

JOURNAL OF THE SENATE

Sixty-second Legislative Assembly

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Bismarck, March 29, 2011

The Senate convened at 1:00 p.m., with President Wrigley presiding.

The prayer was offered by Deacon Randy Frohlich, Church of St. Joseph, Mandan.

The roll was called and all members were present.

A quorum was declared by the President.

CORRECTION AND REVISION OF THE JOURNAL

MR. PRESIDENT: Your **Committee on Correction and Revision of the Journal (Sen. Andrist, Chairman)** has carefully examined the Journal of the Fifty-fifth Day and recommends that it be corrected as follows and when so corrected, recommends that it be approved:

Page 897, line 35, remove "HB 1124,"

Page 897, line 39, after "HB 1112," insert "HB 1124"

SEN. ANDRIST MOVED that the report be adopted, which motion prevailed.

CONSIDERATION OF AMENDMENTS

HB 1468, as reengrossed: SEN. DEVER (Government and Veterans Affairs Committee) MOVED that the amendments on SJ page 905 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a voice vote.

REPORT OF STANDING COMMITTEE

HB 1134, as engrossed: Government and Veterans Affairs Committee (Sen. Dever, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1134 was placed on the Sixth order on the calendar.

Page 2, line 20, remove the overstrike over "Each"

Page 2, line 20, remove "Except for the member contribution increases beginning after June 30, 2012."

Page 2, line 21, remove "each"

Page 3, line 2, after "or" insert ", except for the member contribution increases beginning after June 30, 2012."

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1134, as engrossed: SEN. SORVAAG (Government and Veterans Affairs Committee) MOVED that the amendments on SJ page 911 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a voice vote.

REPORT OF STANDING COMMITTEE

HB 1047, as engrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1047 was placed on the Sixth order on the calendar.

Page 4, line 27, remove "previous year"

Page 4, line 27, remove the overstrike over "~~for taxable~~"

Page 4, line 28, remove the overstrike over "~~year 2008~~"

Page 4, line 28, remove "plus the previous year number of mills of property tax relief under this"

Page 4, line 29, remove "chapter"

Page 5, line 1, remove the overstrike over "~~The grant to a qualifying school district may not be less than the grant to that school~~"

Page 5, line 2, remove the overstrike over "~~district in the preceding school year:~~" and insert immediately thereafter:

"4. The grant to a qualifying school district may not exceed the grant to that school district in the preceding school year by a percentage that is more than the percentage increase in statewide taxable valuation from the previous taxable year to the current taxable year.

5."

Page 5, line 20, overstrike "4." and insert immediately thereafter "6."

Page 5, line 23, overstrike "5." and insert immediately thereafter "7."

Page 5, line 27, overstrike "6." and insert immediately thereafter "8."

Page 5, line 29, overstrike "7." and insert immediately thereafter "9."

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1047, as engrossed: SEN. COOK (Finance and Taxation Committee) MOVED that the amendments on SJ pages 911-912 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a voice vote.

REPORT OF STANDING COMMITTEE

HB 1268: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1268 was placed on the Sixth order on the calendar.

Page 1, line 1, after "reenact" insert "section 21-06-10 and"

Page 1, line 1, remove the second "of the"

Page 1, line 2, after "to" insert "allocation of revenues from the leasing of federal flood control lands and"

Page 1, line 4, remove "and"

Page 1, line 4, after "date" insert "; and to declare an emergency"

Page 1, after line 5, insert:

"SECTION 1. AMENDMENT. Section 21-06-10 of the North Dakota Century Code is amended and reenacted as follows:

21-06-10. Moneys received through leasing of lands acquired by United States for flood control distributed through grants to counties for schools and roads, school districts, and townships.

The state treasurer shall ~~pay~~transfer the moneys allocated to the state under 33 U.S.C. 701(c)(3) 701c-3 to the oil and gas impact grant fund, to be held in a special account within that fund and made available through grants by the energy development impact office only for the benefit of oil and gas development-impacted townships, school districts, or county governments in the counties entitled to receive them in proportion to the area of the land in the county in which land has been acquired by the United States for which compensation is being provided under 33 U.S.C. 701(c)(3) as that area bears to the total of these federal lands in the state. A county receiving an allocation under this section shall disburse the moneys received as follows:

1. ~~One-half must be paid to the school districts in the county which have lost land subject to taxation because of the acquisition of lands by the United States for which compensation is being provided under 33 U.S.C. 701(c)(3) in proportion to the area of these federal lands in each district as that area bears to the total of such lands in all of the school districts in the county. If, however, all of the land in a district has been acquired by the United States, that district's proportionate share of the funds allocated under this subsection must be paid into the county tuition fund and expended according to the law governing that fund.~~
2. ~~One-quarter must be paid to the county for road purposes to be expended as the county commissioners shall determine.~~
3. ~~The final quarter must be allocated among the organized townships, if any, which have lost land subject to taxation because of land acquisitions by the United States for which compensation is being provided under 33 U.S.C. 701(c)(3) and the county for road purposes in proportion to the area of these lands in each township as that area bears to the total area of these federal lands in the county. The county must be allocated a similar proportionate share based on the area of these lands in the county not within an organized township.~~

~~This section applies to all funds heretofore received or to be received by the counties entitled thereto 701c-3. A school district receiving grant funds under this section must deposit the amount received in its general fund and may not transfer the funds received, or other amounts made available by reason of the receipt of grant funds under this section, into its building fund."~~

Page 2, line 6, replace "This" with "Section 1 of this Act is effective for revenue received by the state under 33 U.S.C. 701c-3 after the date of the filing of this Act with the secretary of state. Section 2 of this"

Page 2, after line 7, insert:

"SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1268: SEN. DOTZENROD (Finance and Taxation Committee) MOVED that the amendments on SJ pages 912-913 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a voice vote.

REPORT OF STANDING COMMITTEE

HB 1289, as engrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1289 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 amend and reenact section 57-38-30 and subsection 1 of section 57-38-30.3 of the North Dakota Century Code, relating to a reduction in income tax rates for corporations, individuals, estates, and trusts; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 57-38-30 of the North Dakota Century Code is amended and reenacted as follows:

57-38-30. Imposition and rate of tax on corporations.

A tax is hereby imposed upon the taxable income of every domestic and foreign corporation which must be levied, collected, and paid annually as in this chapter provided:

1. a. For the first twenty-five thousand dollars of taxable income, at the rate of ~~two~~one and ~~one-tenth~~eighty-nine hundredths percent.
- b. On all taxable income exceeding twenty-five thousand dollars and not exceeding fifty thousand dollars, at the rate of ~~five~~four and ~~twenty-five~~seventy-three hundredths percent.
- c. On all taxable income exceeding fifty thousand dollars, at the rate of ~~six~~five and ~~four-tenths~~seventy-six hundredths percent.
2. A corporation that has paid North Dakota alternative minimum tax in years beginning before January 1, 1991, may carry over any alternative minimum tax credit remaining to the extent of the regular income tax liability of the corporation for a period not to exceed four taxable years.

SECTION 2. AMENDMENT. Subsection 1 of section 57-38-30.3 of the North Dakota Century Code is amended and reenacted as follows:

1. A tax is hereby imposed for each taxable year upon income earned or received in that taxable year by every resident and nonresident individual, estate, and trust. A taxpayer computing the tax under this section is only eligible for those adjustments or credits that are specifically provided for in this section. Provided, that for purposes of this section, any person required to file a state income tax return under this chapter, but who has not computed a federal taxable income figure, shall compute a federal taxable income figure using a pro forma return in order to determine a federal taxable income figure to be used as a starting point in computing state income tax under this section. The tax for individuals is equal to North Dakota taxable income multiplied by the rates in the applicable rate schedule in subdivisions a through d corresponding to an individual's filing status used for federal income tax purposes. For an estate or trust, the schedule in subdivision e must be used for purposes of this subsection.
 - a. Single, other than head of household or surviving spouse.

If North Dakota taxable income is: The tax is equal to:

Not over ~~\$33,950~~\$34,500 ~~1.84%~~1.47%

Over ~~\$33,950~~\$34,500 ~~\$624.68~~\$507.15 plus ~~3.44%~~2.75%

but not over ~~\$82,250~~\$83,600 of amount over ~~\$33,950~~\$34,500

Over ~~\$82,250~~\$83,600 ~~\$2,286.20~~\$1,857.40 plus ~~3.81%~~3.05%

but not over ~~\$171,550~~\$174,400 of amount over ~~\$82,250~~\$83,600

Over ~~\$171,550~~\$174,400 ~~\$5,688.53~~\$4,626.80 plus ~~4.42%~~3.54%

but not over ~~\$372,950~~\$379,150 of amount over ~~\$171,550~~\$174,400

Over ~~\$372,950~~\$379,150 \$14,590.41 ~~\$11,874.95~~ plus 4.86%3.89%

of amount over ~~\$372,950~~\$379,150

b. Married filing jointly and surviving spouse.

