insurer or utilization review agent determines to extend the protections of section 5 of this Act to a grandfathered plan"

Page 9, line 26, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 13, line 10, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 13, line 16, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 13, line 30, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 14, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 20, line 23, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 20, line 28, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 63, line 23, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 67, line 23, after "review" and before the period insert "or otherwise provide coverage with no financial penalty to the covered person"

Page 71, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 76, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 76, remove lines 10 through 12

Page 76, line 13, replace "4." with "3."

Page 76, line 20, replace "5." with "4."

Page 76, line 22, replace "6." with "5."

Page 77, remove lines 2 through 4

Page 77, line 5, replace "(e)" with "(d)"

Page 77, line 6, replace "(f)" with "(e)"

Page 77, line 7, replace "(g)" with "(f)"

Page 77, line 8, replace "(h)" with "(g)"

Page 77, line 12, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 77, line 14, remove ", 26.1-36.8-06, and 26.1-36.8-07"

Page 77, line 16, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 77, line 21, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 77, line 31, remove ", 26.1-36.8-06, and 26.1-36.8-07"

Page 83, line 8, remove "the covered person wishes to request"

Page 83, line 9, replace "pursuant to section 26.1-36.8-07" with "is offered by the health carrier"

Page 84, remove lines 11 through 31

Page 85, remove lines 1 through 30

Page 86, remove lines 1 through 29

Page 87, remove lines 1 through 30

Page 88, remove lines 1 through 30

Page 89, remove lines 1 through 30

Page 90, remove lines 1 through 30

Page 91, remove lines 1 through 2

Page 91, line 3, replace "26.1-36.8-08" with "26.1-36.8-06"

Page 94, line 26, replace "26.1-36.8-09" with "26.1-36.8-07"

Page 94, line 28, replace "26.1-36.8-10" with "26.1-36.8-08"

Renumber accordingly

#4

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SANFORD
HEALTH PLAN

Lisa Carlson, Director of Planning and Regulation
Sanford Health Plan
Testimony on HB 1127

March 15, 2011

Sanford Health Plan is submitting this letter to testify against the amended version of HB1127 and respectfully request that the Insurance Department's original version be re-instated. On January 7, 2011, I held conference call with Deputy Commissioner Rebecca Ternes to discuss the technical aspects of this bill. This call with the Insurance Department was followed up with a letter dated on January 14, requesting, minor modifications to the bill based on our experience in with the NAIC model in South Dakota. The Department incorporated such changes into the original bill. On February 8, the bill was amended and stripped of its NAIC model language.

We understand the state's intent to merge NAIC model language with the DOL appeals and grievance and utilization management language. Also, as we previously discussed with the Department, the National Committee for Quality Assurance (NCQA), the accrediting body for health plans, has historically adopted the NAIC model. In NCQA's 2012 product update they have adopted the newest NAIC model. Currently, 40 states recognize NCQA managed care organization accreditation in whole or part in either their commercial market and/or their Medicaid managed care program. As an NCQA accredited plan with "Excellent" accreditation status, we are familiar with this "hybrid" model and the patient protections it grants to health plan members. Additionally, many states, including the state of South Dakota combine both NAIC and DOL language.

Stripping the NAIC language out of HB1127 will have the following negative impact on insured members:

- **Grandfathered health plans will be exempt.** The ACA's provisions providing consumers with new rights to internal and external appeals do not apply to consumers in grandfathered health plans. However, the NAIC's model laws are more expansive than the federal law and provide the appeal protections to *all* state-regulated plans – new plans and grandfathered plans.

- **Professional standards for appeal reviewers are lowered.** The NAIC model laws are more stringent than the DOL rules because they require insurers to designate a "clinical peer" of the "same or similar specialty" to review the appeal. In other words, if a neurologist would typically manage a certain member's condition, the health plan would be required to designate a neurologist to review any appeal associated with that member's coverage. The federal rules give insurers more flexibility in who they appoint to review an appeal and hence may enable reviewers to deny claims for conditions in cases for which they do not have the clinical expertise.

- **Reducing consumers' access to necessary information.** The NAIC model laws have tougher requirements than the federal DOL rules on the following:
    - Timely access to documents. The NAIC model requires health plans to provide to the consumer all documents relevant to the case within three working days after the health plan receives the appeal. The federal rules don't include this timeliness requirement.
    - Access to a broad range of necessary documents. NAIC's model requires that, once a plan has made a decision on an internal appeal, it must provide to the consumer a range of documents and supporting evidence that will help the consumer understand the basis for the decision. The federal rules don't require plans to provide the same breadth of documents.

In summary, stripping the NAIC language out of HB1127 will make the state law less protective of consumers. Opponents of the bill will testify that adopting NAIC language (and hence language that overreaches the minimum DOL rules as outlined by the Accountable Care Act) will result in increasing costs and administrative burden. However, Sanford Health Plan has always viewed NCQA accreditation (and its inherent operational and financial commitments) as an investment in the services we provide and the quality of our plans. Regardless of the legislative outcome of this bill, Sanford Health Plan will abide by the NCQA and NAIC standards as it's our prerogative to maintain compliance with NCQA's accreditation standards. It also provides us with operational efficiencies if we operate our utilization and appeals and grievance procedures consistently across the four states we conduct business in.

Thank you for your time and consideration of these comments.

#5

11.8111.03002
Title.

Prepared by the Legislative Council staff for
Senator Mathern
March 21, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1127

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact chapters 26.1-36.6, 26.1-36.7, and 26.1-36.8 of the North Dakota Century Code, relating to health carrier external review, utilization review, and grievance procedures; to amend and reenact sections 26.1-03-01, 26.1-26.4-01, and 26.1-36-44 of the North Dakota Century Code, relating to limitation on health insurance company risks, utilization review, and independent external reviews; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-01. Limitation on risks acceptable by company.

An insurance company transacting an insurance business in this state may not expose itself to loss on any one risk or hazard to an amount exceeding ten percent of its paid-up capital and surplus if a stock company, or ten percent of its surplus if a mutual company, unless the excess is reinsured. An insurance company offering group or individual insurance that is subject to the lifetime or annual benefit limit restrictions of the Patient Protection and Affordable Care Act [Pub. L.111-148] as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] is not subject to this section.

SECTION 2. AMENDMENT. Section 26.1-26.4-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-01. Purpose and scope.

This chapter applies to grandfathered health plans. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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.

SECTION 3. AMENDMENT. Section 26.1-36-44 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-44. Independent external review.

This section applies to grandfathered health plans. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. 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. A provider may not use an independent external review under this section unless the provider first has exhausted all internal appeal processes offered by the insurance company, nonprofit health service corporation, or health maintenance organization.

SECTION 4. Chapter 26.1-36.6 of the North Dakota Century Code is created and enacted as follows:

26.1-36.6-01. Definitions.

For purposes of this chapter:

1. "Adverse determination" means:

   a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

   b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

   c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or

   d. A rescission of coverage determination.

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

3. "Authorized representative" means:

   a. A person to whom a covered person has given express written consent to represent the covered person in an external review;

   b. A person authorized by law to provide substituted consent for a covered person; or

   c. A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

4. "Best evidence" means evidence based on:

   a. Randomized clinical trials;

   b. If randomized clinical trials are not available, cohort studies or case-control studies;

   c. If subdivisions a and b are not available, case-series; or

   d. If subdivisions a, b, and c are not available, expert opinion.

5. "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

6. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

7. "Case-series" means an evaluation of a series of patients with a particular outcome without the use of a control group.

8. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

9. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

10. "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving specific interventions.

11. "Commissioner" means the insurance commissioner.

12. "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

13. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

14. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

15. "Discharge planning" means the formal process for determining prior to discharge from a facility the coordination and management of the care that a patient receives following discharge from a facility.

16. "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

17. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention if failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

18. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

19. "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

20. "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

21. "Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

22. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier or its designee utilization review organization at the completion of the health carrier's internal grievance process procedures as set forth in chapter 26.1-36.8.

23. "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

24. "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

25. "Health care provider" or "provider" means a health care professional or a facility.

26. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

27. "Health carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

28. "Health information" means information or data whether oral or recorded in any form or medium and personal facts or information about events or relationships that relates to:

a. The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

b. The provision of health care services to an individual; or

c. Payment for the provision of health care services to an individual.

29. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

30. "Medical or scientific evidence" means evidence found in the following sources:

a. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

b. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus (MEDLINE) and elsevier science ltd. for indexing in excerpta medicus (EMBASE);

c. Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the Social Security Act;

d. The following standard reference compendia:

(1) The American hospital formulary service-drug information;

(2) Drug facts and comparisons;

(3) The American dental association accepted dental therapeutics; and

(4) The United States pharmacopoeia-drug information;

e. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(1) The federal agency for health care research and quality;

(2) The national institutes of health;

(3) The national cancer institute;

(4) The national academy of sciences;

(5) The centers for medicare and medicaid services;

(6) The federal food and drug administration; and

(7) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

f. Any other medical or scientific evidence that is comparable to the sources listed in subdivisions a through e.

31. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

32. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

33. "Protected health information" means health information:

a. That identifies an individual who is the subject of the information; or

b. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

34. "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention which includes study of the groups for variables and anticipated outcomes over time.

35. "Retrospective review" means a review of medical necessity 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.

36. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

37. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

38. "Utilization review organization" means an entity that conducts utilization review other than a health carrier performing a review for its own health benefit plans.

26.1-36.6-02. Applicability and scope.

1. Except as provided in subsection 2, this chapter applies to all nongrandfathered health benefit plans. "Nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] and the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] because it failed to achieve or lost grandfathered health plan status. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

2. The provisions of this chapter do not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit, a medicare supplement policy of insurance, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55 of title 10, United States Code, and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

26.1-36.6-03. Notice of right to external review.

1. a. A health carrier shall notify a covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 26.1-36.6-06, 26.1-36.6-07, or 26.1-36.6-08 and include the appropriate statements and information set forth in subdivision b at the same time the health carrier sends written notice of:

   (1) An adverse determination upon completion of the health carrier's utilization review process set forth in chapter 26.1-36.7; and

   (2) A final adverse determination.

   b. As part of the written notice required under subdivision a, a health carrier shall include the following or substantially equivalent language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the North Dakota Insurance Commissioner, 600 East Boulevard Avenue, State Capitol, Bismarck, ND 58505."

c. The commissioner may prescribe the form and content of the notice required under this section.

2. a. The health carrier shall include in the notice required under subsection 1:

(1) For a notice related to an adverse determination, a statement informing the covered person that:

(a) If the covered person has a medical condition and the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in section 26.1-36.8-08 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 26.1-36.6-07 or 26.1-36.6-08 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-08, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(b) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in section 26.1-36.8-05, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to section 26.1-36.6-04 and shall be considered to have exhausted the health carrier's internal grievance process for purposes of section 26.1-36.6-05; and

(2) For a notice related to a final adverse determination, a statement informing the covered person that:

(a) If the covered person has a medical condition and the timeframe for completion of a standard external review pursuant to section 26.1-36.6-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to section 26.1-36.6-07; or

(b) If the final adverse determination concerns:

[1] An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to section 26.1-36.6-07; or

[2] A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to section 26.1-36.6-06 or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under section 26.1-36.6-07.

b. In addition to the information to be provided pursuant to subdivision a, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 26.1-36.6-15, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

c. As part of any forms provided under subdivision b, the health carrier shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508, by which the covered person, for purposes of conducting an external review under this chapter, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in section 26.1-36-12.4.

26.1-36.6-04. Request for external review.

1. a. Except for a request for an expedited external review as set forth in section 26.1-36.6-07, all requests for external review shall be made in writing to the commissioner.

   b. The commissioner may prescribe by the form and content of external review requests required to be submitted under this section.

2. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

26.1-36.6-05. Exhaustion of internal grievance process.

1. a. Except as provided in subsection 2, a request for an external review pursuant to section 26.1-36.6-06, 26.1-36.6-07, or 26.1-36.6-08 shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

   b. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

      (1) Has filed a grievance involving an adverse determination pursuant to section 26.1-36.8-05; and

      (2) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

   c. Notwithstanding subdivision b, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to chapter 26.1-36.7 until the covered person has exhausted the health carrier's internal grievance process.

2. a. (1) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-08, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

      (a) Under section 26.1-36.6-07 if the covered person has a medical condition and the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in section 26.1-36.8-08 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) Under section 26.1-36.6-08 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(2) Upon receipt of a request for an expedited external review under paragraph 1, the independent review organization conducting the external review in accordance with the provisions of section 26.1-36.6-07 or 26.1-36.6-08 shall determine whether the covered person shall be required to complete the expedited review process set forth in section 26.1-36.8-08 before it conducts the expedited external review.

(3) Upon a determination made pursuant to paragraph 2 that the covered person must first complete the expedited grievance review process set forth in section 26.1-36.8-08, the independent review organization immediately shall notify the covered person and the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in section 26.1-36.6-07 until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

b. A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in section 26.1-36.8-05 whenever the health carrier agrees to waive the exhaustion requirement.

3. If the requirement to exhaust the health carrier's internal grievance procedures is waived under subdivision a of subsection 2, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in section 26.1-36.6-06 or 26.1-36.6-08.

26.1-36.6-06. Standard external review.

1. a. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 26.1-36.6-03, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

b. Within one business day after the date of receipt of a request for external review pursuant to subdivision a, the commissioner shall send a copy of the request to the health carrier.

2. Within five business days following the date of receipt of the copy of the external review request from the commissioner under subdivision b of

subsection 1, the health carrier shall complete a preliminary review of the request to determine whether:

a. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

b. The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

c. The covered person has exhausted the health carrier's internal grievance process as set forth in chapter 26.1-36.8 unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 26.1-36.6-05; and

d. The covered person has provided all the information and forms required to process an external review, including the release form provided under section 26.1-36.6-03.