If North Dakota taxable income is: The tax is equal to:

Not over ~~\$56,750~~\$57,700 1.84%1.47%

Over ~~\$56,750~~\$57,700 \$1,044.20 ~~\$848.19~~ plus 3.44%2.75%

but not over ~~\$137,050~~\$139,350 of amount over ~~\$56,750~~\$57,700

Over ~~\$137,050~~\$139,350 \$3,806.52 ~~\$3,093.57~~ plus 3.81%3.05%

but not over ~~\$208,850~~\$212,300 of amount over ~~\$137,050~~\$139,350

Over ~~\$208,850~~\$212,300 \$6,542.10 ~~\$5,318.54~~ plus 4.42%3.54%

but not over ~~\$372,950~~\$379,150 of amount over ~~\$208,850~~\$212,300

Over ~~\$372,950~~\$379,150 \$13,795.32 ~~\$11,225.03~~ plus 4.86%3.89%

of amount over ~~\$372,950~~\$379,150

c. Married filing separately.

If North Dakota taxable income is: The tax is equal to:

Not over ~~\$28,375~~\$28,850 1.84%1.47%

Over ~~\$28,375~~\$28,850 \$522.10 ~~\$424.10~~ plus 3.44%2.75%

but not over ~~\$68,525~~\$69,675 of amount over ~~\$28,375~~\$28,850

Over ~~\$68,525~~\$69,675 \$1,903.26 ~~\$1,546.78~~ plus 3.81%3.05%

but not over ~~\$104,425~~\$106,150 of amount over ~~\$68,525~~\$69,675

Over ~~\$104,425~~\$106,150 \$3,271.05 ~~\$2,659.27~~ plus 4.42%3.54%

but not over ~~\$186,475~~\$189,575 of amount over ~~\$104,425~~\$106,150

Over ~~\$186,475~~\$189,575 \$6,897.66 ~~\$5,612.52~~ plus 4.86%3.89%

of amount over ~~\$186,475~~\$189,575

d. Head of household.

If North Dakota taxable income is: The tax is equal to:

Not over ~~\$45,500~~\$46,250 1.84%1.47%

Over ~~\$45,500~~\$46,250 \$837.20 ~~\$679.88~~ plus 3.44%2.75%

but not over ~~\$117,450~~\$119,400 of amount over ~~\$45,500~~\$46,250

Over ~~\$117,450~~\$119,400 \$3,312.28 ~~\$2,691.50~~ plus 3.81%3.05%

but not over ~~\$190,200~~\$193,350 of amount over ~~\$117,450~~\$119,400

Over ~~\$190,200~~\$193,350 \$6,084.06 ~~\$4,946.98~~ plus 4.42%3.54%

but not over ~~\$372,950~~\$379,150 of amount over ~~\$190,200~~\$193,350

Over ~~\$372,950~~\$379,150 ~~\$14,161.61~~\$11,524.30 plus ~~4.86%~~3.89%

of amount over ~~\$372,950~~\$379,150

e. Estates and trusts.

If North Dakota taxable income is: The tax is equal to:

Not over \$2,300 ~~1.84%~~1.47%

Over \$2,300 ~~\$42.32~~\$33.81 plus ~~3.44%~~2.75%

but not over ~~\$5,350~~\$5,450 of amount over \$2,300

Over ~~\$5,350~~\$5,450 ~~\$147.24~~\$120.44 plus ~~3.81%~~3.05%

but not over ~~\$8,200~~\$8,300 of amount over ~~\$5,350~~\$5,450

Over ~~\$8,200~~\$8,300 ~~\$255.83~~\$207.36 plus ~~4.42%~~3.54%

but not over ~~\$11,150~~\$11,350 of amount over ~~\$8,200~~\$8,300

Over ~~\$11,150~~\$11,350 ~~\$386.22~~\$315.33 plus ~~4.86%~~3.89%

of amount over ~~\$11,150~~\$11,350

- f. For an individual who is not a resident of this state for the entire year, or for a nonresident estate or trust, the tax is equal to the tax otherwise computed under this subsection multiplied by a fraction in which:

- (1) The numerator is the federal adjusted gross income allocable and apportionable to this state; and
- (2) The denominator is the federal adjusted gross income from all sources reduced by the net income from the amounts specified in subdivisions a and b of subsection 2.

In the case of married individuals filing a joint return, if one spouse is a resident of this state for the entire year and the other spouse is a nonresident for part or all of the tax year, the tax on the joint return must be computed under this subdivision.

- g. ~~For taxable years beginning after December 31, 2009, the~~The tax commissioner shall prescribe new rate schedules that apply in lieu of the schedules set forth in subdivisions a through e. The new schedules must be determined by increasing the minimum and maximum dollar amounts for each income bracket for which a tax is imposed by the cost-of-living adjustment for the taxable year as determined by the secretary of the United States treasury for purposes of section 1(f) of the United States Internal Revenue Code of ~~1954~~1986, as amended. For this purpose, the rate applicable to each income bracket may not be changed, and the manner of applying the cost-of-living adjustment must be the same as that used for adjusting the income brackets for federal income tax purposes.
- h. The tax commissioner shall prescribe an optional simplified method of computing tax under this section that may be used by an individual taxpayer who is not entitled to claim an adjustment under subsection 2 or credit against income tax liability under subsection 7.

SECTION 3. EFFECTIVE DATE. This Act is effective for taxable years beginning after December 31, 2010."

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1289, as engrossed: SEN. HOGUE (Finance and Taxation Committee) MOVED that the amendments on SJ pages 913-917 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**.

REQUEST

SEN. WARNER REQUESTED a verification vote, which request was granted.

The question being on the motion to adopt the amendments to Engrossed HB 1289, the motion prevailed on a verification vote.

REPORT OF STANDING COMMITTEE

HB 1424, as engrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1424 was placed on the Sixth order on the calendar.

Page 1, line 1, after "reenact" insert "subsection 2 of section 11-09.1-05, section 40-05.1-06,"

Page 1, line 1, replace the second "and" with ", sections 57-39.2-12.1, 57-39.5-04, and 57-39.6-04,"

Page 1, line 2, after "57-40.2-04" insert ", and section 57-40.2-07.1"

Page 1, line 2, after "to" insert "compensation allowable to retailers for expenses associated with the collection, reporting, and remittance of state and local option sales, use, and gross receipts taxes and"

Page 1, after line 5, insert:

"SECTION 1. AMENDMENT. Subsection 2 of section 11-09.1-05 of the North Dakota Century Code is amended and reenacted as follows:

2. Control its finances and fiscal affairs; appropriate money for its purposes, and make payments of its debts and expenses; subject to the limitations of this section levy and collect property taxes, sales and use taxes, farm machinery gross receipts taxes, alcoholic beverage gross receipts taxes, motor vehicle fuels and special fuels taxes, motor vehicle registration fees, and special assessments for benefits conferred, for its public and proprietary functions, activities, operations, undertakings, and improvements; contract debts, borrow money, issue bonds, warrants, and other evidences of indebtedness; establish charges for any county or other services to the extent authorized by state law; and establish debt and mill levy limitations. Notwithstanding any authority granted under this chapter, all property must be assessed in a uniform manner as prescribed by the state board of equalization and the state supervisor of assessments and all taxable property must be taxed by the county at the same rate unless otherwise provided by law. A charter or ordinance or act of a governing body of a home rule county may not supersede any state law that determines what property or acts are subject to, or exempt from, ad valorem taxes. A charter or ordinance or act of the governing body of a home rule county may not supersede section 11-11-55.1 relating to the sixty percent petition requirement for improvements and of section 40-22-18 relating to the barring proceeding for improvement projects. After December 31, 2005, sales and use taxes, farm machinery gross receipts taxes, and alcoholic beverage gross receipts taxes levied under this chapter:
 - a. Must conform in all respects with regard to the taxable or exempt status of items under chapters 57-39.2, 57-39.5, 57-39.6, and 57-40.2 and may not be imposed at multiple rates with the exception of sales of electricity, piped natural or artificial gas, or other heating

fuels delivered by the seller or the retail sale or transfer of motor vehicles, aircraft, watercraft, modular homes, manufactured homes, or mobile homes.

- b. May not be newly imposed or changed except to be effective on the first day of a calendar quarterly period after a minimum of ninety days' notice to the tax commissioner or, for purchases from printed catalogs, on the first day of a calendar quarter after a minimum of one hundred twenty days' notice to the seller.
- c. May not be limited to apply to less than the full value of the transaction or item as determined for state sales and use tax, except for farm machinery gross receipts tax purposes.
- d. Must be subject to collection by the tax commissioner under an agreement under section 57-01-02.1 and must be administered by the tax commissioner in accordance with the relevant provisions of chapter 57-39.2, including reporting and paying requirements, correction of errors, payment of refunds, and application of penalty and interest.

After December 31, 2005, any portion of a charter or any portion of an ordinance or act of a governing body of a home rule county passed pursuant to a charter which does not conform to the requirements of this subsection or the retailer compensation provisions of chapter 57-39.2 or 57-40.2 is invalid to the extent that it does not conform. The invalidity of a portion of a charter or ordinance or act of a governing body of a home rule county because it does not conform to this subsection does not affect the validity of any other portion of the charter or ordinance or act of a governing body of a home rule county or the eligibility for a refund under section 57-01-02.1. Any taxes imposed under this chapter on farm machinery, farm irrigation equipment, and farm machinery repair parts used exclusively for agricultural purposes, or on alcoholic beverages, which were in effect on December 31, 2005, become gross receipts taxes after December 31, 2005.

SECTION 2. AMENDMENT. Section 40-05.1-06 of the North Dakota Century Code is amended and reenacted as follows:

40-05.1-06. Powers.

From and after the filing with the secretary of state of a charter framed and approved in reasonable conformity with the provisions of this chapter, such city, and the citizens thereof, shall, if included in the charter and implemented through ordinances, have the following powers set out in this chapter:

- 1. To acquire, hold, operate, and dispose of property within or without the corporate limits, and, subject to chapter 32-15, exercise the right of eminent domain for such purposes.
- 2. To control its finances and fiscal affairs; to appropriate money for its purposes, and make payment of its debts and expenses; to levy and collect taxes, excises, fees, charges, and special assessments for benefits conferred, for its public and proprietary functions, activities, operations, undertakings, and improvements; to contract debts, borrow money, issue bonds, warrants, and other evidences of indebtedness; to establish charges for any city or other services; and to establish debt and mill levy limitations. Notwithstanding any authority granted under this chapter, all property must be assessed in a uniform manner as prescribed by the state board of equalization and the state supervisor of assessments and all taxable property must be taxed by the city at the same rate unless otherwise provided by law. The authority to levy taxes under this subsection does not include authority to impose income taxes.

3. To fix the fees, number, terms, conditions, duration, and manner of issuing and revoking licenses in the exercise of its governmental police powers.
4. To provide for city officers, agencies, and employees, their selection, terms, powers, duties, qualifications, and compensation. To provide for change, selection, or creation of its form and structure of government, including its governing body, executive officer, and city officers.
5. To provide for city courts, their jurisdiction and powers over ordinance violations, duties, administration, and the selection, qualifications, and compensation of their officers; however, the right of appeal from judgment of such courts shall not be in any way affected.
6. To provide for all matters pertaining to city elections, except as to qualifications of electors.
7. To provide for the adoption, amendment, and repeal of ordinances, resolutions, and regulations to carry out its governmental and proprietary powers and to provide for public health, safety, morals, and welfare, and penalties for a violation thereof.
8. To lay out or vacate streets, alleys, and public grounds, and to provide for the use, operation, and regulation thereof.
9. To define offenses against private persons and property and the public health, safety, morals, and welfare, and provide penalties for violations thereof.
10. To engage in any utility, business, or enterprise permitted by the constitution or not prohibited by statute or to grant and regulate franchises therefor to a private person, firm, corporation, or limited liability company.
11. To provide for zoning, planning, and subdivision of public or private property within the city limits. To provide for such zoning, planning, and subdivision of public or private property outside the city limits as may be permitted by state law.
12. To levy and collect franchise and license taxes for revenue purposes.
13. To exercise in the conduct of its affairs all powers usually exercised by a corporation.
14. To fix the boundary limits of said city and the annexation and deannexation of territory adjacent to said city except that such power shall be subject to, and shall conform with the state law made and provided.
15. To contract with and receive grants from any other governmental entity or agency, with respect to any local, state, or federal program, project, or works.
16. To impose registration fees on motor vehicles, farm machinery gross receipts taxes, alcoholic beverage gross receipts taxes, or sales and use taxes in addition to any other taxes imposed by law. After December 31, 2005, sales and use taxes and gross receipts taxes levied under this chapter:
 - a. Must conform in all respects with regard to the taxable or exempt status of items under chapters 57-39.2, 57-39.5, 57-39.6, and 57-40.2 and may not be imposed at multiple rates with the exception of sales of electricity, piped natural or artificial gas, or other heating fuels delivered by the seller or the retail sale or transfer of motor

vehicles, aircraft, watercraft, modular homes, manufactured homes, or mobile homes.

- b. May not be newly imposed or changed except to be effective on the first day of a calendar quarterly period after a minimum of ninety days' notice to the tax commissioner or, for purchases from printed catalogs, on the first day of a calendar quarter after a minimum of one hundred twenty days' notice to the seller.
- c. May not be limited to apply to less than the full value of the transaction or item as determined for state sales and use tax purposes, except for farm machinery gross receipts tax.
- d. Must be subject to collection by the tax commissioner under an agreement under section 57-01-02.1 and must be administered by the tax commissioner in accordance with the relevant provisions of chapter 57-39.2, including reporting and paying requirements, correction of errors, payment of refunds, and application of penalty and interest.

It is the intention of this chapter to grant and confirm to the people of all cities coming within its provisions the full right of self-government in both local and city matters within the powers enumerated herein. The statutes of the state of North Dakota, so far as applicable, shall continue to apply to home rule cities, except insofar as superseded by the charters of such cities or by ordinance passed pursuant to such charters.

After December 31, 2005, any portion of a charter or any portion of an ordinance passed pursuant to a charter which does not conform to the requirements of subsection 16 or the retailer compensation provisions of chapter 57-39.2 or 57-40.2 is invalid to the extent that it does not conform. The invalidity of a portion of a charter or ordinance because it does not conform to subsection 16 does not affect the validity of any other portion of the charter or ordinance or the eligibility for a refund under section 57-01-02.1. Any taxes imposed under this chapter on farm machinery, farm irrigation equipment, and farm machinery repair parts used exclusively for agricultural purposes, or on alcoholic beverages, which were in effect on December 31, 2005, become gross receipts taxes after December 31, 2005."

Page 1, after line 14, insert:

"SECTION 4. AMENDMENT. Section 57-39.2-12.1 of the North Dakota Century Code is amended and reenacted as follows:

57-39.2-12.1. Deduction to reimburse retailer for administrative expenses.

1. a. A retailer required registered to report and pay monthly remit sales, use, or gross receipts tax imposed under section 57-39.2-12 chapter 57-39.2, 57-39.5, 57-39.6, or 57-40.2 may deduct and retain one and one-half percent of the tax due. The aggregate of deductions allowed by this section and section 57-40.2-07.1 may not exceed eighty-five dollars per month. Retailers that receive compensation under this subsection may not receive additional compensation under subsection 2 or 3 for the same period from the tax remitted to the tax commissioner compensation or a monetary allowance as provided in this subsection.
- b. The following two rates of compensation apply to the combined state and local options sales, use, and gross receipts taxes remitted for each month of activity included in a sales, use, or gross receipts tax return:
 - (1) One and one-half percent of the first six thousand two hundred fifty dollars of tax.

- (2) Thirty-three one-hundredths of one percent of tax amounts greater than six thousand two hundred fifty dollars but less than seven hundred fifty thousand dollars of tax.
2. A certified service provider that contracts with retailers to calculate, collect, and remit tax due on behalf of retailers may deduct and retain from the tax remitted to the tax commissioner compensation or a monetary allowance up to the amount approved by the streamlined sales and use tax governing board effective June 1, 2006. The compensation provided in this subsection applies only to tax remitted by certified service providers on behalf of retailers that are remote sellers registered to collect sales and use tax in this state under chapter 57-39.4. Certified service providers that receive compensation under this subsection may not receive additional compensation under subsection 1 or 3 for the same period.
 3. A retailer that is a remote seller registered to collect sales and use tax under chapter 57-39.4 and that uses a certified automated system to calculate, report, and remit tax due under chapters 57-39.2, 57-39.4, and 57-40.2 may deduct and retain compensation or a monetary allowance up to the amount approved by the streamlined sales and use tax governing board during its December 2006 meeting. Retailers that receive compensation under this subsection may not receive additional compensation under subsection 1 or 2 for the same period.
 4. For purposes of this section, "remote seller" means a retailer that does not have an adequate physical presence to establish nexus in this state for sales and use tax purposes.
 5. Compensation may not be deducted and retained under this section unless the tax due is paid within the time limitations under section 57-39.2-12 or 57-40.2-07 or chapter 57-39.4.
 6. The deduction allowed retailers or certified service providers by this section is to reimburse retailers directly or indirectly for expenses incurred in keeping records, preparing and filing returns, remitting the tax, and supplying information to the tax commissioner upon request.

SECTION 5. AMENDMENT. Section 57-39.5-04 of the North Dakota Century Code is amended and reenacted as follows:

57-39.5-04. Administration.

The provisions of chapter 57-39.2 pertaining to administration of the retail sales tax, including provisions for refund, credits, retailer compensation, or adoption of rules, not in ~~compliance~~conflict with this chapter or federal law, govern the administration of the gross receipts tax imposed in this chapter.

SECTION 6. AMENDMENT. Section 57-39.6-04 of the North Dakota Century Code is amended and reenacted as follows:

57-39.6-04. Administration.

The provisions of chapter 57-39.2, pertaining to administration of the retail sales tax, including provisions for refund, credits, retailer compensation, or adoption of rules, not in conflict with this chapter or federal law, govern the administration of the gross receipts tax imposed in this chapter."

Page 1, after line 23, insert:

"SECTION 8. AMENDMENT. Section 57-40.2-07.1 of the North Dakota Century Code is amended and reenacted as follows:

57-40.2-07.1. Deduction to reimburse retailer for administrative expenses.