3. a. Within one business day after completion of the preliminary review, the health carrier shall notify the commissioner and covered person and the covered person's authorized representative in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

b. If the request:

(1) Is not complete, the health carrier shall inform the covered person and the covered person's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall inform the covered person and the covered person's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(2) The notice of initial determination shall include a statement informing the covered person and the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under section 26.1-36.6-06 notwithstanding a

health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

4. a. Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection 3, within one business day after the date of receipt of the notice, the commissioner shall:

(1) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the covered person and the covered person's authorized representative of the request's eligibility and acceptance for external review.

b. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

c. The commissioner shall include in the notice provided to the covered person and the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision a additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

5. a. Within five business days after the date of receipt of the notice provided pursuant to subdivision a of subsection 4, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

b. Except as provided in subdivision c, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subdivision a shall not delay the conduct of the external review.

c. (1) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subdivision a, the assigned independent review organization

may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(2) Within one business day after making the decision under paragraph 1, the independent review organization shall notify the covered person and the covered person's authorized representative, the health carrier, and the commissioner.

6. a. The assigned independent review organization shall review all of the information and documents received pursuant to subsection 5 and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision c of subsection 4.

b. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision c of subsection 4, the assigned independent review organization shall within one business day forward the information to the health carrier.

7. a. Upon receipt of the information, if any, required to be forwarded pursuant to subdivision b of subsection 6, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

b. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision a shall not delay or terminate the external review.

c. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

d. (1) Within one business day after making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision c, the health carrier shall notify the covered person and the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(2) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to paragraph 1.

8. In addition to the documents and information provided pursuant to subsection 5, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's medical records;

b. The attending health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

e. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions a through f to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

9. a. Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(1) The covered person;

(2) If applicable, the covered person's authorized representative;

(3) The health carrier; and

(4) The commissioner.

b. The independent review organization shall include in the notice sent pursuant to subdivision a:

(1) A general description of the reason for the request for external review;

(2) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(3) The date the external review was conducted;

(4) The date of its decision;

(5) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(6) The rationale for its decision; and

(7) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

c. Upon receipt of a notice of a decision pursuant to subdivision a reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

10. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 26.1-36.6-11.

26.1-36.6-07. Expedited external review.

1. Except as provided in subsection 5, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

   a. An adverse determination if:

      (1) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in section 26.1-36.8-08 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

      (2) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-08; or

   b. A final adverse determination:

      (1) If the covered person has a medical condition and the timeframe for completion of a standard external review pursuant to section 26.1-36.6-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

      (2) If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

2. a. Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier.

   b. Immediately upon receipt of the request pursuant to subdivision a, the health carrier shall determine whether the request meets the reviewability requirements set forth in section 26.1-36.6-06. The

health carrier shall immediately notify the commissioner and the covered person and the covered person's authorized representative of its eligibility determination.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(2) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under section 26.1-36.6-06 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

e. Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10. The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

f. In reaching a decision in accordance with subsection 5, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in 26.1-36.8.

3. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subdivision e of subsection 2, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

4. In addition to the documents and information provided or transmitted pursuant to subsection 3, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's pertinent medical records;

b. The attending health care professional's recommendation;

(4) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(5) A description of the health carrier's internal review procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures;

(6) A description of the health carrier's expedited review procedures established pursuant to section 26.1-36.8-08;

(7) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(8) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(9) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with paragraph 7; or

(b) The written statement of the scientific or clinical rationale for the adverse determination in accordance with paragraph 8; and

(10) A statement explaining the availability of and right of the covered person to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under chapter 26.1-36.8, to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language,

offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. If the adverse determination is a rescission, the health carrier shall provide, in addition to any applicable disclosures required:

(1) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) The date the health carrier made the decision to rescind the coverage; and

(4) The date when the advance notice of the health carrier's decision to rescind the coverage ends.

d. (1) A health carrier may provide the notice required under this section orally, in writing, or electronically.

(2) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

26.1-36.7-09. Emergency services.

1. When conducting utilization review or making a benefit determination for emergency services, a health carrier that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

2. A health carrier shall cover emergency services to screen and stabilize a covered person in the following manner:

a. Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

b. Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;

c. If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

d. If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection 3; and

e. Without regard to any other term or condition of coverage, other than:

(1) The exclusion of or coordination of benefits;

(2) An affiliation or waiting period as permitted under section 2704 of the Public Health Service Act; or

(3) Applicable cost-sharing, as provided in subsection three.

3. a. For in-network emergency services, coverage of emergency services shall be subject to applicable copayments, coinsurance, and deductibles.

b. (1) For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in network.

(2) Notwithstanding paragraph 1, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this subparagraph.

(3) A health carrier complies with the requirements of this paragraph if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

(a) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(b) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-town network cost-sharing provisions; or

(c) The amount that would be paid under medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

(4) (a) For capitated or other health benefit plans that do not have a negotiated per service amount for in-network providers, subparagraph a of paragraph 3 does not apply.

(b) If a heath benefit plan has more than one negotiated amount for in-network providers for a particular emergency

service, the amount in subparagraph a of paragraph 3 is the median of these negotiated amounts.

c. (1) Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out of network benefits.

(2) A deductible may be imposed with respect to out of network emergency services only as part of a deductible that generally applies to out of network benefits.

(3) If an out-of-pocket maximum generally applies to out of network benefits, that out-of-network maximum must apply to out of network emergency services.

4. For immediately required postevaluation or poststabilization services, a health carrier shall provide access to a designated representative twenty-four hours a day seven days a week to facilitate review.

26.1-36.7-10. Confidentiality requirements.

A health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

26.1-36.7-11. Disclosure requirements.

1. In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations and a statement of rights and responsibilities of covered persons with respect to those procedures.

2. A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

26.1-36.7-12. Rules.

The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.7-13. Penalties.

The commissioner may assess a penalty against a health carrier that violates this chapter of not more than ten thousand dollars for each violation. The fine may be recovered in an action brought in the name of the state. In addition to imposing a monetary penalty, the commissioner may also cancel, revoke, or refuse to renew the certificate of authority of a health carrier that has violated this chapter.

SECTION 6. Chapter 26.1-36.8 of the North Dakota Century Code is created and enacted as follows:

26.1-36.8-01. Definitions.

As used in this chapter:

1. "Adverse determination" means:

   a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

   b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

   c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or

   d. A rescission of coverage determination.

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

3. "Authorized representative" means:

   a. A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;

   b. A person authorized by law to provide substituted consent for a covered person;

   c. A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

   d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

   e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

4. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

5. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and based on the

information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

6. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

7. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

8. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

9. "Commissioner" means the insurance commissioner.

10. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

11. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

12. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

13. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

14. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a 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.

15. "Emergency services" means, with respect to an emergency medical condition:

    a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

    b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

16. "Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

17. "Final adverse determination" means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under section 26.1-36.8-05 or 26.1-36.8-08 or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 26.1-36.8-04.

18. "Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

    a. Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

    b. Claims payment, handling, or reimbursement for health care services; or

    c. Matters pertaining to the contractual relationship between a covered person and a health carrier.

19. a. "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

    b. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

    c. "Health benefit plan" does not include:

        (1) Coverage only for accident or disability income insurance, or any combination thereof;

        (2) Coverage issued as a supplement to liability insurance;

        (3) Liability insurance, including general liability insurance and automobile liability insurance;

        (4) Workers' compensation or similar insurance;

        (5) Automobile medical payment insurance;

        (6) Credit-only insurance;

        (7) Coverage for onsite medical clinics; and

        (8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191], under which

benefits for medical care are secondary or incidental to other insurance benefits.

d. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].

e. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

f. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (civilian health and medical program of the uniformed services (CHAMPUS)); or

(3) Similar supplemental coverage provided to coverage under a group health plan.

20. "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

21. "Health care provider" or "provider" means a health care professional or a facility.

22. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

23. "Health carrier" means an entity subject to the insurance laws and administrative rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service

corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

24. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

25. a. "Managed care plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

b. "Managed care plan" includes:

(1) A closed plan, as defined in subsection 8; and

(2) An open plan, as defined in subsection 27.

26. "Network" means the group of participating providers providing services to a managed care plan.

27. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

28. "Participating provider" means a provider who under a contract with the health carrier or with its contractor or subcontractor has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

29. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

30. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

31. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under a health benefit plan if:

a. The cancellation or discontinuance of coverage has only a prospective effect; or

b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

32. a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

33. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

34. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

35. a. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

b. (1) Except as provided in paragraph 2, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(2) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision a must be treated as an urgent care request.

36. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

37. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

26.1-36.8-02. Applicability and scope.

Except as otherwise specified, this chapter applies to all health carriers offering a nongrandfathered health benefit plan. "Nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] and the Health Care and Education

Reconciliation Act of 2010 [Pub. L. 111-152] because it failed to achieve or lost grandfathered health plan status. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

26.1-36.8-03. Grievance reporting and recordkeeping requirements.

1. a. A health carrier shall maintain a written register to document all grievances received, including the notices and claims associated with the grievances, during a calendar year.

   b. (1) Notwithstanding the provisions under subsection 6, a health carrier shall maintain the records required under this section for at least six years related to the notices provided under sections 26.1-36.8-05 and 26.1-36.8-08.

   (2) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.

2. A health carrier shall process a request for a first-level review of a grievance involving an adverse determination in compliance with section 26.1-36.8-05 shall be included in the register.

3. A health carrier shall include in its register requests for additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to section 26.1-36.8-07.

4. For each grievance the register must contain, at a minimum, the following information:

   a. A general description of the reason for the grievance;

   b. The date received;

   c. The date of each review or review meeting;

   d. Resolution at each level of the grievance;

   e. Date of resolution at each level; and

   f. Name of the covered person for whom the grievance was filed.

5. A health carrier shall maintain the register in a manner that is reasonably clear and accessible to the commissioner.

6. a. Subject to the provisions of subsection 1, a health carrier shall retain the register compiled for a calendar year for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

   b. (1) A health carrier shall submit to the commissioner at least annually a report in the format specified by the commissioner.

   (2) The report shall include for each type of health benefit plan offered by the health carrier:

(a) The certificate of compliance required by section 26.1-36.8-04;

(b) The number of covered lives;

(c) The total number of grievances;

(d) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to section 26.1-36.8-07;

(e) The number of grievances resolved at each level and their resolution;

(f) The number of grievances appealed to the commissioner of which the health carrier has been informed;

(g) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(h) A synopsis of actions being taken to correct problems identified.

26.1-36.8-04. Grievance review procedures.

1. a. Except as specified in section 26.1-36.8-08, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in sections 26.1-36.8-05, 26.1-36.8-06, and 26.1-36.8-07.

   b. (1) Whenever a health carrier fails to strictly adhere to the requirements of section 26.1-36.8-05 or 26.1-36.8-08 with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this chapter and may take action under paragraph 2 regardless of whether the health carrier asserts that it substantially complied with the requirements of section 26.1-36.8-05 or 26.1-36.8-08, as applicable, or that any error it committed was de minimis.

   (2) (a) A covered person may file a request for external review in accordance with the procedures outlined in chapter 26.1-36.6.

   (b) In addition, a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

2. a. A health carrier shall file with the commissioner a copy of the procedures required under subsection 1, including all forms used to process requests made pursuant to sections 26.1-36.8-05, 26.1-36.8-06, and 26.1-36.8-07. A health carrier shall file with the commissioner any subsequent material modifications to the documents.

b. The commissioner may disapprove a filing received in accordance with subdivision a that fails to comply with this chapter or applicable rules.

3. In addition to subsection 2, a health carrier shall file annually with the commissioner as part of its annual report required by section 26.1-36.8-03 a certificate of compliance stating that the health carrier has established and maintains for each of its health benefit plans grievance procedures that fully comply with the provisions of this chapter.

4. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

5. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office or ombudsman's office for assistance at any time. The statement shall include the telephone number and address of the commissioner's or ombudsman's office.

26.1-36.8-05. First-level reviews of grievances involving an adverse determination.

1. Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to chapter 26.1-36.7, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first-level review of the adverse determination.

2. a. The health carrier shall provide the covered person with the name, address, and telephone number of a person or organizational unit designated to coordinate the first-level review on behalf of the health carrier.

b. (1) In providing for a first-level review under this section, the health carrier shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first-level review decision.

(2) In ensuring the independence and impartiality of individuals involved in making the first-level review decision, the health carrier shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

3. a. (1) In the case of an adverse determination involving utilization review, the health carrier shall designate an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer may not have been involved in the initial adverse determination.

(2) In designating an appropriate clinical peer or peers pursuant to paragraph 1, the health carrier shall ensure that if more than one clinical peer is involved in the review a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

b. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or the covered person's authorized representative without regard to whether the information was submitted or considered in making the initial adverse determination.

4. a. (1) A covered person does not have the right to attend or to have a representative in attendance at the first-level review but the covered person or the covered person's authorized representative is entitled to:

(a) Submit written comments, documents, records, and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(b) Receive from the health carrier upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the covered person's request for benefits.

(2) For purposes of subparagraph b of paragraph 1, a document, record, or other information shall be considered relevant to a covered person's request for benefits if the document, record, or other information:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;

(c) Demonstrates that in making the benefit determination the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(d) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis without regard to whether the advice or statement was relied upon in making the benefit determination.

b. The health carrier shall make the provisions of subdivision a known to the covered person or the covered person's authorized representative within three working days after the date of receipt of the grievance.

5. For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection 6, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.8-04 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

6. a. A health carrier shall notify and issue a decision in writing or electronically to the covered person or the covered person's authorized representative within the timeframes provided in subdivision b or c.

   b. With respect to a grievance requesting a first-level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition but no later than thirty days after the date of the health carrier's receipt of the grievance requesting the first-level review made pursuant to subsection 1.

   c. With respect to a grievance requesting a first-level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time but no later than sixty days after the date of the health carrier's receipt of the grievance requesting the first-level review made pursuant to subsection 1.