1.
 - a. A retailer required registered to report and pay monthly remit sales, use, or gross receipts tax imposed under section 57-40.2-07 chapter 57-39.2, 57-39.5, 57-39.6, or 57-40.2 may deduct and retain one and one-half percent of the tax due. The aggregate of deductions allowed by this section and section 57-39.2-12.1 may not exceed eighty five dollars per month. Retailers that receive compensation under this subsection may not receive additional compensation under subsection 2 or 3 for the same period from the tax remitted to the tax commissioner compensation or a monetary allowance as provided in this subsection.
 - b. The following two rates of compensation apply to the combined state and local options sales, use, and gross receipts taxes remitted for each month of activity included in a sales, use, or gross receipts tax return:
 - (1) One and one-half percent of the first six thousand two hundred fifty dollars of tax.
 - (2) Thirty-three one-hundredths of one percent of tax amounts greater than six thousand two hundred fifty dollars but less than seven hundred fifty thousand dollars of tax.
2. A certified service provider that contracts with retailers to calculate, collect, and remit tax due on behalf of retailers may deduct and retain from the tax remitted to the tax commissioner compensation or a monetary allowance up to the amount approved by the streamlined sales and use tax governing board effective June 1, 2006. The compensation provided in this subsection applies only to tax remitted by certified service providers on behalf of retailers that are remote sellers registered to collect sales and use tax in this state under chapter 57-39.4. Certified service providers that receive compensation under this subsection may not receive additional compensation under subsection 1 or 3 for the same period.
3. A retailer that is a remote seller registered to collect sales and use tax under chapter 57-39.4 and that uses a certified automated system to calculate, report, and remit tax due under chapters 57-39.2, 57-39.4, and 57-40.2 may deduct and retain compensation or a monetary allowance up to the amount approved by the streamlined sales and use tax governing board during its December 2006 meeting. Retailers that receive compensation under this subsection may not receive additional compensation under subsection 1 or 2 for the same period.
4. For purposes of this section, "remote seller" means a retailer that does not have an adequate physical presence to establish nexus in this state for sales and use tax purposes.
5. Compensation may not be deducted and retained under this section unless the tax due is paid within the time limitations under section 57-39.2-12 or 57-40.2-07 or chapter 57-39.4.
6. The deduction allowed retailers or certified service providers by this section is to reimburse retailers directly or indirectly for expenses incurred in keeping records, preparing and filing returns, remitting the tax, and supplying information to the tax commissioner upon request."

Page 2, line 1, replace "This" with "Sections 3 and 7 of this"

Page 2, line 1, replace "is" with "are"

Page 2, line 2, after "2011" insert ", and sections 1, 2, 4, 5, 6, and 8 of this Act are effective for taxable events occurring after December 31, 2011"

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1424, as engrossed: SEN. COOK (Finance and Taxation Committee) MOVED that the amendments on SJ pages 917-923 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a voice vote.

REPORT OF STANDING COMMITTEE

HB 1451, as engrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1451 was placed on the Sixth order on the calendar.

Page 1, line 3, remove "6-09.6-01.1, 6-09.6-01.2, 6-09.6-03,"

Page 1, line 3, replace ", 15-08.1-09," with "and"

Page 1, line 3, remove ", and 61-33-07"

Page 1, line 4, after "fund" insert ", legacy fund, state infrastructure fund,"

Page 1, line 6, replace "a transfer" with "transfers"

Page 1, remove lines 9 through 24

Page 2, remove lines 1 through 31

Page 3, remove lines 1 through 14

Page 3, line 17, remove the overstrike over "~~lands and minerals~~"

Page 3, line 18, remove the overstrike over "~~trust~~"

Page 3, line 18, remove "~~state infrastructure~~"

Page 3, line 18, remove "- ~~Legislative intent~~"

Page 3, line 22, remove the overstrike over "~~lands and minerals trust~~"

Page 3, line 22, remove "~~state infrastructure~~"

Page 3, line 22, after the period insert "Deposits in the lands and minerals trust fund are limited to one hundred fifty million dollars during a biennium and any amounts exceeding this limitation must be deposited in the legacy fund."

Page 3, line 23, overstrike "such" and insert immediately thereafter "the lands and minerals"

Page 3, line 23, after "trust" insert "fund"

Page 3, line 23, remove "for"

Page 3, remove lines 24 through 27

Page 3, line 28, remove "appropriations are authorized"

Page 3, remove lines 29 and 30

Page 4, remove lines 1 through 6

Page 4, line 12, after the first "fund" insert ". property tax relief sustainability fund."

Page 4, line 20, replace "three" with "two"

Page 4, line 22, after "hundred" insert "fifty"

Page 4, remove lines 26 through 31

Page 5, line 6, replace "**TRANSFER**" with "**TRANSFERS - PERMANENT OIL TAX TRUST FUND TO LEGACY FUND AND GENERAL FUND**"

Page 5, line 6, replace "At" with "As soon as practicable after"

Page 5, line 7, after "transfer" insert "\$52,000,000 from the permanent oil tax trust fund to the legacy fund and"

Page 5, line 8, after the second "fund" insert "and then shall close out the permanent oil tax trust fund"

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1451, as engrossed: SEN. MILLER (Finance and Taxation Committee) MOVED that the amendments on SJ pages 923-924 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a verification vote.

REPORT OF STANDING COMMITTEE

HB 1417: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1417 was placed on the Sixth order on the calendar.

Page 1, line 2, after the semicolon insert "to provide for a legislative management study;"

Page 1, after line 9, insert:

"SECTION 2. LEGISLATIVE MANAGEMENT STUDY - SALES TAX EXEMPTION FOR PURCHASES BY CLINICS. The legislative management shall consider studying, during the 2011-12 interim, under what circumstances, if any, purchases by clinics should be exempt from sales and use taxes. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

CONSIDERATION OF AMENDMENTS

HB 1417: SEN. HOGUE (Finance and Taxation Committee) MOVED that the amendments on SJ page 924 be adopted and then be **REREFERRED** to the **Appropriations Committee** with **DO PASS**, which motion prevailed on a voice vote.

CONSIDERATION OF AMENDMENTS

HB 1248, as engrossed: SEN. FLAKOLL (Education Committee) MOVED that the amendments on SJ page 904 be adopted and then be placed on the Fourteenth order with **DO PASS**, which motion prevailed on a voice vote.

SECOND READING OF HOUSE BILL

HB 1248: A BILL for an Act to create and enact a new section to chapter 15.1-19 of the North Dakota Century Code, relating to educational transfers involving children of military families; and to provide for a legislative management study of the interstate compact on educational opportunity for military children.

ROLL CALL

The question being on the final passage of the amended bill, which has been read, and has committee recommendation of DO PASS, the roll was called and there were 47 YEAS, 0 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Bowman; Burckhard; Christmann; Cook; Dever; Dotzenrod; Erbele; Fischer; Flakoll; Freborg; Grindberg; Heckaman; Hogue; Holmberg; Kilzer; Klein; Krebsbach; Laffen; Larsen; Lee, G.; Lee, J.; Luick; Lyson; Marcellais; Mathern; Miller; Murphy; Nelson; Nething; Nodland; O'Connell; Oehlke; Olafson; Robinson; Schaible; Schneider; Sitte; Sorvaag; Stenehjerm; Taylor; Triplett; Uglem; Wanzek; Wardner; Warner

Engrossed HB 1248, as amended, passed.

CONSIDERATION OF AMENDMENTS

HB 1318, as engrossed: SEN. HOGUE (Natural Resources Committee) MOVED that the amendments on SJ pages 904-905 be adopted and then be placed on the Fourteenth order with **DO PASS**, which motion prevailed on a voice vote.

SECOND READING OF HOUSE BILL

HB 1318: A BILL for an Act to create and enact chapter 61-24.8 of the North Dakota Century Code, relating to creation of special assessment districts for irrigation works by the Garrison Diversion Conservancy District; to amend and reenact section 54-35-02.7 of the North Dakota Century Code, relating to membership and duties of the water-related topics overview committee; and to provide for reports to the state water commission.

ROLL CALL

The question being on the final passage of the amended bill, which has been read, and has committee recommendation of DO PASS, the roll was called and there were 42 YEAS, 5 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Bowman; Burckhard; Christmann; Cook; Dever; Dotzenrod; Erbele; Fischer; Flakoll; Freborg; Grindberg; Heckaman; Hogue; Holmberg; Kilzer; Klein; Krebsbach; Laffen; Larsen; Lee, G.; Luick; Lyson; Mathern; Miller; Murphy; Nething; Nodland; O'Connell; Olafson; Robinson; Schaible; Schneider; Sitte; Sorvaag; Stenehjerm; Taylor; Uglem; Wanzek; Wardner; Warner

NAYS: Lee, J.; Marcellais; Nelson; Oehlke; Triplett

Engrossed HB 1318, as amended, passed.

CONSIDERATION OF AMENDMENTS

HB 1313: SEN. SCHAIBLE (Government and Veterans Affairs Committee) MOVED that the amendments on SJ page 904 be adopted and then be placed on the Fourteenth order with **DO PASS**, which motion prevailed on a voice vote.

SECOND READING OF HOUSE BILL

HB 1313: A BILL for an Act to create and enact a new section to chapter 40-01 of the North Dakota Century Code, relating to authorizing firefighters to solicit charitable contributions from motorists in cities; and to declare an emergency.

ROLL CALL

The question being on the final passage of the amended bill, which has been read, and has committee recommendation of DO PASS, the roll was called and there were 46 YEAS, 1 NAY, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Bowman; Burckhard; Christmann; Cook; Dever; Dotzenrod; Erbele; Fischer; Flakoll; Freborg; Grindberg; Heckaman; Hogue; Holmberg; Kilzer; Klein; Krebsbach; Laffen; Larsen; Lee, G.; Lee, J.; Luick; Lyson; Marcellais; Mathern; Miller; Murphy; Nelson; Nething; Nodland; O'Connell; Oehlke; Olafson; Robinson; Schaible; Schneider; Sitte; Sorvaag; Stenehjerm; Taylor; Uglem; Wanzek; Wardner; Warner

NAYS: Triplett

HB 1313, as amended, passed and the emergency clause was declared carried.

CONSIDERATION OF AMENDMENTS

HCR 3016: SEN. DEVER (Human Services Committee) MOVED that the amendments on SJ pages 905-906 be adopted and then be placed on the Fourteenth order with **DO PASS**, which motion prevailed on a voice vote.

SECOND READING OF HOUSE CONCURRENT RESOLUTION

HCR 3016: A concurrent resolution urging Congress to repeal the Patient Protection and Affordable Care Act.

The question being on the final adoption of the amended resolution, which has been read, and has committee recommendation of DO PASS.

HCR 3016, as amended, was declared adopted on a voice vote.

SECOND READING OF HOUSE BILL

HB 1127: A BILL 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; to provide an effective date; and to declare an emergency.

MOTION

SEN. MATHERN MOVED that HB 1127, which is on the Fourteenth order, be laid over one legislative day, which motion failed.

MOTION

SEN. MATHERN MOVED that Engrossed HB 1127, as amended, be amended as follows.

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

- 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.
 - 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;
 - 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 covered 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;
 - (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 health 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
 - (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

REQUEST

SEN. MATHERN REQUESTED a recorded roll call vote on the motion to adopt the proposed amendments to Engrossed HB 1127, as amended, which request was granted.

ROLL CALL

The question being on the motion to adopt the proposed amendments to Engrossed HB 1127, as amended, the roll was called and there were 11 YEAS, 36 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Dotzenrod; Heckaman; Marcellais; Mathern; Murphy; Nelson; Robinson; Schneider; Taylor; Triplett; Warner

NAYS: Andrist; Berry; Bowman; Burckhard; Christmann; Cook; Dever; Erbele; Fischer; Flakoll; Freborg; Grindberg; Hogue; Holmberg; Kilzer; Klein; Krebsbach; Laffen; Larsen; Lee, G.; Lee, J.; Luick; Lyson; Miller; Nething; Nodland; O'Connell; Oehlke; Olafson; Schaible; Sitte; Sorvaag; Stenehjerm; Uglem; Wanzek; Wardner

The proposed amendments to Engrossed HB 1127, as amended, failed on a recorded roll call vote.

ROLL CALL

The question being on the final passage of the amended bill, which has been read, and has committee recommendation of DO PASS, the roll was called and there were 45 YEAS, 2 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Bowman; Burckhard; Cook; Dever; Dotzenrod; Erbele; Fischer; Flakoll; Freborg; Grindberg; Heckaman; Hogue; Holmberg; Kilzer; Klein; Krebsbach; Laffen; Larsen; Lee, G.; Lee, J.; Luick; Lyson; Marcellais; Mathern; Miller; Murphy; Nelson; Nething; Nodland; Oehlke; Olafson; Robinson; Schaible; Schneider; Sitte; Sorvaag; Stenehjerm; Taylor; Triplett; Uglem; Wanzek; Wardner; Warner

NAYS: Christmann; O'Connell

Engrossed HB 1127, as amended, passed and the emergency clause was declared carried.

SECOND READING OF HOUSE BILL

HB 1411: A BILL for an Act to amend and reenact sections 15-10-10, 54-44.1-04, and 54-44.1-06 of the North Dakota Century Code, relating to duties of the commissioner of higher education and the budget requests and appropriations for the North Dakota university system.

REQUEST

SEN. TRIPLETT REQUESTED that the Senate divide HB 1411, which request was granted.

DIVISION A: Section 1**DIVISION B:** Remainder of the bill**ROLL CALL**

The question being on the final adoption of Division A of HB 1411, the roll was called and there were 13 YEAS, 34 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Christmann; Cook; Fischer; Flakoll; Freborg; Klein; Luick; Schaible; Sitte; Sorvaag; Stenehjem

NAYS: Bowman; Burckhard; Dever; Dotzenrod; Erbele; Grindberg; Heckaman; Hogue; Holmberg; Kilzer; Krebsbach; Laffen; Larsen; Lee, G.; Lee, J.; Lyson; Marcellais; Mathern; Miller; Murphy; Nelson; Nething; Nodland; O'Connell; Oehlke; Olafson; Robinson; Schneider; Taylor; Triplett; Uglem; Wanzek; Wardner; Warner

Division A of HB 1411 failed on a recorded roll call vote.

ROLL CALL

The question being on the final adoption of Division B of HB 1411, the roll was called and there were 20 YEAS, 27 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Christmann; Cook; Fischer; Flakoll; Freborg; Grindberg; Hogue; Klein; Lee, J.; Luick; Lyson; Oehlke; Schaible; Sitte; Sorvaag; Stenehjem; Triplett; Uglem

NAYS: Bowman; Burckhard; Dever; Dotzenrod; Erbele; Heckaman; Holmberg; Kilzer; Krebsbach; Laffen; Larsen; Lee, G.; Marcellais; Mathern; Miller; Murphy; Nelson; Nething; Nodland; O'Connell; Olafson; Robinson; Schneider; Taylor; Wanzek; Wardner; Warner

Division B of HB 1411 failed on a recorded roll call vote.

SECOND READING OF HOUSE BILL

HB 1442: A BILL for an Act to provide for a legislative management study relating to consistency of regulations for drivers and motor vehicles.

ROLL CALL

The question being on the final passage of the amended bill, which has been read, and has committee recommendation of DO PASS, the roll was called and there were 44 YEAS, 3 NAYS, 0 EXCUSED, 0 ABSENT AND NOT VOTING.

YEAS: Andrist; Berry; Bowman; Burckhard; Christmann; Cook; Dever; Dotzenrod; Erbele; Fischer; Flakoll; Freborg; Grindberg; Heckaman; Hogue; Holmberg; Kilzer; Klein; Krebsbach; Larsen; Lee, G.; Lee, J.; Luick; Lyson; Mathern; Miller; Murphy; Nelson; Nething; Nodland; O'Connell; Oehlke; Olafson; Robinson; Schaible; Schneider; Sitte; Sorvaag; Stenehjem; Taylor; Triplett; Uglem; Wanzek; Wardner

NAYS: Laffen; Marcellais; Warner

Engrossed HB 1442, as amended, passed.

MESSAGE TO THE HOUSE FROM THE SENATE (WILLIAM R. HORTON, SECRETARY)

MR. SPEAKER: The Senate has passed, unchanged: HB 1160, HB 1302, HB 1308, HCR 3031.

MESSAGE TO THE HOUSE FROM THE SENATE (WILLIAM R. HORTON, SECRETARY)

MR. SPEAKER: The Senate has amended and subsequently passed: HB 1007, HB 1174, HB 1190, HB 1229, HB 1329, HB 1389, HCR 3036, HCR 3037, HCR 3039.

MESSAGE TO THE HOUSE FROM THE SENATE (WILLIAM R. HORTON, SECRETARY)

MR. SPEAKER: The Senate has amended and subsequently passed: HB 1195.

MESSAGE TO THE HOUSE FROM THE SENATE (WILLIAM R. HORTON, SECRETARY)

MR. SPEAKER: The Senate has failed to pass, unchanged: HB 1171, HB 1292, HB 1406, HCR 3033.

MESSAGE TO THE SENATE FROM THE HOUSE (BUELL J. REICH, CHIEF CLERK)

MR. PRESIDENT: The House has passed, unchanged: SB 2211.

MESSAGE TO THE SENATE FROM THE HOUSE (BUELL J. REICH, CHIEF CLERK)

MR. PRESIDENT: The House has amended and subsequently passed: SB 2098, SB 2110, SB 2155, SB 2172, SB 2195, SB 2210, SB 2218, SB 2248, SB 2258.

HOUSE AMENDMENTS TO SENATE BILL NO. 2098

Page 1, line 2, after the semicolon insert "and"

Page 1, line 3, replace "43-11-05" with "43-11-03, 43-11-04"

Page 1, line 4, remove "43-11-17, 43-11-19,"

Page 1, line 4, remove "43-11-27,"

Page 1, line 6, after "powers" insert ", membership,"

Page 1, line 7, remove "; to repeal section 43-11-28 of the North Dakota"

Page 1, line 8, remove "Century Code, relating to fees; and to provide an effective date"

Page 3, replace lines 21 through 29 with:

"SECTION 3. AMENDMENT. Section 43-11-03 of the North Dakota Century Code is amended and reenacted as follows:

43-11-03. State board of cosmetology - Appointment - Term - Removal.

The state board of cosmetology consists of ~~three~~five members appointed by the governor for three years each, with their terms of office so arranged that ~~one term expires~~no more than two terms expire on June thirtieth of each year. Each member shall qualify by taking the oath required of civil officers and shall hold office until a successor is appointed and qualified. The governor may remove from office a member for misconduct, malfeasance, neglect of duty in office, crime in office, gross incompetency, or habitual drunkenness. A vacancy on the board must be filled by appointment by the governor for the unexpired term.