7. a. Prior to issuing a decision in accordance with the timeframes provided in subsection 6, the health carrier shall provide free of charge to the covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

   b. Before the health carrier issues or provides notice of a final adverse determination in accordance with the timeframes provided in subsection 6 that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

8. The decision issued pursuant to subsection 6 shall set forth in a manner calculated to be understood by the covered person or the covered person's authorized representative:

   a. The titles and qualifying credentials of the reviewers participating in the first-level review process;

b. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

c. A statement of the reviewers' understanding of the covered person's grievance;

d. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

e. A reference to the evidence or documentation used as the basis for the decision;

f. For a first-level review decision issued pursuant to subsection 6 that upholds the grievance:

(1) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(2) The reference to the specific plan provisions on which the determination is based;

(3) A statement that the covered person is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant, as the term relevant is defined in subdivision a of subsection 4 to the covered person's benefit request;

(4) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(5) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit either an explanation of the scientific or clinical judgment for making the determination applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

(6) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the final adverse determination, as provided in paragraph 4; and

(b) The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 5;

g. If applicable, a statement indicating:

(1) A description of the process to obtain an additional voluntary review of the first-level review decision if the covered person wishes to request a voluntary review pursuant to section 26.1-36.8-07;

(2) The written procedures governing the voluntary review, including any required timeframe for the review;

(3) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to chapter 26.1-36.6 if the covered person decides not to file for an additional voluntary review of the first-level review decision involving an adverse determination; and

(4) The covered person's right to bring a civil action in a court of competent jurisdiction;

h. If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

i. Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

9. a. A health carrier shall provide the notice required under subsection 8 in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

b. If a health carrier is required to provide the notice required under this subsection in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(1) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(2) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(3) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

26.1-36.8-06. Standard reviews of grievances not involving an adverse determination.

1. A health carrier shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

2. a. The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under this section.

b. (1) A covered person does not have the right to attend or to have a representative in attendance at the standard review but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection 3 to consider when conducting the review.

(2) The health carrier shall make the provisions of paragraph 1 known to the covered person or the covered person's authorized representative within three working days after the date of receiving the grievance.

3. a. Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance.

b. The health carrier shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

c. The health carrier shall provide the covered person or the covered person's authorized representative with the name, address, and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

4. a. The health carrier shall notify in writing the covered person or the covered person's authorized representative of the decision within twenty working days after the date of receipt of the request for a standard review of a grievance filed pursuant to subsection 2.

b. (1) Subject to paragraph 2, if due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notify the covered person or the covered person's authorized representative pursuant to subdivision a within twenty working days, the health carrier may take up to an additional ten working days to issue a written decision.

(2) A health carrier may extend the time for making and notifying the covered person or the covered person's authorized representative in accordance with paragraph 1, if on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or the covered person's authorized representative of the extension and the reasons for the delay.

5. The written decision issued pursuant to subsection 4 must contain:

a. The titles and qualifying credentials of the reviewers participating in the standard review process;

b. A statement of the reviewers' understanding of the covered person's grievance;

c. The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health carrier's position;

d. A reference to the evidence or documentation used as the basis for the decision;

e. If applicable, a statement indicating:

(1) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to section 26.1-36.8-07; and

(2) The written procedures governing the voluntary review, including any required timeframe for the review; and

f. Notice of the covered person's right, at any time, to contact the commissioner's office, including the telephone number and address of the commissioner's office.

26.1-36.8-07. Voluntary level of reviews of grievances.

1. a. A health carrier that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons who are dissatisfied with the first-level review decision made pursuant to section 26.1-36.8-05 or who are dissatisfied with the standard review decision made pursuant to section 26.1-36.8-06, the option to request an additional voluntary review, at which the covered person or the covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier.

b. This section shall not apply to health indemnity plans.

2. a. A health carrier required by this section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice pursuant to subsection 7 of section 26.1-36.8-05 or subsection 5 of section 26.1-36.8-06 as appropriate of the option to file a request with the health carrier for an additional voluntary review of the first-level review decision received under section 26.1-36.8-05 or the standard review decision received under section 26.1-36.8-06.

b. Upon receipt of a request for an additional voluntary review, the health carrier shall send notice to the covered person or the covered person's authorized representative of the covered person's right to:

(1) Request within the timeframe specified in paragraph 1 of subdivision c the opportunity to appear in person before a review panel of the health carrier's designated representatives;

(2) Receive from the health carrier upon request copies of all documents, records, and other information that is not confidential or privileged relevant to the covered person's request for benefits;

(3) Present the covered person's case to the review panel;

(4) Submit written comments, documents, records, and other material relating to the request for benefits for the review panel to consider when conducting the review both before and at a review meeting;

(5) Ask questions of any representative of the health carrier on the review panel; and

(6) Be assisted or represented by an individual of the covered person's choice.

c. (1) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within five working days after the date of receipt of the notice sent in accordance with subdivision b.

(2) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

3. a. (1) With respect to a voluntary review of a first-level review decision made pursuant to section 26.1-36.8-05, a health carrier shall appoint a review panel to review the request.

(2) In conducting the review, the review panel shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to subdivision b of subsection 2, without regard to whether the information was submitted or considered in reaching the first-level review decision.

(3) The panel shall have the legal authority to bind the health carrier to the panel's decision.

b. (1) Except as provided in paragraph 2, a majority of the panel shall be comprised of individuals who were not involved in the first-level review decision made pursuant to section 26.1-36.8-05.

(2) An individual who was involved with the first-level review decision may be a member of the panel or appear before the panel to present information or answer questions.

(3) The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first-level review decision made pursuant to section 26.1-36.8-05 are health care professionals who have appropriate expertise.

(4) Except when a reviewing health care professional who has appropriate expertise is not reasonably available, in cases in which there has been a denial of a health care service, the reviewing health care professional may not:

(a) Be a provider in the covered person's health benefit plan; and

applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

(2) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(3) Reference to the specific plan provisions on which the determination is based;

(4) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

(5) A description of the health carrier's grievance procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures;

(6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(7) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(8) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination; or

(9) The written statement of the scientific or clinical rationale for the adverse determination; and

(10) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under chapter 26.1-36.8, to file a civil suit in a court of competent jurisdiction.The statement shall include contact information for the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. If the adverse determination is a rescission, the health carrier shall provide in the advance notice of the rescission determination required to be provided under applicable state or federal law or regulation related to the advance notice requirement of a proposed rescission, in addition to any applicable disclosures required under subdivision a:

(1) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of a material fact;

(2) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to chapter 26.1-36.8;

(4) A description of the health carrier's grievance procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures; and

(5) The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

d. A health carrier may provide the notice required under this section in writing or electronically.

26.1-36.7-08. Procedures for expedited utilization review and benefit determinations.

1. a. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

b. (1) As part of the procedures required under subdivision a, a health carrier shall provide that in the case of a failure by a covered person or the covered person's authorized representative to follow the health carrier's procedures for filing an urgent care request the covered person or the covered person's authorized representative shall be notified of the failure and the proper procedures to be following for filing the request.

(2) A health carrier shall provide the notice required under paragraph 1:

(a) To the covered person or the covered person's authorized representative as soon as possible but not later than twenty-four hours after receipt of the request; and

(b) Orally unless the covered person or the covered person's authorized representative requests the notice in writing.

(3) The provisions of this paragraph apply only in the case of a failure that:

(a) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(b) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which approval is being requested.

2. a. (1) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or the covered person's authorized representative of the health carrier's determination

with respect to the request, whether the determination is an adverse determination as soon as possible taking into account the medical condition of the covered person but in no event later than twenty-four hours after the receipt of the request by the health carrier.

(2) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

b. (1) If the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible but in no event later than twenty-four hours after receipt of the request.

(2) The health carrier shall provide the covered person or the covered person's authorized representative a reasonable period of time to submit the necessary information taking into account the circumstances but in no event less than forty-eight hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in paragraph 1.

(3) The health carrier shall notify the covered person or the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible but in no event more than forty-eight hours after the earlier of:

(a) The health carrier's receipt of the requested specified information; or

(b) The end of the period provided for the covered person or the covered person's authorized representative to submit the requested specified information.

(4) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in paragraph 2, the health carrier may deny the certification of the requested benefit.

(5) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

3. a. For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible taking into account the covered person's medical condition but in no event more than twenty-four hours after the health carrier's receipt of the request.

b. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

4. For purposes of calculating the time periods within which a determination is required to be made under subsection 2 or 3, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.7-05 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5. a. A notification of an adverse determination under this section shall in a manner calculated to be understood by the covered person set forth:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if

applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(2) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(3) Reference to the specific plan provisions on which the determination is based;

(4) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(5) A description of the health carrier's internal review procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures;

(6) A description of the health carrier's expedited review procedures established pursuant to section 26.1-36.8-06;

(7) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(8) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination applying the terms of the health benefit plan to the covered person's medical circumstances

or a statement that an explanation will be provided to the covered person free of charge upon request;

(9) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with paragraph 7; or

(b) The written statement of the scientific or clinical rationale for the adverse determination in accordance with paragraph 8; and

(10) A statement explaining the availability of and right of the covered person to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under chapter 26.1-36.8, to file a civil suit in a court of competent jurisdiction.The statement shall include contact information for the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. If the adverse determination is a rescission, the health carrier shall provide, in addition to any applicable disclosures required:

(1) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) The date the health carrier made the decision to rescind the coverage; and

(4) The date when the advance notice of the health carrier's decision to rescind the coverage ends.

d. (1) A health carrier may provide the notice required under this section orally, in writing, or electronically.

(2) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

26.1-36.7-09. Emergency services.

1. When conducting utilization review or making a benefit determination for emergency services, a health carrier that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

2. A health carrier shall cover emergency services to screen and stabilize a covered person in the following manner:

a. Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an

emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

b. Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;

c. If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

d. If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection 3; and

e. Without regard to any other term or condition of coverage, other than:

(1) The exclusion of or coordination of benefits;

(2) An affiliation or waiting period as permitted under section 2704 of the Public Health Service Act; or

(3) Applicable cost-sharing, as provided in subsection three.

3. a. For in-network emergency services, coverage of emergency services shall be subject to applicable copayments, coinsurance, and deductibles.

b. (1) For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in network.

(2) Notwithstanding paragraph 1, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this subparagraph.

(3) A health carrier complies with the requirements of this paragraph if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

(a) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(b) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-town network cost-sharing provisions; or

(c) The amount that would be paid under medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

(4) (a) For capitated or other health benefit plans that do not have a negotiated per service amount for in-network providers, subparagraph a of paragraph 3 does not apply.

(b) If a heath benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subparagraph a of paragraph 3 is the median of these negotiated amounts.

c. (1) Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-o f-pocket maximum, may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out of network benefits.

(2) A deductible may be imposed with respect to out of network emergency services only as part of a deductible that generally applies to out of network benefits.

(3) If an out-of-pocket maximum generally applies to out of network benefits, that out-of-network maximum must apply to out of network emergency services.

4. For immediately required postevaluation or poststabilization services, a health carrier shall provide access to a designated representative twenty-four hours a day seven days a week to facilitate review or otherwise provide coverage with no financial penalty to the covered person.

26.1-36.7-10. Confidentiality requirements. A health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

26.1-36.7-11. Disclosure requirements.

1. In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations and a statement of rights and responsibilities of covered persons with respect to those procedures.

2. A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

26.1-36.7-12. Rules. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.7-13. Penalties. The commissioner may assess a penalty against a health carrier that violates this chapter of not more than ten thousand dollars for each violation.The fine may be recovered in an action brought in the name of the state.In addition to imposing a monetary penalty, the commissioner may also cancel, revoke, or refuse to renew the certificate of authority of a health carrier that has violated this chapter.

SECTION 6. Chapter 26.1-36.8 of the North Dakota Century Code is created and enacted as follows:

26.1-36.8-01. Definitions. As used in this chapter:

1. "Adverse determination" means:

a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or

d. A rescission of coverage determination.

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

3. "Authorized representative" means:

a. A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;

b. A person authorized by law to provide substituted consent for a covered person;

c. A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

4. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

5. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

6. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

7. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

8. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

9. "Commissioner" means the insurance commissioner.

10. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

11. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

12. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

13. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management

of the care that a patient receives following discharge from a facility.

14. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a 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.

15. "Emergency services" means, with respect to an emergency medical condition:

    a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

    b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

16. "Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

17. "Final adverse determination" means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under section 26.1-36.8-05 or 26.1-36.8-06 or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 26.1-36.8-04.

18. "Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

a. Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

b. Claims payment, handling, or reimbursement for health care services; or

c. Matters pertaining to the contractual relationship between a covered person and a health carrier.

19. a. "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

b. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

c. "Health benefit plan" does not include:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub.L.104-191], under which benefits for medical care are secondary or incidental to other insurance benefits.

d. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub.L.104-191].

e. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

f. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1)of the Social Security Act;

(2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (civilian health and medical program of the uniformed services (CHAMPUS)); or

(3) Similar supplemental coverage provided to coverage under a group health plan.

20. "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

21. "Health care provider" or "provider" means a health care professional or a facility.

22. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

23. "Health carrier" means an entity subject to the insurance laws and administrative rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

24. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

25. a. "Managed care plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

b. "Managed care plan" includes:

(1) A closed plan, as defined in subsection 8; and

(2) An open plan, as defined in subsection 27.

26. "Network" means the group of participating providers providing services to a managed care plan.

27. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

28. "Participating provider" means a provider who under a contract with the health carrier or with its contractor or subcontractor has agreed to provide health care services to covered persons with an

expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

29. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

30. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

31. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.Rescission does not include a cancellation or discontinuance of coverage under a health benefit plan if:

    a. The cancellation or discontinuance of coverage has only a prospective effect; or

    b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

32. a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

    b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

33. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

34. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

35. a. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

b. (1) Except as provided in paragraph 2, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(2) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision a must be treated as an urgent care request.

36. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities.Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

37. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

26.1-36.8-02. Applicability and scope. Except as otherwise specified, this chapter applies to all health carriers offering a nongrandfathered health benefit plan."Nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub.L.111-148] and the Health Care and Education Reconciliation Act of 2010 [Pub.L.111-152] because it failed to achieve or lost grandfathered health plan status."Grandfathered health plan" has the meaning stated in the Patient

Protection and Affordable Care Act [Pub.L.111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub.L.111-152].