SECTION 4. AMENDMENT. Section 43-11-04 of the North Dakota Century Code is amended and reenacted as follows:

43-11-04. Members of board - Qualifications.

Each member of the board must be a citizen of this state ~~and. Three of the members of the board must each be~~ a licensed cosmetologist who has had at least three years' practical experience in the occupation. The other two members of the board must be citizen members.

Page 4, line 2, overstrike "of one hundred dollars" and insert immediately thereafter "in the amount provided for members of the legislative management under section 54-35-10"

Page 4, remove lines 20 through 31

Page 5, remove lines 1 through 8

Page 5, line 17, remove the overstrike over "~~pursuant to section 43-11-28~~"

Page 5, line 17, remove "by rule"

Page 5, line 20, remove the overstrike over "~~section 43-11-28~~"

Page 5, line 20, remove "rule"

Page 6, line 1, remove the overstrike over "~~as set forth in section 43-11-28~~"

Page 6, line 23, remove the overstrike over "~~as set forth in section 43-11-28~~"

Page 6, remove lines 26 through 31

Page 7, remove lines 1 through 31

Page 8, remove lines 1 through 6

Page 8, remove lines 25 through 27

Renumber accordingly

HOUSE AMENDMENTS TO SENATE BILL NO. 2110

Page 2, line 23, overstrike "the bid" and insert immediately thereafter "one or more bids"

Page 2, line 24, overstrike "carrier" and insert immediately thereafter "carriers"

Renumber accordingly

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2155

Page 1, remove lines 14 through 16

Page 1, line 17, replace "3." with "2."

Page 1, line 18, replace "4." with "3."

Page 1, line 20, replace "5." with "4."

Page 2, line 1, replace "6." with "5."

Page 2, line 5, replace "7." with "6."

Page 2, line 7, replace "8." with "7."

Page 2, remove lines 12 and 13

Page 2, line 14, replace "(2)" with "(1)"

Page 2, line 14, replace "implement" with "supervise"

Page 2, line 16, replace "(3)" with "(2)"

Page 2, line 16, replace "implement" with "supervise"

Page 2, line 18, replace "(4)" with "(3)"

Page 2, line 24, replace "9." with "8."

Page 3, line 10, replace "10." with "9."

Page 3, line 12, replace "11." with "10."

Page 3, line 15, replace "12." with "11."

Page 3, line 16, after "analyst" insert "and is supervised by a licensed psychologist or applied behavior analyst"

Page 3, line 18, replace "13." with "12."

Page 5, line 7, remove the overstrike over "~~one-hundred-fifty~~"

Page 5, line 8, remove the overstrike over "~~dollars~~"

Page 5, line 8, remove "the costs incurred by the board in issuing the license or registration"

Page 6, line 29, remove ", registrant"

Page 8, after line 13, insert:

"11. An individual licensed as an occupational therapist or an occupational therapy assistant pursuant to chapter 43-40 within the body of knowledge and scope of professional practice of occupational therapy."

Page 9, remove lines 11 through 23

Page 9, line 24, replace "4." with "3."

Page 9, line 28, replace "5." with "4."

Page 10, line 1, replace "6." with "5."

Renumber accordingly

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2172

Page 5, line 26, replace "2013" with "2012"

Renumber accordingly

HOUSE AMENDMENTS TO SENATE BILL NO. 2195

Page 1, replace lines 6 and 7 with "In an action for a violation of this section, the court may award statutory damages of one thousand dollars. The court also may award actual damages, reasonable attorney's fees, costs, and disbursements."

Renumber accordingly

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2218

Page 1, line 1, after "Act" insert "to create and enact a new subsection to section 40-63-07 of the North Dakota Century Code, relating to restrictions on renaissance fund organization investments in enterprises owned by renaissance fund organization officers, employees, and investors;"

Page 1, line 1, replace "subsection" with "subsections 2 and"

Page 1, after line 4, insert:

"SECTION 1. AMENDMENT. Subsection 2 of section 40-63-07 of the North Dakota Century Code is amended and reenacted as follows:

2. The purpose of a renaissance fund organization is solely to raise funds to be used to ~~make investments in finance zone projects and to make investments in other projects located in designated renaissance zone cities zones.~~ A renaissance fund organization may provide financing to projects undertaken by individuals, partnerships, limited partnerships, limited liability companies, trusts, corporations, nonprofit organizations, and public entities. The financing may include any combination of equity

investments, loans, guarantees, and commitments for financing. The amount of financing is not limited by this chapter."

Page 1, line 10, overstrike "these additional" and insert immediately thereafter "the"

Page 1, line 10, overstrike "may not" and insert immediately thereafter "shall"

Page 1, line 11, overstrike "more than fifty percent of such" and insert immediately thereafter "those"

Page 1, line 11, overstrike "for organization investments outside of" and insert immediately thereafter "to finance projects within"

Page 1, after line 12, insert:

"SECTION 3. A new subsection to section 40-63-07 of the North Dakota Century Code is created and enacted as follows:

Renaissance fund organization officers, employees, and investors may be actively involved in the enterprises in which the renaissance fund organization invests but the renaissance fund organization may not invest in any enterprise if any one renaissance fund organization investor owns more than forty-nine percent of the ownership interest in the enterprise. A renaissance fund organization may not invest in an enterprise if renaissance fund organization officers, employees, and investors collectively own more than forty-nine percent of the ownership interests, either through direct ownership or through ownership of interest in a passthrough entity."

Page 1, line 13, replace "This" with "The changes in sections 1 and 2 of this"

Page 1, line 13, replace "is" with "requiring a renaissance fund organization to limit its financing to projects located in a renaissance zone are"

Page 1, line 13, replace "taxable years beginning" with "new financing initiated"

Page 1, line 14, replace "December 31, 2010" with "June 30, 2011"

Page 1, line 14, after the period insert "Section 3 of this Act is effective for investments made in a renaissance fund organization after December 31, 2011."

Renumber accordingly

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2248

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new subsection to section 57-38-57 of the North Dakota Century Code, relating to angel fund investment disclosure; to amend and reenact section 57-38-01.26 of the North Dakota Century Code, relating to the angel fund investment tax credit; to provide an effective date; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 57-38-01.26 of the North Dakota Century Code is amended and reenacted as follows:

57-38-01.26. Angel fund investment tax credit.

1. A taxpayer is entitled to a credit against state income tax liability under section 57-38-30 or 57-38-30.3 for an investment made in an angel fund that is incorporated in this state. The amount of the credit to which a taxpayer is entitled is forty-five percent of the amount invested by the taxpayer in an angel fund during the taxable year. The aggregate annual credit for which a taxpayer may obtain a tax credit is not more than forty-five thousand dollars.

2. To be eligible for the credit, the investment must be at risk in the angel fund for at least three years. Investments placed in escrow do not qualify for the credit. The credit must be claimed in the taxable year in which the investment in the angel fund was received by the angel fund. The credit allowed may not exceed the liability for tax under this chapter. If the amount of credit determined under this section exceeds the liability for tax under this chapter, the excess may be carried forward to each of the four succeeding taxable years. A taxpayer claiming a credit under this section may not claim any credit available to the taxpayer as a result of an investment made by the angel fund in a qualified business under chapter 57-38.5 or 57-38.6.
3. An angel fund must:
 - a. Be a partnership, limited partnership, corporation, limited liability company, limited liability partnership, trust, or estate organized on a for-profit basis which is headquartered in this state.
 - b. Be organized for the purpose of investing in a portfolio of at least three early-stage and mid-stage private, nonpublicly traded enterprises with strong growth potential. For purposes of this section, an early-stage entity means an entity with annual revenues of up to two million dollars and a mid-stage entity means an entity with annual revenues over two million dollars not to exceed ten million dollars.
 - c. Consist of at least six accredited investors as defined by securities and exchange commission regulation D, rule 501.
 - d. Not have more than twenty-five percent of its capitalized investment assets owned by an individual investor.
 - e. Have at least five hundred thousand dollars in commitments from accredited investors and that capital must be subject to call to be invested over an unspecified number of years to build a portfolio of investments in enterprises.
 - f. Be member-managed or a manager-managed limited liability company and the investor members or a designated board that includes investor members must make decisions as a group on which enterprises are worthy of investments.
 - g. Be certified as an angel fund that meets the requirements of this section by the department of commerce.
 - h. Be in compliance with the securities laws of this state.
4. Within thirty days after the date on which an investment in an angel fund is made, the angel fund shall file with the tax commissioner and provide to the investor completed forms prescribed by the tax commissioner which show as to each investment in the angel fund the following:
 - a. The name, address, and social security number or federal employer identification number of the taxpayer or passthrough entity that made the investment;
 - b. The dollar amount paid for the investment by the taxpayer or passthrough entity; and
 - c. The date on which full consideration was received by the angel fund for the investment.
5. Angel fund investors may be actively involved in the enterprises in which the angel fund invests but the angel fund may not invest in any enterprise if any one angel fund investor owns directly or indirectly more than

forty-nine percent of the ownership interests in the enterprise. The angel fund may not invest in an enterprise if angel fund officers, employees, and investors collectively own more than forty-nine percent of the ownership interests in the enterprise, either through direct ownership or through ownership of interests in a passthrough entity.

5-6. Investors in one angel fund may not receive more than five million dollars in aggregate credits under this section during the life of the angel fund but this provision may not be interpreted to limit additional investments in that angel fund.

7. A partnership, subchapter S corporation, limited partnership, limited liability company, or any other passthrough entity entitled to the credit under this section must be considered to be the taxpayer for purposes of this section, and the amount of the credit allowed must be determined at the passthrough entity level.

SECTION 2. A new subsection to section 57-38-57 of the North Dakota Century Code is created and enacted as follows:

The tax commissioner, upon written request, may disclose a taxpayer's name and address, the amount of tax credits the taxpayer claimed under section 57-38-01.26, and the name and address of the angel fund with which the taxpayer invested.

SECTION 3. EFFECTIVE DATE - EXPIRATION DATE. Section 1 of this Act is effective for the first four taxable years beginning after December 31, 2010, and is thereafter ineffective. Section 2 of this Act is effective for angel fund investments made after June 30, 2011."

Renumber accordingly

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2258

Page 1, line 12, replace the first "an" with "more than four"

Page 1, line 12, replace "order" with "orders"

Page 1, line 13, after the underscored period insert "An income payer that employs more than twenty-four employees at any time and has received fewer than five income withholding orders under this chapter may choose to opt out of an electronic method approved by the child support agency only through a written request."

Page 3, line 26, remove the overstrike over "may"

Page 3, line 26, remove "shall"

Page 3, line 27, after "designee" insert ", but a government self-insurance pool shall exchange personal information about the claimant with the department"

Page 5, line 15, replace "electronic" with "internet-based"

Page 5, line 15, replace "approved" with "provided"

Renumber accordingly

HOUSE AMENDMENTS TO ENGROSSED SENATE BILL NO. 2210

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 54-17, a new subdivision to subsection 2 of section 54-60.1-01, a new subsection to section 57-35.3-05, a new section to chapter 57-38, and a new subdivision to subsection 7 of section 57-38-30.3 of the North Dakota Century Code, relating to a housing incentive fund and tax credits for contributions to the fund; to amend and reenact subsection 2 of section 54-17-07.2 and section 57-35.3-07 of the North Dakota Century Code, relating to the definition

of multifamily housing facility and payment of the financial institutions tax; to provide a continuing appropriation; to provide an effective date; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 54-17-07.2 of the North Dakota Century Code is amended and reenacted as follows:

2. "Multifamily housing facility" means any facility containing ~~five~~^{four} or more residential dwelling units; provided, that at least twenty percent of the units in each facility must be held for occupancy by persons or families of low and moderate income for ~~such~~^{the} period of time as the industrial commission may determine and may include ~~such~~^{the} related public or private facilities intended for commercial, cultural, recreational, community, or other civic purpose as the commission may approve.

SECTION 2. Two new sections to chapter 54-17 of the North Dakota Century Code are created and enacted as follows:

Housing incentive fund - Continuing appropriation.

1. The housing incentive fund is created as a special revolving fund at the Bank of North Dakota. The housing finance agency may direct disbursements from the fund and a continuing appropriation from the fund is provided for that purpose.
2. After a public hearing, the housing finance agency shall create an annual allocation plan for the distribution of the fund. At least twenty-five percent of the fund must be used to assist developing communities with a population of not more than ten thousand individuals to address an unmet housing need or alleviate a housing shortage. At least fifty percent of the fund must be used to benefit households with incomes at not more than fifty percent of the area median income. The agency may collect a reasonable administrative fee from the fund.
3. The housing finance agency shall adopt guidelines for the fund so as to address unmet housing needs in this state. Assistance from the fund may be used solely for:
 - a. New construction, rehabilitation, or acquisition of a multifamily housing project;
 - b. Gap assistance, matching funds, and accessibility improvements;
 - c. Assistance that does not exceed the amount necessary to qualify for a loan using underwriting standards acceptable for secondary market financing or to make the project feasible; and
 - d. Rental assistance, emergency assistance, or targeted supportive services designated to prevent homelessness.
4. Eligible recipients include units of local, state, and tribal government; local and tribal housing authorities; community action agencies; regional planning councils; and nonprofit organizations and for-profit developers of multifamily housing. Individuals may not receive direct assistance from the fund.
5. Except for subdivision d of subsection 3, assistance is subject to repayment or recapture under the guidelines adopted by the housing finance agency. Any assistance that is repaid or recaptured must be deposited in the fund and is appropriated on a continuing basis for the purposes of this section.

Report.

Upon request, the housing finance agency shall report to the industrial commission on the activities of the housing incentive fund.

SECTION 3. A new subdivision to subsection 2 of section 54-60.1-01 of the North Dakota Century Code is created and enacted as follows:

Assistance from the housing finance agency through housing incentive funds.

SECTION 4. A new subsection to section 57-35.3-05 of the North Dakota Century Code is created and enacted as follows:

There is allowed a credit against the tax imposed by sections 57-35.3-01 through 57-35.3-12 in an amount equal to the contribution to the housing incentive fund under section 2 of this Act. The taxpayer may not claim more than twenty percent of the credit for each separate contribution made in any taxable year. For the purposes of the credit allowed in this subsection, subsections 2 through 8 of section 6 of this Act apply.

SECTION 5. AMENDMENT. Section 57-35.3-07 of the North Dakota Century Code is amended and reenacted as follows:

57-35.3-07. Payment of tax.

Two-sevenths of the tax before credits allowed under section 57-35.3-05, less the credit credits allowed under subsection 1 of section 57-35.3-05 and section 4 of this Act, must be paid to the commissioner on or before April fifteenth of the year in which the return is due, regardless of any extension of the time for filing the return granted under section 57-35.3-06. Five-sevenths of the tax before credits allowed under section 57-35.3-05, less the credit allowed under subsection 2 of section 57-35.3-05, must be paid to the commissioner on or before January fifteenth of the year after the return is due. Payment must be made by check, draft, or money order, payable to the commissioner, or as prescribed by the commissioner under subsection 15 of section 57-01-02.

SECTION 6. A new section to chapter 57-38 of the North Dakota Century Code is created and enacted as follows:

Housing incentive fund tax credit.

1. A taxpayer is entitled to a credit as determined under this section against state income tax liability under section 57-38-30 or 57-38-30.3 for contributing to the housing incentive fund under section 2 of this Act. The amount of the credit is equal to the amount contributed to the fund during the taxable year. The taxpayer may not claim more than twenty percent of the credit for each separate contribution made in any taxable year.
2. North Dakota taxable income must be increased by the amount of the contribution upon which the credit under this section is computed but only to the extent the contribution reduced federal taxable income.
3. The contribution amount used to calculate the credit under this section may not be used to calculate any other state income tax deduction or credit allowed by law.
4. If the amount of the credit exceeds the taxpayer's tax liability for the taxable year, the excess may be carried forward to each of the ten succeeding taxable years.
5. The aggregate amount of tax credits allowed to all eligible contributors is limited to four million dollars per biennium. This limitation applies to all contributions for which tax credits are claimed under section 57-35.3-05 and this section.

6. Within thirty days after the date on which a taxpayer makes a contribution to the housing incentive fund, the housing finance agency shall file with each contributing taxpayer, and a copy with the tax commissioner, completed forms that show as to each contribution to the fund by that taxpayer the following:
 - a. The name, address, and social security number or federal employer identification number of the taxpayer that made the contribution.
 - b. The dollar amount paid for the contribution by the taxpayer.
 - c. The date the payment was received by the fund.
7. To receive the tax credit provided under this section, a taxpayer shall claim the credit on the taxpayer's state income or financial institutions tax return in the manner prescribed by the tax commissioner and file with the return a copy of the form issued by the housing finance agency under subsection 6.
8. Notwithstanding the time limitations contained in section 57-38-38, this section does not prohibit the tax commissioner from conducting an examination of the credit claimed and assessing additional tax due under section 57-38-38.
9. A partnership, subchapter S corporation, limited partnership, limited liability company, or any other passthrough entity making a contribution to the housing incentive fund under this section is considered to be the taxpayer for purposes of this section, and the amount of the credit allowed must be determined at the passthrough entity level. The amount of the total credit determined at the entity level must be passed through to the partners, shareholders, or members in proportion to their respective interests in the passthrough entity.

SECTION 7. A new subdivision to subsection 7 of section 57-38-30.3 of the North Dakota Century Code is created and enacted as follows:

Housing incentive fund tax credit under section 6 of this Act.

SECTION 8. EFFECTIVE DATE - EXPIRATION DATE. Sections 1, 2, and 3 of this Act are effective through June 30, 2013, and are thereafter ineffective. Sections 4, 5, 6, and 7 of this Act are effective for the first two taxable years beginning after December 31, 2010, and are thereafter ineffective."

Renumber accordingly

MESSAGE TO THE SENATE FROM THE HOUSE (BUELL J. REICH, CHIEF CLERK)

MR. PRESIDENT: The House has failed to pass, unchanged: SB 2355.

MESSAGE TO THE HOUSE FROM THE SENATE (WILLIAM R. HORTON, SECRETARY)

MR. SPEAKER: Your signature is respectfully requested on: SB 2188, SB 2204.

MESSAGE TO THE SENATE FROM THE HOUSE (BUELL J. REICH, CHIEF CLERK)

MR. PRESIDENT: Your signature is respectfully requested on: HB 1008, HB 1117, HB 1380, HB 1407, HB 1454.