26.1-36.8-03. Grievance reporting and recordkeeping requirements.

1. a. A health carrier shall maintain a written register to document all grievances received, including the notices and claims associated with the grievances, during a calendar year.

   b. (1) Notwithstanding the provisions under subsection 6, a health carrier shall maintain the records required under this section for at least six years related to the notices provided under sections 26.1-36.8-05 and 26.1-36.8-06.

   (2) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.

2. A health carrier shall process a request for a firs t-level review of a grievance involving an adverse determination in compliance with section 26.1-36.8-05 shall be included in the register.

3. For each grievance the register must contain, at a minimum, the following information:

   a. A general description of the reason for the grievance;

   b. The date received;

   c. The date of each review or review meeting;

   d. Resolution at each level of the grievance;

   e. Date of resolution at each level; and

   f. Name of the covered person for whom the grievance was filed.

4. A health carrier shall maintain the register in a manner that is reasonably clear and accessible to the commissioner.

5. a. Subject to the provisions of subsection 1, a health carrier shall retain the register compiled for a calendar year for the longer of three years or until the commissioner has adopted

a final report of an examination that contains a review of the register for that calendar year.

b. (1) A health carrier shall submit to the commissioner at least annually a report in the format specified by the commissioner.

(2) The report shall include for each type of health benefit plan offered by the health carrier:

(a) The certificate of compliance required by section 26.1-36.8-04;

(b) The number of covered lives;

(c) The total number of grievances;

(d) The number of grievances resolved at each level and their resolution;

(e) The number of grievances appealed to the commissioner of which the health carrier has been informed;

(f) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(g) A synopsis of actions being taken to correct problems identified.

26.1-36.8-04. Grievance review procedures.

1. a. Except as specified in section 26.1-36.8-06, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in sections 26.1-36.8-05.

b. (1) Whenever a health carrier fails to strictly adhere to the requirements of section 26.1-36.8-05 or 26.1-36.8-06 with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this chapter and may take action under paragraph 2 regardless of whether the health carrier asserts that it substantially complied with the

requirements of section 26.1-36.8-05 or 26.1-36.8-06, as applicable, or that any error it committed was de minimis.

(2) (a) A covered person may file a request for external review in accordance with the procedures outlined in chapter 26.1-36.6.(b)In addition, a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

2. a. A health carrier shall file with the commissioner a copy of the procedures required under subsection 1, including all forms used to process requests made pursuant to sections 26.1-36.8-05.A health carrier shall file with the commissioner any subsequent material modifications to the documents.

b. The commissioner may disapprove a filing received in accordance with subdivision a that fails to comply with this chapter or applicable rules.

3. In addition to subsection 2, a health carrier shall file annually with the commissioner as part of its annual report required by section 26.1-36.8-03 a certificate of compliance stating that the health carrier has established and maintains for each of its health benefit plans grievance procedures that fully comply with the provisions of this chapter.

4. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

5. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office or ombudsman's office for assistance at any time.The statement shall include the telephone number and address of the commissioner's or ombudsman's office.

26.1-36.8-05. First-level reviews of grievances involving an adverse determination.

1. Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to chapter 26.1-36.7, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a firs t-level review of the adverse determination.

2. a. The health carrier shall provide the covered person with the name, address, and telephone number of a person or organizational unit designated to coordinate the first-level review on behalf of the health carrier.

b. (1) In providing for a firs t-level review under this section, the health carrier shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first-level review decision.

(2) In ensuring the independence and impartiality of individuals involved in making the first-level review decision, the health carrier shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

3. a. (1) In the case of an adverse determination involving utilization review, the health carrier shall designate an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination.The clinical peer may not have been involved in the initial adverse determination.

(2) In designating an appropriate clinical peer or peers pursuant to paragraph 1, the health carrier shall ensure that if more than one clinical peer is involved in the review a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

b. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or the covered person's authorized representative without regard to

whether the information was submitted or considered in making the initial adverse determination.

4. a. (1) A covered person does not have the right to attend or to have a representative in attendance at the first-level review but the covered person or the covered person's authorized representative is entitled to:

(a) Submit written comments, documents, records, and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(b) Receive from the health carrier upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the covered person's request for benefits.

(2) For purposes of subparagraph b of paragraph 1, a document, record, or other information shall be considered relevant to a covered person's request for benefits if the document, record, or other information:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;

(c) Demonstrates that in making the benefit determination the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(d) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis without regard to whether the advice or

statement was relied upon in making the benefit determination.

b. The health carrier shall make the provisions of subdivision a known to the covered person or the covered person's authorized representative within three working days after the date of receipt of the grievance.

5. For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection 6, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.8-04 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

6. a. A health carrier shall notify and issue a decision in writing or electronically to the covered person or the covered person's authorized representative within the timeframes provided in subdivision b or c.

b. With respect to a grievance requesting a first-level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition but no later than thirty days after the date of the health carrier's receipt of the grievance requesting the first-level review made pursuant to subsection 1.

c. With respect to a grievance requesting a firs t-level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time but no later than sixty days after the date of the health carrier's receipt of the grievance requesting the firs t-level review made pursuant to subsection 1.

7. a. Prior to issuing a decision in accordance with the timeframes provided in subsection 6, the health carrier shall provide free of charge to the covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is

required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

b. Before the health carrier issues or provides notice of a final adverse determination in accordance with the timeframes provided in subsection 6 that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

8. The decision issued pursuant to subsection 6 shall set forth in a manner calculated to be understood by the covered person or the covered person's authorized representative:

a. The titles and qualifying credentials of the reviewers participating in the first-level review process;

b. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

c. A statement of the reviewers' understanding of the covered person's grievance;

d. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

e. A reference to the evidence or documentation used as the basis for the decision;

f. For a first-level review decision issued pursuant to subsection 6 that upholds the grievance:

(1) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of

the health carrier's standard, if any, that was used in reaching the denial;

(2) The reference to the specific plan provisions on which the determination is based;

(3) A statement that the covered person is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant, as the term relevant is defined in subdivision a of subsection 4 to the covered person's benefit request;

(4) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(5) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit either an explanation of the scientific or clinical judgment for making the determination applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

(6) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the final adverse determination, as provided in paragraph 4; and

(b) The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 5;

g. If applicable, a statement indicating:

(1) A description of the process to obtain an additional voluntary review of the first-level review decision if a voluntary review is offered by the health carrier;

(2) The written procedures governing the voluntary review, including any required timeframe for the review;

(3) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to chapter 26.1-36.6 if the covered person decides not to file for an additional voluntary review of the first-level review decision involving an adverse determination; and

(4) The covered person's right to bring a civil action in a court of competent jurisdiction;

h. If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation.One way to find out what may be available is to contact your state Insurance Commissioner."; and

i. Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

9. a. A health carrier shall provide the notice required under subsection 8 in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

b. If a health carrier is required to provide the notice required under this subsection in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(1) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(2) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(3) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

26.1-36.8-06. Expedited reviews of grievances involving an adverse determination.

1. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

2. In addition to subsection 1, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility.

3. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

4. A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination.The clinical peer or peers may not have been involved in making the initial adverse determination.

5. In an expedited review all necessary information, including the health carrier's decision shall be transmitted between the health carrier and the covered person or the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

6. a. An expedited review decision shall be made and the covered person or the covered person's authorized representative shall be notified of the decision in accordance with subsection 8 as expeditiously as the covered person's medical condition requires, but in no event more than

seventy-two hours after the receipt of the request for the expedited review.

b. If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

7. For purposes of calculating the time periods within which a decision is required to be made under subsection 6, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.8-04 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

8. a. A notification of a decision under this section must set forth in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(1) The titles and qualifying credentials of the reviewers participating in the expedited review process;

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(3) A statement of the reviewers' understanding of the covered person's grievance;

(4) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(5) A reference to the evidence or documentation used as the basis for the decision; and

(6) If the decision involves a final adverse determination, the notice shall provide:

(a) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(b) Reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(f) If applicable, instructions for requesting:

[1] A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with subparagraph d; or

[2] The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph e;

(g) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to chapter 26.1-36.6;

(h) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

(i) The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation.One way to find out what may be available is to contact your state Insurance Commissioner."; and

(j) A notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices

to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. (1) A health carrier may provide the notice required under this section orally, in writing, or electronically.

(2) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

26.1-36.8-07. Rulemaking. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.8-08. Penalties. The commissioner may assess a penalty against a health carrier that violates this chapter of not more than ten thousand dollars for each violation.The fine may be recovered in an action brought in the name of the state.In addition to imposing a monetary penalty, the commissioner may also cancel, revoke, or refuse to renew the certificate of authority of a health carrier that has violated this chapter."

The commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the federal government adopts standards regarding internal claims and appeals and external review that are less stringent than the standards contained in this Act.

Renumber accordingly

#7

March 22, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1127

Page 1, line 1, replace "two new sections to chapter 26.1-36" with "chapters 26.1-36.6, 26.1-36.7, and 26.1-26.8"

Page 1, line 2, replace "appeals and internal claims and appeals" with "review, utilization review, and grievance"

Page 1, line 5, after the first semicolon and before "to" insert "and" and replace "for application; and to declare an" with "a penalty"

Page 1, line 6, remove "emergency"

Page 2, line 30, remove "The insurance commissioner shall take steps"

Page 2, remove line 31

Page 3, remove lines 1 through 31

Page 4, remove lines 1 through 9

Page 4, after line 9, insert the following:

"**SECTION 4.** Chapter 26.1-36.6 of the North Dakota Century Code is created and enacted as follows:

26.1-36.6-01. Definitions. For purposes of this chapter:

26.1-36.6-02. Applicability and scope.

26.1-36.6-03. Notice of right to external review.

26.1-36.6-04. Request for external review.
26.1-36.6-05. Exhaustion of internal grievance process.

26.1-36.6-07. Expedited external review.

26.1-36.6-08. External review of experimental or investigational treatment adverse determinations.

26.1-36.6-09. Binding nature of external review decision.

26.1-36.6-10. Approval of independent review organizations.

26.1-36.6-11. Minimum qualifications for independent review organizations.

26.1-36.6-12. Hold harmless for independent review organizations. No
26.1-36.6-13. External review reporting requirements.

26.1-36.6-14. Funding of external review.
26.1-36.6-15. Disclosure requirements.

26.1-36.6-16. Rulemaking. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.6-17. Confidentiality. Any protected health information that the commissioner receives pursuant to this chapter is confidential.

SECTION 5. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36.7-01. Definitions. As used in this chapter:

(1

26.1-36.7-02. Applicability and scope.

26.1-36.7-03. Corporate oversight of utilization review program.

26.1-36.7-04. Contracting.

26.1-36.7-05. Scope and content of utilization review program.

26.1-36.7-06. Operational requirements.

26.1-36.7-07. Procedures for standard utilization review and benefit determinations.

26.1-36.7-08. Procedures for expedited utilization review and benefit determinations.

26.1-36.7-09. Emergency services.
26.1-36.7-10. Confidentiality requirements. 26.1-36.7-11. Disclosure requirements.

26.1-36.7-12. Rules.
26.1-36.7-13. Penalties.
SECTION 6.
26.1-36.8-01. Definitions. As used in this chapter:

26.1-36.8-02. Applicability and scope.

26.1-36.8-03. Grievance reporting and recordkeeping requirements.

26.1-36.8-04. Grievance review procedures.

26.1-36.8-05. First-level reviews of grievances involving an adverse determination.

26.1-36.8-06. Expedited reviews of grievances involving an adverse determination.

26.1-36.8-07. Rulemaking. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.8-08. Penalties. The commissioner may assess a penalty against a health carrier that violates this chapter of not more than ten thousand dollars for each violation.The fine may be recovered in an action brought in the name of the state.In addition to imposing a monetary penalty, the commissioner may also cancel, revoke, or refuse to renew the certificate of authority of a health carrier that has violated this chapter."

The commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the federal government adopts standards regarding internal claims and appeals and external review that are less stringent than the standards contained in this Act.

Renumber accordingly

#8

Mathern, Tim

From: Hauer, Melissa A.
Sent: Wednesday, March 23, 2011 8:45 AM
To: Mathern, Tim; Clark, Jennifer S.
Cc: Hamm, Adam W.; Ternes, Rebecca L.; Fix, Michael L.
Subject: RE: HB 1127 Amendments

Good morning Senator Mathern,

Our proposed amendment would restore HB 1127 to its form as introduced, with the following changes:

1. It keeps the change in the engrossed bill on page 1, line 21 that allows grandfathered plans to use these appeal processes if they choose to do so.
2. It removes the entire section (26.1-36.8-07) that required insurers to give a voluntary level of review of grievances and it removes any cross references to this section.
3. It removes the requirement that was in 26.1-36.8-03(3) and (6) which required an insurer to keep certain records regarding voluntary reviews.
4. It removes the entire section (26.1-36.8-06) that required insurers to establish written procedures for a standard review of a grievance that does not involve an adverse determination and it removes any cross references to this section.

5, page 4

I hope this is helpful. I will be at the Committee meeting this morning at 9:00.

Melissa

From: Mathern, Tim
Sent: Wednesday, March 23, 2011 7:24 AM
To: Hauer, Melissa A.; Clark, Jennifer S.
Cc: Hamm, Adam W.; Ternes, Rebecca L.; Fix, Michael L.
Subject: RE: HB 1127 Amendments

Thanks Melissa. Something in narrative form like your email below would be helpful to me. If you could get to me by email by 8:45 that would be great. Thanks.

Senator Tim Mathern

From: Hauer, Melissa A.
Sent: Tuesday, March 22, 2011 7:42 PM
To: Clark, Jennifer S.
Cc: Mathern, Tim; Hamm, Adam W.; Ternes, Rebecca L.; Fix, Michael L.
Subject: RE: HB 1127 Amendments

Jenn,

I am at home right now and I don't have access to our computer network so I can't look at the documents that detail the amendments. Off the top of my head, the amendments remove the portion of the bill that required a voluntary level of review. They allow grandfathered plans to use the new appeal process if they choose to. And they remove the portion of the bill that dealt with appeals not involving adverse determinations. The rest of the amendments renumber remaining sections due to these two portions being taken out.

(b) Have a financial interest in the outcome of the review.

4. a. (1) With respect to a voluntary review of a standard review decision made pursuant to section 26.1-36.8-06, a health carrier shall appoint a review panel to review the request.

(2) The panel shall have the legal authority to bind the health carrier to the panel's decision.

b. (1) Except as provided in paragraph 2, a majority of the panel shall be comprised of employees or representatives of the health carrier who were not involved in the standard review decision made pursuant to section 26.1-36.8-06.

(2) An employee or representative of the health carrier who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions.

5. a. (1) Whenever a covered person or the covered person's authorized representative requests within the timeframe specified in paragraph 1 of subdivision c of subsection 2 the opportunity to appear in person before the review panel appointed pursuant to subsection 3 or 4, the procedures for conducting the review shall include the provisions described in this paragraph.

(2) (a) The review panel shall schedule and hold a review meeting within forty-five working days after the date of receipt of the request.

(b) The covered person or the covered person's authorized representative shall be notified in writing at least fifteen working days in advance of the date of the review meeting.

(c) The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative.

(3) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or the covered person's authorized representative.

(4) In cases in which a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or the covered person's authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, videoconferencing, or other appropriate technology.

(5) If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person or the covered person's authorized representative at least fifteen working days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of the covered person's own.

(6) The review panel shall issue a written decision, as provided in subsection 6, to the covered person or the covered person's authorized representative within five working days of completing the review meeting.

b. Whenever the covered person or the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified timeframe provided under paragraph 1 of subdivision c of subsection 2, the review panel shall issue a decision and notify the covered person or the covered person's authorized representative of the decision, as provided in subsection 6, in writing or electronically, within forty-five working days after the earlier of:

(1) The date the covered person or the covered person's authorized representative notifies the health carrier of the covered person's decision not to request the opportunity to appear in person before the review panel; or

(2) The date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to paragraph 1 of subdivision c of subsection 2.

(3) For purposes of calculating the time periods within which a decision is required to be made and notice provided under subdivisions a and b, the time period shall begin on the date the request for an additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.8-04 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

6. A decision issued pursuant to subsection 5 shall include:

a. The titles and qualifying credentials of the members of the review panel;

b. A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

c. The rationale for the review panel's decision;

d. A reference to evidence or documentation considered by the review panel in making that decision;

e. In cases concerning a grievance involving an adverse determination:

(1) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(2) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to chapter 26.1-36.6; and

f. Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim,

grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

26.1-36.8-08. Expedited reviews of grievances involving an adverse determination.

1. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

2. In addition to subsection 1, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility.

3. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

4. A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers may not have been involved in making the initial adverse determination.

5. In an expedited review all necessary information, including the health carrier's decision shall be transmitted between the health carrier and the covered person or the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

6. a. An expedited review decision shall be made and the covered person or the covered person's authorized representative shall be notified of the decision in accordance with subsection 8 as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the receipt of the request for the expedited review.

   b. If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

7. For purposes of calculating the time periods within which a decision is required to be made under subsection 6, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.8-04 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

8. a. A notification of a decision under this section must set forth in a manner calculated to be understood by the covered person or the covered person's authorized representative:

   (1) The titles and qualifying credentials of the reviewers participating in the expedited review process;

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(3) A statement of the reviewers' understanding of the covered person's grievance;

(4) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(5) A reference to the evidence or documentation used as the basis for the decision; and

(6) If the decision involves a final adverse determination, the notice shall provide:

(a) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(b) Reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(f) If applicable, instructions for requesting:

[1] A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with subparagraph d; or

[2] The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph e;

(g) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to chapter 26.1-36.6;

(h) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

(i) The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(j) A notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. (1) A health carrier may provide the notice required under this section orally, in writing, or electronically.

(2) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

26.1-36.8-09. Rulemaking.

The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.8-10. Penalties.

The commissioner may assess a penalty against a health carrier that violates this chapter of not more than ten thousand dollars for each violation. The fine may be recovered in an action brought in the name of the state. In addition to imposing a monetary penalty, the commissioner may also cancel, revoke, or refuse to renew the certificate of authority of a health carrier that has violated this chapter."

Renumber accordingly

#6

March 22, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1127

Page 1, line 1, replace "two new sections to chapter 26.1-36" with "chapters 26.1-36.6, 26.1-36.7, and 26.1-26.8"

Page 1, line 2, replace "appeals and internal claims and appeals" with "review, utilization review, and grievance"

Page 1, line 5, after the first semicolon and before "to" insert "and" and replace "for application; and to declare an" with "a penalty"

Page 1, line 6, remove "emergency"

Page 2, line 30, remove "The insurance commissioner shall take steps"

Page 2, remove line 31

Page 3, remove lines 1 through 31

Page 4, remove lines 1 through 9

Page 4, after line 9, insert the following:

"**SECTION 4.** Chapter 26.1-36.6 of the North Dakota Century Code is created and enacted as follows:

26.1-36.6-01. Definitions. For purposes of this chapter:

1. "Adverse determination" means:

   a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or

d. A rescission of coverage determination.

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

3. "Authorized representative" means:

a. A person to whom a covered person has given express written consent to represent the covered person in an external review;

b. A person authorized by law to provide substituted consent for a covered person; or

c. A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

4. "Best evidence" means evidence based on:

a. Randomized clinical trials;

b. If randomized clinical trials are not available, cohort studies or case-control studies;

c. If subdivisions a and b are not available, case-series; or

d. If subdivisions a, b, and c are not available, expert opinion.

5. "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

6. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

7. "Case-series" means an evaluation of a series of patients with a particular outcome without the use of a control group.

8. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

9. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

10. "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving specific interventions.

11. "Commissioner" means the insurance commissioner.\

12. "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

13. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

14. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

15. "Discharge planning" means the formal process for determining prior to discharge from a facility the coordination and management of the care that a patient receives following discharge from a facility.

16. "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

17. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention if failure to provide medical attention would result in a serious impairment to bodily functions, serious

dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

18. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

19. "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

20. "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

21. "Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

22. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier or its designee utilization review organization at the completion of the health carrier's internal grievance process procedures as set forth in chapter 26.1-36.8.

23. "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

24. "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

25. "Health care provider" or "provider" means a health care professional or a facility.

26. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

27. "Health carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

28. "Health information" means information or data whether oral or recorded in any form or medium and personal facts or information about events or relationships that relates to:

a. The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

b. The provision of health care services to an individual; or

c. Payment for the provision of health care services to an individual.

29. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

30. "Medical or scientific evidence" means evidence found in the following sources:

a. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

b. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus (MEDLINE) and elsevier science ltd.for indexing in excerpta medicus (EMBASE);

c. Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the Social Security Act;

d. The following standard reference compendia:

(1) The American hospital formulary service-drug information;

(2) Drug facts and comparisons;

(3) The American dental association accepted dental therapeutics; and

(4) The United States pharmacopoeia-drug information;

e. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(1) The federal agency for health care research and quality;

(2) The national institutes of health;

(3) The national cancer institute;

(4) The national academy of sciences;

(5) The centers for medicare and medicaid services;

(6) The federal food and drug administration; and

(7) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

f. Any other medical or scientific evidence that is comparable to the sources listed in subdivisions a through e.

31. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

32. "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

33. "Protected health information" means health information:

a. That identifies an individual who is the subject of the information; or

b. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

34. "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention which includes study of the groups for variables and anticipated outcomes over time.

35. "Retrospective review" means a review of medical necessity 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.

36. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

37. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

38. "Utilization review organization" means an entity that conducts utilization review other than a health carrier performing a review for its own health benefit plans.

26.1-36.6-02. Applicability and scope.

1. Except as provided in subsection 2, this chapter applies to all nongrandfathered health benefit plans."Nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub.L.111-148] and the Health Care and Education Reconciliation Act of 2010 [Pub.L.111-152] because it failed to achieve or lost grandfathered health plan status."Grandfathered health plan" has

the meaning stated in the Patient Protection and Affordable Care Act [Pub.L.111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub.L.111-152].

2. The provisions of this chapter do not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit, a medicare supplement policy of insurance, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55 of title 10, United States Code, and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

26.1-36.6-03. Notice of right to external review.

1. a. A health carrier shall notify a covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 26.1-36.6-06, 26.1-36.6-07, or 26.1-36.6-08 and include the appropriate statements and information set forth in subdivision b at the same time the health carrier sends written notice of:

   (1) An adverse determination upon completion of the health carrier's utilization review process set forth in chapter 26.1-36.7; and

   (2) A final adverse determination.

   b. As part of the written notice required under subdivision a, a health carrier shall include the following or substantially equivalent language: "We have denied your request for the provision of or payment for a health care service or course of treatment.You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the North Dakota Insurance

Commissioner, 600 East Boulevard Avenue, State Capitol, Bismarck, ND 58505."

c. The commissioner may prescribe the form and content of the notice required under this section.

2. a. The health carrier shall include in the notice required under subsection 1:

(1) For a notice related to an adverse determination, a statement informing the covered person that:

(a) If the covered person has a medical condition and the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in section 26.1-36.8-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 26.1-36.6-07 or 26.1-36.6-08 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-08, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(b) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in section 26.1-36.8-05, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to section 26.1-36.6-04 and shall be considered to have exhausted the health carrier's internal grievance process for purposes of section 26.1-36.6-05; and

(2) For a notice related to a final adverse determination, a statement informing the covered person that:

(a) If the covered person has a medical condition and the timeframe for completion of a standard external review pursuant to section 26.1-36.6-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to section 26.1-36.6-07; or

(b) If the final adverse determination concerns:

[1] An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to section 26.1-36.6-07; or

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

e. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions a through f to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

5. a. As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 26.1-36.6-06, the assigned independent review organization shall:

(1) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(2) Notify the covered person and the covered person's authorized representative, the health carrier, and the commissioner of the decision.

b. If the notice provided pursuant to subdivision a was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall:

(1) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative the health carrier, and the commissioner; and

(2) Include the information set forth in subdivision b of subsection 9 of section 26.1-36.6-06.

c. Upon receipt of the notice of a decision pursuant to paragraph 1 reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

6. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

7. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section

shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection 4 of section 26.1-36.6-11.

26.1-36.6-08. External review of experimental or investigational treatment adverse determinations.

1. a. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 26.1-36.6-03 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.

   b. (1) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subdivision a if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

   (2) Upon receipt of a request for an expedited external review, the commissioner immediately shall notify the health carrier.

   (3) (a) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection 2. The health carrier shall immediately notify the commissioner and the covered person and the covered person's authorized representative of its eligibility determination.

   (b) The commissioner may specify the form for the health carrier's notice of initial determination under subparagraph a and any supporting information to be included in the notice.

   (c) The notice of initial determination under subparagraph a shall include a statement informing the covered person and the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

   (4) (a) The commissioner may determine that a request is eligible for external review under subdivision b of subsection 2 notwithstanding a health carrier's initial determination the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph a, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

(5) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subdivision b of subsection 2, the commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 and notify the health carrier of the name of the assigned independent review organization.

(6) At the time the health carrier receives the notice of the assigned independent review organization pursuant to paragraph 5, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

2. a. Except for a request for an expedited external review made pursuant to subdivision b of subsection 1, within one business day after the date of receipt of the request, the commissioner receives a request for an external review, the commissioner shall notify the health carrier.

b. Within five business days following the date of receipt of the notice sent pursuant to subdivision a, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(a) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) The covered person's treating physician has certified that one of the following situations is applicable:

(a) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(b) Standard health care services or treatments are not medically appropriate for the covered person; or

(c) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in paragraph 4;

(4) The covered person's treating physician:

(a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(b) Who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) The covered person has exhausted the health carrier's internal grievance process as set forth in chapter 26.1-36.8 unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 26.1-36.6-05; and

(6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under subsection 2 of section 26.1-36.6-03.

3. a. Within one business day after completion of the preliminary review, the health carrier shall notify the commissioner and the covered person and the covered person's authorized representative in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

b. If the request:

(1) Is not complete, the health carrier shall inform in writing the commissioner and the covered person and the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized

representative, and the commissioner in writing and include in the notice the reasons for its ineligibility.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under subdivision b and any supporting information to be included in the notice.

(2) The notice of initial determination provided under subdivision b shall include a statement informing the covered person and the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under subdivision b of subsection 2 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

e. Whenever a request for external review is determined eligible for external review, the health carrier shall notify the commissioner and the covered person and the covered person's authorized representative.

4. a. Within one business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to paragraph 4 of subdivision b of subsection 1 or subdivision e of subsection 3, the commissioner shall:

(1) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the covered person and the covered person's authorized representative of the request's eligibility and acceptance for external review.

b. The commissioner shall include in the notice provided to the covered person and the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision a additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

c. Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to subdivision a, the assigned independent review organization shall:

(1) Select one or more clinical reviewers, as it determines is appropriate, pursuant to subdivision d to conduct the external review; and

(2) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

d. (1) In selecting clinical reviewers pursuant to paragraph 1 of subdivision c, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 26.1-36.6-11 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(2) Neither the covered person, the covered person's authorized representative, nor the health carrier may choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

e. In accordance with subsection 8, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

f. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

5. a. Within five business days after the date of receipt of the notice provided pursuant to subdivision a of subsection 4, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination.

b. Except as provided in subdivision c, failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in subdivision a shall not delay the conduct of the external review.

c. (1) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in subdivision a, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(2) Immediately upon making the decision under paragraph 1, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.