MESSAGE TO THE SENATE FROM THE HOUSE (BUELL J. REICH, CHIEF CLERK)

MR. PRESIDENT: The Speaker has signed: SB 2188, SB 2204.

MESSAGE TO THE HOUSE FROM THE SENATE (WILLIAM R. HORTON, SECRETARY)

MR. SPEAKER: The President has signed: HB 1008, HB 1055, HB 1072, HB 1117, HB 1125, HB 1165, HB 1211, HB 1215, HB 1230, HB 1304, HB 1371, HB 1380, HB 1407, HB 1419, HB 1454, HB 1461, HB 1464, HCR 3003.

MOTION

SEN. CHRISTMANN MOVED that the Senate be on the Fourth, Fifth, Seventh, and

Thirteenth orders of business and at the conclusion of those orders, the Senate stand adjourned until 1:00 p.m., Wednesday, March 30, 2011, which motion prevailed.

REPORT OF STANDING COMMITTEE

HB 1093: Judiciary Committee (Sen. Nething, Chairman) recommends **DO PASS** (5 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). HB 1093 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1110, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1110 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1123, as engrossed: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1123 was rereferred to the **Appropriations Committee**.

REPORT OF STANDING COMMITTEE

HB 1173: Transportation Committee (Sen. G. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1173 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1189, as engrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **DO NOT PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1189 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1224, as engrossed: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1224 was placed on the Sixth order on the calendar.

Page 1, line 3, after the semicolon insert "to amend and reenact subsection 2 of section 12.1-31-01.1 of the North Dakota Century Code, relating to disorderly conduct at a funeral;"

Page 1, after line 13, insert:

"SECTION 2. AMENDMENT. Subsection 2 of section 12.1-31-01.1 of the North Dakota Century Code is amended and reenacted as follows:

2. An individual is guilty of disorderly conduct at a funeral if the individual:
 - a. Engages, with knowledge of the existence of a funeral site, in any loud singing, playing of music, chanting, whistling, yelling, or noisemaking within ~~three hundred~~ one thousand feet [91-44300.48 meters] of any ingress or egress of that funeral site if the volume of the singing, music, chanting, whistling, yelling, or noisemaking is likely to be audible at and disturbing to the funeral site; or
 - b. Displays, with knowledge of the existence of a funeral site and within ~~three hundred~~ one thousand feet [91-44300.48 meters] of any ingress or egress of that funeral site, any visual images that convey fighting words or actual or veiled threats against any other individual."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1249: Judiciary Committee (Sen. Nething, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1249 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1269, as reengrossed: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1269 was placed on the Sixth order on the calendar.

In lieu of the amendments adopted by the Senate as printed on page 813 of the Senate Journal, Reengrossed House Bill No. 1269 is amended as follows:

Page 1, line 4, replace "for application" with "an appropriation"

Page 1, line 4, remove the second "for"

Page 1, line 5, replace "retroactive application" with "a contingent effective date"

Page 4, line 29, remove "The petitioner may appeal a denial of the"

Page 4, line 30, remove "requested relief, and review on appeal is de novo."

Page 5, replace lines 7 through 13 with:

"SECTION 4. APPROPRIATION. There is appropriated the sum of \$585,859, or so much of the sum as may become available from a grant under the Act of Congress entitled NICS Improvement Act of 2007 [Pub. L. 110-180, 121 Stat. 2559] or other funds, to the attorney general for the purpose of implementing software and administering the system, for the biennium beginning July 1, 2011, and ending June 30, 2013.

SECTION 5. CONTINGENT EFFECTIVE DATE. Subsections 2 and 5 of section 3 of this Act become effective when the attorney general certifies to the secretary of state, the office of management and budget, and the legislative council that the state has received the grant under section 4 of this Act and has implemented the software and system to carry out the provisions of subsections 2 and 5 of section 3 of this Act."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1285, as engrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **DO NOT PASS** (5 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1285 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1314, as engrossed: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1314 was placed on the Sixth order on the calendar.

Page 1, line 1, after "reenact" insert "subdivision a of subsection 1 of section 54-05.1-03 and"

Page 1, line 2, after "to" insert "a duplicate lobbyist badge and to"

Page 1, after line 4, insert:

"SECTION 1. AMENDMENT. Subdivision a of subsection 1 of section 54-05.1-03 of the North Dakota Century Code is amended and reenacted as follows:

- a. Before engaging in any of the activities listed in section 54-05.1-02, an individual shall register with the secretary of state and receive a certificate of registration and a distinctive lobbyist identification badge that must be prominently worn by the lobbyist when engaged in any of the activities listed in section 54-05.1-02 while on the

capitol grounds. In lieu of wearing the official badge provided by the secretary of state, a lobbyist may wear a reasonable reproduction of the official badge that contains the name of the lobbyist and any of the following: the word lobbyist, the registration number of the lobbyist, or the organization name of the lobbyist in characters no smaller than one-quarter inch [6.35 millimeters]. If a lobbyist's official badge is lost or destroyed, the lobbyist may obtain a duplicate badge by applying to the secretary of state and paying a fee of ten dollars."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1321, as reengrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1321 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1322, as reengrossed: Finance and Taxation Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1322 was placed on the Sixth order on the calendar.

Page 1, line 1, replace "40-23-07 and 40-23.1-01" with "40-26-01 and 40-26-07"

Page 1, line 3, after the semicolon insert "to provide for a legislative management study;"

Page 1, remove lines 5 through 24

Page 2, replace lines 1 through 23 with:

"SECTION 1. AMENDMENT. Section 40-26-01 of the North Dakota Century Code is amended and reenacted as follows:

40-26-01. Courts to review levy and apportionment of special assessments - De novo review for agricultural property assessments.

The courts shall review the levy and apportionment of the special assessments in all actions and proceedings involving the validity or apportionment of any special assessment for local or special improvements. If an action challenges the determination of benefits and special assessments imposed for agricultural property, the decision of the special assessment commission regarding agricultural property is not entitled to deference by the court and the court shall consider the determination of benefits and special assessments imposed for agricultural property de novo. An appeal taken under this section must be in accordance with the procedure provided in section 28-34-01.

SECTION 2. AMENDMENT. Section 40-26-07 of the North Dakota Century Code is amended and reenacted as follows:

40-26-07. Actions to restrain collection of special assessments, avoid tax judgments - Duty of court.

The court shall determine the true and just amount which any property attempted to be specially assessed for a special improvement should pay to make the same uniform with other special assessments for the same purpose, whenever any action or proceeding shall be commenced and maintained before the court to prevent or restrain the collection of any special assessment or part thereof made or levied by the officers of any municipality for any purpose authorized by law, if such assessment shall be held to be void by reason of noncompliance with any provision of the laws of this state. The~~Unless the action challenges the determination of benefits and special assessments imposed for agricultural property, the~~ amount of the assessment as the same appears on the assessment list shall be prima facie evidence of the true and just amount, and judgment must be rendered and given therefor against the party liable for such special assessment without regard to the proceedings had for the levy thereof. The judgment shall be a lien upon the property

upon which a special assessment shall have been levied, of the same force and effect as the lien of a special assessment, and the lien of such special judgment shall be enforced by the court in such action. No action for said purposes shall be maintained unless it is commenced within six months after the special assessment is approved.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - SPECIAL ASSESSMENTS AND AGRICULTURAL PROPERTY ASSESSMENTS. During the 2011-12 interim, the legislative management shall consider studying use of special assessments for public improvements, use and administration of special assessments across the state, and alternative funding mechanisms available, with emphasis on imposition and relative rate of special assessments against agricultural property. The study must include examination of agricultural property tax classification and assessment issues, with emphasis on these issues within and near city boundaries. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1435: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1435 was placed on the Sixth order on the calendar.

Page 1, line 3, after "requirements" insert "; and to declare an emergency"

Page 1, line 9, after the underscored period insert "Before arriving at a state park for overnight lodging or camping, a sexual offender who is assigned a moderate or high-risk level by the attorney general shall notify a park and recreation department law enforcement officer at the state park where the sexual offender will be staying."

Page 1, after line 9, insert:

"SECTION 2. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1438, as engrossed: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **DO PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1438 was placed on the Fourteenth order on the calendar.

REPORT OF STANDING COMMITTEE

HB 1452: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). HB 1452 was placed on the Sixth order on the calendar.

Page 1, line 9, after "1." insert "a."

Page 1, line 11, replace "a." with "(1)"

Page 1, line 14, replace "b." with "(2)"

Page 1, line 16, replace "c." with "(3)"

Page 1, line 18, replace "(1)" with "(a)"

Page 1, line 20, replace "(2)" with "(b)"

Page 1, line 22, replace "(3)" with "(c)"

Page 2, line 1, replace "(4)" with "(d)"

Page 2, line 4, replace "(5)" with "(e)"

Page 2, after line 5, insert:

- b. For purposes of this subsection, artificial condition means a structure or other manmade condition and does not include living animals.

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1456, as engrossed: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1456 was placed on the Sixth order on the calendar.

Page 1, line 10, replace "of an injury" with "that a potential claim exists"

Renumber accordingly

REPORT OF STANDING COMMITTEE

HCR 3011: Judiciary Committee (Sen. Nething, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HCR 3011 was placed on the Fourteenth order on the calendar.

The Senate stood adjourned pursuant to Senator Christmann's motion.

William R. Horton, Secretary