6. a. Each clinical reviewer selected pursuant to subsection 4 shall review all of the information and documents received pursuant to subsection 5 and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subdivision b of subsection 4.

b. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision b of subsection 4, within one business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

7. a. Upon receipt of the information required to be forwarded pursuant to subdivision b of subsection 6, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

b. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision a shall not delay or terminate the external review.

c. The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

d. (1) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision c, the health carrier shall notify the covered person, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(2) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to paragraph 1.

8. a. Except as provided in subdivision c, within twenty days after being selected in accordance with subsection 4 to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection 9 on whether the recommended or requested health care service or treatment should be covered.

b. Except for an opinion provided pursuant to subdivision c, each clinical reviewer's opinion shall be in writing and include the following information:

(1) A description of the covered person's medical condition;

(2) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(3) A description and analysis of any medical or scientific evidence, as that term is defined in subsection 30 of section 26.1-36.6-01, considered in reaching the opinion;

(4) A description and analysis of any evidence-based standard, as that term is defined in subsection 19 of section 26.1-36.6-01; and

(5) Information on whether the reviewer's rationale for the opinion is based on paragraph 1 or 2 of subdivision e of subsection 9.

c. (1) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five calendar days after being selected in accordance with subsection 4.

(2) If the opinion provided pursuant to paragraph 1 was not in writing, within forty-eight hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under subdivision b.

9. In addition to the documents and information provided pursuant to subsection 1 or 5, each clinical reviewer selected pursuant to subsection 4, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection 8:

a. The covered person's pertinent medical records;

b. The attending physician or health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

e. Whether:

(1) The recommended or requested health care service or treatment has been approved by the federal food and drug administration, if applicable, for the condition; or

(2) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

10. a. (1) Except as provided in paragraph 2, within twenty days after the date it receives the opinion of each clinical reviewer pursuant to subsection 9, the assigned independent review organization, in accordance with subdivision b, shall make a decision and provide written notice of the decision to:

(a) The covered person;

(b) If applicable, the covered person's authorized representative;

(c) The health carrier; and

(d) The commissioner.

(2) (a) For an expedited external review, within forty-eight hours after the date it receives the opinion of each clinical reviewer pursuant to subsection 9, the assigned independent review organization, in accordance with subdivision b, shall make a decision and provide notice of the decision orally or in writing to the persons listed in paragraph 1.

(b) If the notice provided under subparagraph b was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in paragraph 1 and include the information set forth in subdivision c.

b. (1) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(2) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(3) (a) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to paragraph 1 or 2.

(b) The additional clinical reviewer selected under subparagraph a shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection 9.

(c) The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection 4 pursuant to subdivision a.

c. The independent review organization shall include in the notice provided pursuant to subdivision a:

(1) A general description of the reason for the request for external review;

(2) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(3) The date the independent review organization was assigned by the commissioner to conduct the external review;

(4) The date the external review was conducted;

(5) The date of its decision;

(6) The principal reason or reasons for its decision; and

(7) The rationale for its decision.

d. Upon receipt of a notice of a decision pursuant to subdivision a reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

11. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other

circumstances, including conflict of interest concerns pursuant to subsection 4 of section 26.1-36.6-11.

26.1-36.6-09. Binding nature of external review decision.

1. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

2. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

3. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this chapter.

26.1-36.6-10. Approval of independent review organizations.

1. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this chapter.

2. In order to be eligible for approval by the commissioner under this section to conduct external reviews under this chapter an independent review organization:

   a. Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 26.1-36.6-11; and

   b. Shall submit an application for approval in accordance with subsection 4.

3. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

4. a. Any independent review organization wishing to be approved to conduct external reviews shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under section 26.1-36.6-11.

   b. (1) Subject to paragraph 2, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or

exceed the minimum qualifications for independent review organizations under section 26.1-36.6-11.

(2) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

c. The commissioner shall charge a fee of one hundred dollars that independent review organizations must submit to the commissioner with an application for initial approval. The commissioner shall charge a fee of twenty-five dollars for each reapproval.

5. a. An approval is effective for two years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under section 26.1-36.6-11.

b. Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 26.1-36.6-11, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this chapter that is maintained by the commissioner pursuant to subsection 6.

6. The commissioner shall maintain and periodically update a list of approved independent review organizations.

26.1-36.6-11. Minimum qualifications for independent review organizations.

1. To be approved under section 26.1-36.6-10 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:

a. A quality assurance mechanism in place that:

(1) Ensures that external reviews are conducted within the specified timeframes and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(3) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this chapter;

b. A toll-free telephone service to receive information on a twenty-four-hour-day seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

c. Maintain and provide to the commissioner the information set out in section 26.1-36.6-13.

2. All clinical reviewers assigned by an independent review organization to conduct external reviews must be physicians or other appropriate health care providers who meet the following minimum qualifications:

a. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

b. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

c. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

d. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

3. In addition to the requirements set forth in subsection 1, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans or a national, state, or local trade association of health care providers.

4. a. In addition to the requirements set forth in subsections 1, 2, and 3, to be approved pursuant to section 26.1-36.6-10 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The health carrier that is the subject of the external review;

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(3) Any officer, director, or management employee of the health carrier that is the subject of the external review;

(4) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(5) The facility at which the recommended health care service or treatment would be provided; or

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

b. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subdivision a, the commissioner shall take into consideration situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subdivision a, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

5. a. An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under section 26.1-36.6-10.

b. The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the national association for insurance commissioners for the purpose of the determination under this subdivision.

c. Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the national association of insurance commissioners in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the national association of insurance commissioners.

6. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

26.1-36.6-12. Hold harmless for independent review organizations.

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

26.1-36.6-13. External review reporting requirements.

1. a. An independent review organization assigned pursuant to section 26.1-36.6-06, 26.1-36.6-07, or 26.1-36.6-08 to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and upon request submit a report to the commissioner as required under subdivision b.

   b. Each independent review organization required to maintain written records on all requests for external review pursuant to subdivision a for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

   c. The report shall include in the aggregate by state and for each health carrier:

      (1) The total number of requests for external review;

      (2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

      (3) The average length of time for resolution;

      (4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

      (5) The number of external reviews pursuant to subsection 7 of section 26.1-36.6-06 that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

      (6) Any other information the commissioner may request or require.

d. The independent review organization shall retain the written records required pursuant to this subsection for at least three years.

2. a. Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this chapter.

b. Each health carrier required to maintain written records on all requests for external review pursuant to subdivision a shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

c. The report shall include in the aggregate, by state, and by type of health benefit plan:

(1) The total number of requests for external review;

(2) From the total number of requests for external review reported under paragraph 1, the number of requests determined eligible for a full external review; and

(3) Any other information the commissioner may request or require.

d. The health carrier shall retain the written records required pursuant to this subsection for at least three years.

26.1-36.6-14. Funding of external review.

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

26.1-36.6-15. Disclosure requirements.

1. a. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

b. The disclosure required by subdivision a shall be in a format prescribed by the commissioner.

2. The description required under subsection 1 shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the telephone number and address of the commissioner.

3. In addition to subsection 2, the statement shall inform the covered person that when filing a request for an external review the covered person will be required to authorize the release of any medical records of the covered

person that may be required to be reviewed for the purpose of reaching a decision on the external review.

26.1-36.6-16. Rulemaking.

The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.6-17. Confidentiality.

Any protected health information that the commissioner receives pursuant to this chapter is confidential.

SECTION 5. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36.7-01. Definitions.

As used in this chapter:

1. "Adverse determination" means:
   a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
   b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;
   c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or
   d. A rescission of coverage determination.
2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.
3. "Authorized representative" means:
   a. A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;
   b. A person authorized by law to provide substituted consent for a covered person;
   c. A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

4. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

5. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

6. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

7. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

8. "Commissioner" means the insurance commissioner.

9. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

10. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

11. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

12. "Discharge planning" means the formal process for determining prior to discharge from a facility the coordination and management of the care that a patient receives following discharge from a facility.

13. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a 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.

14. "Emergency services" means, with respect to an emergency medical condition:

a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

15. "Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical, or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

16. a. "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

b. "Health benefit plan" includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

c. "Health benefit plan" does not include:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191], under which benefits for medical care are secondary or incidental to other insurance benefits.

d. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].

e. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

f. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (civilian health and medical program of the uniformed services (CHAMPUS)); or

(3) Similar supplemental coverage provided to coverage under a group health plan.

17. "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

18. "Health care provider" or "provider" means a health care professional or a facility.

19. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

20. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

21. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

22. "Network" means the group of participating providers providing services to a managed care plan.

23. "Participating provider" means a provider who under a contract with the health carrier or with its contractor or subcontractor has agreed to provide health care services to covered persons with an expectation of receiving payment other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

24. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

25. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

26. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under a health benefit plan if:

    a. The cancellation or discontinuance of coverage has only a prospective effect; or

    b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

27. a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

    b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

28. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

29. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

30. a. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination:

        (1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

        (2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the

health care service or treatment that is the subject of the request.

b. (1) Except as provided in paragraph 2, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(2) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision a must be treated as an urgent care request.

31. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

32. "Utilization review organization" means an entity that conducts utilization review other than a health carrier performing utilization review for its own health benefit plans.

26.1-36.7-02. Applicability and scope.

This chapter shall apply to a health carrier offering health benefit plans that provides or performs utilization review services, to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf, and to a health carrier or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations regarding coverage provided under a nongrandfathered health benefit plan. For purposes of this chapter, "nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] and the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] because it failed to achieve or lost grandfathered health plan status. For purposes of this chapter, "grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

26.1-36.7-03. Corporate oversight of utilization review program.

A health carrier shall be responsible for monitoring all utilization review activities carried out by or on behalf of the health carrier and for ensuring that all requirements of this chapter and

applicable rules are met. The health carrier also shall ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

26.1-36.7-04. Contracting.

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by this chapter or applicable rules, the commissioner shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of this chapter and applicable rules are met.

26.1-36.7-05. Scope and content of utilization review program.

1. a. A health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and nondelegated for:

   (1) The filing of benefit requests;

   (2) The notification of utilization review and benefit determinations; and

   (3) The review of adverse determinations in accordance with chapter 26.1-36.8.

   b. The program document shall describe the following:

   (1) Procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

   (2) Data sources and clinical review criteria used in decisionmaking;

   (3) Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

   (4) Data collection processes and analytical methods used in assessing utilization of health care services;

   (5) Provisions for assuring confidentiality of clinical and proprietary information;

   (6) The organizational structure, such as a utilization review committee, quality assurance, or other committee, that periodically assesses utilization review activities and reports to the health carrier's governing body; and

   (7) The staff position functionally responsible for day-to-day program management.

2. a. A health carrier shall file an annual summary report of its utilization review program activities with the commissioner in the format approved by the commissioner.

   b. (1) In addition to the summary report, a health carrier shall maintain records for a minimum of six years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with sections 26.1-36.7-07 and 26.1-36.7-08.

(2) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agencies upon request.

26.1-36.7-06. Operational requirements.

1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to the commissioner.

2. Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

3. a. A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of sections 26.1-36.7-07 and 26.1-36.7-08.

   b. (1) Whenever a health carrier fails to strictly adhere to the requirements of sections 26.1-36.7-07 or 26.1-36.7-08 with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this chapter and may take action under paragraph 2 regardless of whether the health carrier asserts that it substantially complied with the requirements of sections 26.1-36.7-07 or 26.1-36.7-08, as applicable, or that any error it committed was de minimis.

   (2) (a) A covered person may file a request for external review in accordance with the procedures outlined in chapter 26.1-36.6.

   (b) In addition, a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

4. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently in conducting utilization review.

5. A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

6. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

7. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which must include:

a. A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

b. Evidence of formal approval of the utilization review organization program by the health carrier; and

c. A process by which the health carrier evaluates the performance of the utilization review organization.

8. The health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

9. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

10. When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

11. a. In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

b. In ensuring the independence and impartiality of individuals involved in making the utilization review or benefit determination, the health carrier may not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

26.1-36.7-07. Procedures for standard utilization review and benefit determinations.

1. A health carrier shall maintain written procedures pursuant to this section for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified timeframes required under this section.

2. a. (1) Subject to paragraph 2, for prospective review determinations, a health carrier shall make the determination and notify the covered person or the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition but in no event later than fifteen days after the date the health carrier receives the request.

Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with subsection 6.

(2) The time period for making a determination and notifying the covered person or the covered person's authorized representative of the determination pursuant to paragraph 1 may be extended one time by the health carrier for up to fifteen days, provided the health carrier:

(a) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(b) Notifies the covered person or the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(3) If the extension under paragraph 2 is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(a) Specifically describe the required information necessary to complete the request; and

(b) Give the covered person or the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

b. (1) Whenever the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

(2) (a) The notice required under paragraph 1 shall be provided as soon as possible but in no event later than five days following the date of the failure.

(b) The health carrier may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing.

(3) The provisions of this paragraph apply only in the case of a failure that:

(a) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(b) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which certification is being requested.

3. a. For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and

(2) The health carrier shall notify the covered person of the adverse determination in accordance with subsection 6 at a time sufficiently in advance of the reduction or termination to allow the covered person or the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to chapter 26.1-36.8 and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

b. The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the health carrier with respect to the internal review request made pursuant to chapter 26.1-36.8.

4. a. (1) For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time but in no event later than thirty days after the date of receiving the benefit request.

(2) If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or the covered person's authorized representative in accordance with subsection 6.

b. (1) The time period for making a determination and notifying the coveted person or the covered person's authorized representative of the determination pursuant to subdivision a may be extended one time by the health carrier for up to fifteen days, provided the health carrier:

(a) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(b) Notifies the covered person or the covered person's authorized representative prior to the expiration of the initial thirty-day time period of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(2) If the extension under paragraph 1 is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(a) Specifically describe the required information necessary to complete the request; and

(b) Give the covered person or the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

5. a. For purposes of calculating the time periods within which a determination is required to be made under subsections 2 and 4, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.7-05 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

b. (1) If the time period for making the determination under subsection 2 or 4 is extended due to the covered person's or the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or the covered person's authorized representative until the earlier of:

(a) The date on which the covered person or the covered person's authorized representative responds to the request for additional information; or

(b) The date on which the specified information was to have been submitted.

(2) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection 2 or 4, the health carrier may deny the certification of the requested benefit.

6. a. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

(2) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(3) Reference to the specific plan provisions on which the determination is based;

(4) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

(5) A description of the health carrier's grievance procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures;

(6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(7) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(8) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination; or

(9) The written statement of the scientific or clinical rationale for the adverse determination; and

(10) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under chapter 26.1-36.8, to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing

claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. If the adverse determination is a rescission, the health carrier shall provide in the advance notice of the rescission determination required to be provided under applicable state or federal law or regulation related to the advance notice requirement of a proposed rescission, in addition to any applicable disclosures required under subdivision a:

(1) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of a material fact;

(2) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to chapter 26.1-36.8;

(4) A description of the health carrier's grievance procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures; and

(5) The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

d. A health carrier may provide the notice required under this section in writing or electronically.

26.1-36.7-08. Procedures for expedited utilization review and benefit determinations.

1. a. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

b. (1) As part of the procedures required under subdivision a, a health carrier shall provide that in the case of a failure by a covered person or the covered person's authorized representative to follow the health carrier's procedures for filing an urgent care request the covered person or the covered person's authorized representative shall be notified of the failure and the proper procedures to be following for filing the request.

(2) A health carrier shall provide the notice required under paragraph 1:

(a) To the covered person or the covered person's authorized representative as soon as possible but not later than twenty-four hours after receipt of the request; and

(b) Orally unless the covered person or the covered person's authorized representative requests the notice in writing.

(3) The provisions of this paragraph apply only in the case of a failure that:

(a) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(b) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which approval is being requested.

2. a. (1) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or the covered person's authorized representative of the health carrier's determination with respect to the request, whether the determination is an adverse determination as soon as possible taking into account the medical condition of the covered person but in no event later than twenty-four hours after the receipt of the request by the health carrier.

(2) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

b. (1) If the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible but in no event later than twenty-four hours after receipt of the request.

(2) The health carrier shall provide the covered person or the covered person's authorized representative a reasonable period of time to submit the necessary information taking into account the circumstances but in no event less than forty-eight hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in paragraph 1.

(3) The health carrier shall notify the covered person or the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible but in no event more than forty-eight hours after the earlier of:

(a) The health carrier's receipt of the requested specified information; or

(b) The end of the period provided for the covered person or the covered person's authorized representative to submit the requested specified information.

(4) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in paragraph 2, the health carrier may deny the certification of the requested benefit.

(5) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

3. a. For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible taking into account the covered person's medical condition but in no event more than twenty-four hours after the health carrier's receipt of the request.

b. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

4. For purposes of calculating the time periods within which a determination is required to be made under subsection 2 or 3, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.7-05 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5. a. A notification of an adverse determination under this section shall in a manner calculated to be understood by the covered person set forth:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(2) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(3) Reference to the specific plan provisions on which the determination is based;

[2] A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to section 26.1-36.6-06 or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under section 26.1-36.6-07.

b. In addition to the information to be provided pursuant to subdivision a, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 26.1-36.6-15, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

c. As part of any forms provided under subdivision b, the health carrier shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508, by which the covered person, for purposes of conducting an external review under this chapter, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review, as provided in section 26.1-36-12.4.

26.1-36.6-04. Request for external review.

1. a. Except for a request for an expedited external review as set forth in section 26.1-36.6-07, all requests for external review shall be made in writing to the commissioner.

b. The commissioner may prescribe by the form and content of external review requests required to be submitted under this section.

2. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

26.1-36.6-05. Exhaustion of internal grievance process.

1. a. Except as provided in subsection 2, a request for an external review pursuant to section 26.1-36.6-06, 26.1-36.6-07, or 26.1-36.6-08 shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

b. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

(1) Has filed a grievance involving an adverse determination pursuant to section 26.1-36.8-05; and

(2) Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

c. Notwithstanding subdivision b, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to chapter 26.1-36.7 until the covered person has exhausted the health carrier's internal grievance process.

2. a. (1) At the same time a covered person or the covered person's authorized representative files a request for

an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-06, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(a) Under section 26.1-36.6-07 if the covered person has a medical condition and the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in section 26.1-36.8-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(b) Under section 26.1-36.6-08 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(2) Upon receipt of a request for an expedited external review under paragraph 1, the independent review organization conducting the external review in accordance with the provisions of section 26.1-36.6-07 or 26.1-36.6-08 shall determine whether the covered person shall be required to complete the expedited review process set forth in section 26.1-36.8-06 before it conducts the expedited external review.

(3) Upon a determination made pursuant to paragraph 2 that the covered person must first complete the expedited grievance review process set forth in section 26.1-36.8-06, the independent review organization immediately shall notify the covered person and the covered person's authorized representative of this determination and that it will not

proceed with the expedited external review set forth in section 26.1-36.6-07 until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

b. A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in section 26.1-36.8-05 whenever the health carrier agrees to waive the exhaustion requirement.

3. If the requirement to exhaust the health carrier's internal grievance procedures is waived under subdivision a of subsection 2, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in section 26.1-36.6-06 or 26.1-36.6-08.

26.1-36.6-06. Standard external review.

1. a. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 26.1-36.6-03, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner.

b. Within one business day after the date of receipt of a request for external review pursuant to subdivision a, the commissioner shall send a copy of the request to the health carrier.

2. Within five business days following the date of receipt of the copy of the external review request from the commissioner under subdivision b of subsection 1, the health carrier shall complete a preliminary review of the request to determine whether:

a. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

b. The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care

service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

c. The covered person has exhausted the health carrier's internal grievance process as set forth in chapter 26.1-36.8 unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 26.1-36.6-05; and

d. The covered person has provided all the information and forms required to process an external review, including the release form provided under section 26.1-36.6-03.

3. a. Within one business day after completion of the preliminary review, the health carrier shall notify the commissioner and covered person and the covered person's authorized representative in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

b. If the request:

(1) Is not complete, the health carrier shall inform the covered person and the covered person's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall inform the covered person and the covered person's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(2) The notice of initial determination shall include a statement informing the covered person and the covered person's authorized representative that a

health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under section 26.1-36.6-06 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

4. a. Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection 3, within one business day after the date of receipt of the notice, the commissioner shall:

(1) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the covered person and the covered person's authorized representative of the request's eligibility and acceptance for external review.

b. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

c. The commissioner shall include in the notice provided to the covered person and the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the

notice provided pursuant to subdivision a additional information that the independent review organization shall consider when conducting the external review.The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

5. a. Within five business days after the date of receipt of the notice provided pursuant to subdivision a of subsection 4, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

b. Except as provided in subdivision c, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subdivision a shall not delay the conduct of the external review.

c. (1) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subdivision a, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(2) Within one business day after making the decision under paragraph 1, the independent review organization shall notify the covered person and the covered person's authorized representative, the health carrier, and the commissioner.

6. a. The assigned independent review organization shall review all of the information and documents received pursuant to subsection 5 and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision c of subsection 4.

b. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision c of subsection 4, the assigned

independent review organization shall within one business day forward the information to the health carrier.

7. a. Upon receipt of the information, if any, required to be forwarded pursuant to subdivision b of subsection 6, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

b. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision a shall not delay or terminate the external review.

c. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

d. (1) Within one business day after making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision c, the health carrier shall notify the covered person and the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(2) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to paragraph 1.

8. In addition to the documents and information provided pursuant to subsection 5, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's medical records;

b. The attending health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health

carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

e. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions a through f to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

9. a. Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(1) The covered person;

(2) If applicable, the covered person's authorized representative;

(3) The health carrier; and

(4) The commissioner.

b. The independent review organization shall include in the notice sent pursuant to subdivision a:

(1) A general description of the reason for the request for external review;

(2) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(3) The date the external review was conducted;

(4) The date of its decision;

(5) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(6) The rationale for its decision; and

(7) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

c. Upon receipt of a notice of a decision pursuant to subdivision a reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

10. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 26.1-36.6-11.

26.1-36.6-07. Expedited external review.

1. Except as provided in subsection 5, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

a. An adverse determination if:

(1) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse

determination set forth in section 26.1-36.8-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(2) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-06; or

b. A final adverse determination:

(1) If the covered person has a medical condition and the timeframe for completion of a standard external review pursuant to section 26.1-36.6-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(2) If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

2. a. Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier.

b. Immediately upon receipt of the request pursuant to subdivision a, the health carrier shall determine whether the request meets the reviewability requirements set forth in section 26.1-36.6-06.The health carrier shall immediately notify the commissioner and the covered person and the covered person's authorized representative of its eligibility determination.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(2) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial

determination that an external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under section 26.1-36.6-06 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

e. Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10.The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

f. In reaching a decision in accordance with subsection 5, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in 26.1-36.8.

3. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subdivision e of subsection 2, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

4. In addition to the documents and information provided or transmitted pursuant to subsection 3, the assigned independent review organization, to the extent the information or documents are

available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's pertinent medical records;

b. The attending health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

e. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions a through f to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

5. a. As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 26.1-36.6-06, the assigned independent review organization shall:

(1) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(2) Notify the covered person and the covered person's authorized representative, the health carrier, and the commissioner of the decision.

b. If the notice provided pursuant to subdivision a was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall:

(1) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative the health carrier, and the commissioner; and

(2) Include the information set forth in subdivision b of subsection 9 of section 26.1-36.6-06.

c. Upon receipt of the notice of a decision pursuant to paragraph 1 reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

6. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

7. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection 4 of section 26.1-36.6-11.

26.1-36.6-08. External review of experimental or investigational treatment adverse determinations.

1. a. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 26.1-36.6-03 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the

covered person's authorized representative may file a request for external review with the commissioner.

b. (1) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subdivision a if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(2) Upon receipt of a request for an expedited external review, t he commissioner immediately shall notify the health carrier.

(3) (a) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection 2.The health carrier shall immediately notify the commissioner and the covered person and the covered person's authorized representative of its eligibility determination.

(b) The commissioner may specify the form for the health carrier's notice of initial determination under subparagraph a and any supporting information to be included in the notice.

(c) The notice of initial determination under subparagraph a shall include a statement informing the covered person and the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(4) (a) The commissioner may determine that a request is eligible for external review under subdivision b of subsection 2 notwithstanding a health carrier's initial determination the request is ineligible and require that it be referred for external review.

(b) In making a determination under subparagraph a, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

(5) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subdivision b of subsection 2, the commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 and notify the health carrier of the name of the assigned independent review organization.

(6) At the time the health carrier receives the notice of the assigned independent review organization pursuant to paragraph 5, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

2. a. Except for a request for an expedited external review made pursuant to subdivision b of subsection 1, within one business day after the date of receipt of the request, the commissioner receives a request for an external review, the commissioner shall notify the health carrier.

b. Within five business days following the date of receipt of the notice sent pursuant to subdivision a, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(2) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(a) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(b) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) The covered person's treating physician has certified that one of the following situations is applicable:

(a) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(b) Standard health care services or treatments are not medically appropriate for the covered person; or

(c) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in paragraph 4;

(4) The covered person's treating physician:

(a) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(b) Who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health

care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(5) The covered person has exhausted the health carrier's internal grievance process as set forth in chapter 26.1-36.8 unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 26.1-36.6-05; and

(6) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the release form provided under subsection 2 of section 26.1-36.6-03.

3. a. Within one business day after completion of the preliminary review, the health carrier shall notify the commissioner and the covered person and the covered person's authorized representative in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

b. If the request:

(1) Is not complete, the health carrier shall inform in writing the commissioner and the covered person and the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, and the commissioner in writing and include in the notice the reasons for its ineligibility.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under

subdivision b and any supporting information to be included in the notice.

(2) The notice of initial determination provided under subdivision b shall include a statement informing the covered person and the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under subdivision b of subsection 2 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

e. Whenever a request for external review is determined eligible for external review, the health carrier shall notify the commissioner and the covered person and the covered person's authorized representative.

4. a. Within one business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to paragraph 4 of subdivision b of subsection 1 or subdivision e of subsection 3, the commissioner shall:

(1) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the covered person and the covered person's authorized representative of the request's eligibility and acceptance for external review.

b. The commissioner shall include in the notice provided to the covered person and the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision a additional information that the independent review organization shall consider when conducting the external review.The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

c. Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to subdivision a, the assigned independent review organization shall:

(1) Select one or more clinical reviewers, as it determines is appropriate, pursuant to subdivision d to conduct the external review; and

(2) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

d. (1) In selecting clinical reviewers pursuant to paragraph 1 of subdivision c, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 26.1-36.6-11 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(2) Neither the covered person, the covered person's authorized representative, nor the health carrier may choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

e. In accordance with subsection 8, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

f. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

5. a. Within five business days after the date of receipt of the notice provided pursuant to subdivision a of subsection 4, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination.

b. Except as provided in subdivision c, failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in subdivision a shall not delay the conduct of the external review.

c. (1) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in subdivision a, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(2) Immediately upon making the decision under paragraph 1, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the commissioner.

6. a. Each clinical reviewer selected pursuant to subsection 4 shall review all of the information and documents received pursuant to subsection 5 and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subdivision b of subsection 4.

b. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision b of subsection 4, within one business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

7. a. Upon receipt of the information required to be forwarded pursuant to subdivision b of subsection 6, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

b. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision a shall not delay or terminate the external review.

c. The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

d. (1) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision c, the health carrier shall notify the covered person, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(2) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to paragraph 1.

8. a. Except as provided in subdivision c, within twenty days after being selected in accordance with subsection 4 to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection 9 on whether the recommended or requested health care service or treatment should be covered.

b. Except for an opinion provided pursuant to subdivision c, each clinical reviewer's opinion shall be in writing and include the following information:

(1) A description of the covered person's medical condition;

(2) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(3) A description and analysis of any medical or scientific evidence, as that term is defined in subsection 30 of section 26.1-36.6-01, considered in reaching the opinion;

(4) A description and analysis of any evidence-based standard, as that term is defined in subsection 19 of section 26.1-36.6-01; and

(5) Information on whether the reviewer's rationale for the opinion is based on paragraph 1 or 2 of subdivision e of subsection 9.

c. (1) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five calendar days after being selected in accordance with subsection 4.

(2) If the opinion provided pursuant to paragraph 1 was not in writing, within forty-eight hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under subdivision b.

9. In addition to the documents and information provided pursuant to subsection 1 or 5, each clinical reviewer selected pursuant to subsection 4, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection 8:

a. The covered person's pertinent medical records;

b. The attending physician or health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

e. Whether:

(1) The recommended or requested health care service or treatment has been approved by the federal food and drug administration, if applicable, for the condition; or

(2) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

10. a. (1) Except as provided in paragraph 2, within twenty days after the date it receives the opinion of each clinical

reviewer pursuant to subsection 9, the assigned independent review organization, in accordance with subdivision b, shall make a decision and provide written notice of the decision to:

(a) The covered person;

(b) If applicable, the covered person's authorized representative;

(c) The health carrier; and

(d) The commissioner.

(2) (a) For an expedited external review, within forty-eight hours after the date it receives the opinion of each clinical reviewer pursuant to subsection 9, the assigned independent review organization, in accordance with subdivision b, shall make a decision and provide notice of the decision orally or in writing to the persons listed in paragraph 1.

(b) If the notice provided under subparagraph b was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in paragraph 1 and include the information set forth in subdivision c.

b. (1) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(2) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(3) (a) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to paragraph 1 or 2.

(b) The additional clinical reviewer selected under subparagraph a shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection 9.

(c) The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection 4 pursuant to subdivision a.

c. The independent review organization shall include in the notice provided pursuant to subdivision a:

(1) A general description of the reason for the request for external review;

(2) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(3) The date the independent review organization was assigned by the commissioner to conduct the external review;

(4) The date the external review was conducted;

(5) The date of its decision;

(6) The principal reason or reasons for its decision; and

(7) The rationale for its decision.

d. Upon receipt of a notice of a decision pursuant to subdivision a reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

11. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection 4 of section 26.1-36.6-11.

26.1-36.6-09. Binding nature of external review decision.

1. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

2. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

3. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this chapter.

26.1-36.6-10. Approval of independent review organizations.

1. The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this chapter.

2. In order to be eligible for approval by the commissioner under this section to conduct external reviews under this chapter an independent review organization:

a. Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 26.1-36.6-11; and

b. Shall submit an application for approval in accordance with subsection 4.

3. The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

4. a. Any independent review organization wishing to be approved to conduct external reviews shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under section 26.1-36.6-11.

b. (1) Subject to paragraph 2, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under section 26.1-36.6-11.

(2) The commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

c. The commissioner shall charge a fee of one hundred dollars that independent review organizations must submit to the commissioner with an application for initial approval. The commissioner shall charge a fee of twenty-five dollars for each reapproval.

5. a. An approval is effective for two years, unless the commissioner determines before its expiration that the

independent review organization is not satisfying the minimum qualifications established under section 26.1-36.6-11.

b. Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 26.1-36.6-11, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this chapter that is maintained by the commissioner pursuant to subsection 6.

6. The commissioner shall maintain and periodically update a list of approved independent review organizations.

26.1-36.6-11. Minimum qualifications for independent review organizations.

1. To be approved under section 26.1-36.6-10 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:

a. A quality assurance mechanism in place that:

(1) Ensures that external reviews are conducted within the specified timeframes and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(3) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this chapter;

b. A toll-free telephone service to receive information on a twenty-four-hour-day seven-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

c. Maintain and provide to the commissioner the information set out in section 26.1-36.6-13.

2. All clinical reviewers assigned by an independent review organization to conduct external reviews must be physicians or other appropriate health care providers who meet the following minimum qualifications:

a. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

b. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

c. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

d. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

3. In addition to the requirements set forth in subsection 1, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans or a national, state, or local trade association of health care providers.

4. a. In addition to the requirements set forth in subsections 1, 2, and 3, to be approved pursuant to section 26.1-36.6-10 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The health carrier that is the subject of the external review;

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(3) Any officer, director, or management employee of the health carrier that is the subject of the external review;

(4) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(5) The facility at which the recommended health care service or treatment would be provided; or

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

b. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subdivision a, the commissioner shall take into consideration situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subdivision a, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the

independent review organization or the clinical reviewer from conducting the external review.

5. a. An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under section 26.1-36.6-10.

b. The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the national association for insurance commissioners for the purpose of the determination under this subdivision.

c. Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the national association of insurance commissioners in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the national association of insurance commissioners.

6. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

26.1-36.6-12. Hold harmless for independent review organizations. No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

26.1-36.6-13. External review reporting requirements.

1. a. An independent review organization assigned pursuant to section 26.1-36.6-06 , 26.1-36.6-07, or 26.1-36.6-08 to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and upon request submit a report to the commissioner as required under subdivision b.

b. Each independent review organization required to maintain written records on all requests for external review pursuant to subdivision a for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

c. The report shall include in the aggregate by state and for each health carrier:

(1) The total number of requests for external review;

(2) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(3) The average length of time for resolution;

(4) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(5) The number of external reviews pursuant to subsection 7 of section 26.1-36.6-06 that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(6) Any other information the commissioner may request or require.

d. The independent review organization shall retain the written records required pursuant to this subsection for at least three years.

2. a. Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this chapter.

b. Each health carrier required to maintain written records on all requests for external review pursuant to subdivision a shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

c. The report shall include in the aggregate, by state, and by type of health benefit plan:

(1) The total number of requests for external review;

(2) From the total number of requests for external review reported under paragraph 1, the number of requests determined eligible for a full external review; and

(3) Any other information the commissioner may request or require.

d. The health carrier shall retain the written records required pursuant to this subsection for at least three years.

26.1-36.6-14. Funding of external review. The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

26.1-36.6-15. Disclosure requirements.

1. a. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

b. The disclosure required by subdivision a shall be in a format prescribed by the commissioner.

2. The description required under subsection 1 shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the commissioner.The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness.The statement shall include the telephone number and address of the commissioner.

3. In addition to subsection 2, the statement shall inform the covered person that when filing a request for an external review the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

26.1-36.6-16. Rulemaking. The commissioner may adopt rules to carry out the provisions of this chapter.

26.1-36.6-17. Confidentiality. Any protected health information that the commissioner receives pursuant to this chapter is confidential.

SECTION 5. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36.7-01. Definitions. As used in this chapter:

1. "Adverse determination" means:

   a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

   b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or

d. A rescission of coverage determination.

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

3. "Authorized representative" means:

a. A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;

b. A person authorized by law to provide substituted consent for a covered person;

c. A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

4. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

5. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

6. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

7. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

8. "Commissioner" means the insurance commissioner.

9. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

10. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

11. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

12. "Discharge planning" means the formal process for determining prior to discharge from a facility the coordination and management of the care that a patient receives following discharge from a facility.

13. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a 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.

14. "Emergency services" means, with respect to an emergency medical condition:

    a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

15. "Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical, or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

16. a. "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

b. "Health benefit plan" includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

c. "Health benefit plan" does not include:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub.L.104-191], under which benefits for medical care are secondary or incidental to other insurance benefits.

d. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub.L.104-191].

e. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

f. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1)of the Social Security Act;

(2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (civilian health and medical program of the uniformed services (CHAMPUS)); or

(3) Similar supplemental coverage provided to coverage under a group health plan.

17. "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

18. "Health care provider" or "provider" means a health care professional or a facility.

19. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

20. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

21. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

22. "Network" means the group of participating providers providing services to a managed care plan.

23. "Participating provider" means a provider who under a contract with the health carrier or with its contractor or subcontractor has agreed to provide health care services to covered persons with an expectation of receiving payment other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

24. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

25. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

26. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.Rescission does not include a cancellation or discontinuance of coverage under a health benefit plan if:

a. The cancellation or discontinuance of coverage has only a prospective effect; or

b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

27. a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

28. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

29. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

30. a. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

b. (1) Except as provided in paragraph 2, in determining whether a request is to be treated as an urgent care request.an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(2) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision a must be treated as an urgent care request.

31. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

32. "Utilization review organization" means an entity that conducts utilization review other than a health carrier performing utilization review for its own health benefit plans.

26.1-36.7-02. Applicability and scope. This chapter shall apply to a health carrier offering health benefit plans that provides or performs utilization review services, to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf, and to a health carrier or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations regarding coverage provided under a nongrandfathered health benefit plan.For purposes of this chapter, "nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub.L.111-148] and the Health Care and Education Reconciliation Act of 2010 [Pub.L.111-152] because it failed to achieve or lost grandfathered health plan status.For purposes of this chapter, "grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub.L.111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub.L.111-152].

26.1-36.7-03. Corporate oversight of utilization review program. A health carrier shall be responsible for monitoring all utilization review activities carried out by or on behalf of the health carrier and for ensuring that all requirements of this chapter and applicable rules are met.The health carrier also shall ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

26.1-36.7-04. Contracting. Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by this chapter or applicable rules, the commissioner shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of this chapter and applicable rules are met.

26.1-36.7-05. Scope and content of utilization review program.

1. a. A health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and nondelegated for:

   (1) The filing of benefit requests;

   (2) The notification of utilization review and benefit determinations; and

   (3) The review of adverse determinations in accordance with chapter 26.1-36.8.

   b. The program document shall describe the following:

   (1) Procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

   (2) Data sources and clinical review criteria used in decisionmaking;

   (3) Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

   (4) Data collection processes and analytical methods used in assessing utilization of health care services;

   (5) Provisions for assuring confidentiality of clinical and proprietary information;

   (6) The organizational structure, such as a utilization review committee, quality assurance, or other committee, that periodically assesses utilization

review activities and reports to the health carrier's governing body; and

(7) The staff position functionally responsible for day-to-day program management.

2. a. A health carrier shall file an annual summary report of its utilization review program activities with the commissioner in the format approved by the commissioner.

b. (1) In addition to the summary report, a health carrier shall maintain records for a minimum of six years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with sections 26.1-36.7-07 and 26.1-36.7-08.

(2) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agencies upon request.

26.1-36.7-06. Operational requirements.

1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy.A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors.A health carrier shall make available its clinical review criteria upon request to the commissioner.

2. Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions.A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

3. a. A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of sections 26.1-36.7-07 and 26.1-36.7-08.

b. (1) Whenever a health carrier fails to strictly adhere to the requirements of sections 26.1-36.7-07 or 26.1-36.7-08 with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted

the provisions of this chapter and may take action under paragraph 2 regardless of whether the health carrier asserts that it substantially complied with the requirements of sections 26.1-36.7-07 or 26.1-36.7-08, as applicable, or that any error it committed was de minimis.

(2) (a) A covered person may file a request for external review in accordance with the procedures outlined in chapter 26.1-36.6.

(b) In addition, a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

4. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently in conducting utilization review.

5. A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

6. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

7. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which must include:

a. A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

b. Evidence of formal approval of the utilization review organization program by the health carrier; and

c. A process by which the health carrier evaluates the performance of the utilization review organization.

8. The health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier,

such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

9. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

10. When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

11. a. In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

b. In ensuring the independence and impartiality of individuals involved in making the utilization review or benefit determination, the health carrier may not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

26.1-36.7-07. Procedures for standard utilization review and benefit determinations.

1. A health carrier shall maintain written procedures pursuant to this section for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified timeframes required under this section.

2. a. (1) Subject to paragraph 2, for prospective review determinations, a health carrier shall make the determination and notify the covered person or the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition but in no event later than fifteen days after the date the health carrier receives the request.Whenever the determination is an adverse determination, the health carrier shall make the

notification of the adverse determination in accordance with subsection 6.

(2) The time period for making a determination and notifying the covered person or the covered person's authorized representative of the determination pursuant to paragraph 1 may be extended one time by the health carrier for up to fifteen days, provided the health carrier:

(a) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(b) Notifies the covered person or the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(3) If the extension under paragraph 2 is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(a) Specifically describe the required information necessary to complete the request; and

(b) Give the covered person or the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

b. (1) Whenever the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

(2) (a) The notice required under paragraph 1 shall be provided as soon as possible but in no event

later than five days following the date of the failure.

(b) The health carrier may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing.

(3) The provisions of this paragraph apply only in the case of a failure that:

(a) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(b) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which certification is being requested.

3. a. For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and

(2) The health carrier shall notify the covered person of the adverse determination in accordance with subsection 6 at a time sufficiently in advance of the reduction or termination to allow the covered person or the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to chapter 26.1-36.8 and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

b. The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the health carrier with respect to the internal review request made pursuant to chapter 26.1-36.8.

4. a. (1) For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time but in no event later than thirty days after the date of receiving the benefit request.

(2) If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or the covered person's authorized representative in accordance with subsection 6.

b. (1) The time period for making a determination and notifying the coveted person or the covered person's authorized representative of the determination pursuant to subdivision a may be extended one time by the health carrier for up to fifteen days, provided the health carrier:

(a) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(b) Notifies the covered person or the covered person's authorized representative prior to the expiration of the initial thirty-day time period of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(2) If the extension under paragraph 1 is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(a) Specifically describe the required information necessary to complete the request; and

(b) Give the covered person or the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

5. a. For purposes of calculating the time periods within which a determination is required to be made under subsections 2 and 4, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.7-05 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

b. (1) If the time period for making the determination under subsection 2 or 4 is extended due to the covered person's or the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or the covered person's authorized representative until the earlier of:

(a) The date on which the covered person or the covered person's authorized representative responds to the request for additional information; or

(b) The date on which the specified information was to have been submitted.

(2) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection 2 or 4, the health carrier may deny the certification of the requested benefit.

6. a. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if