**2011 JOINT HEALTH CARE REFORM**

**HB 1476**

# 2011 SPECIAL SESSION
# JOINT COMMITTEE MINUTES
## JOINT HEALTH CARE REFORM
Roughrider Room, State Capitol

HB 1476
November 9, 2011
Job # 16950

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

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

Relating to the external review procedures for health insurance; and to provide an effective date.

**Minutes:** You may make reference to "attached testimony."

**Chairman Keiser:** We have a bit of a conflict as some of our committee members are serving also on Appropriations which are meeting right now.

**Rep. Kreidt:** I will be going down to appropriations in a few minutes, but before I go I want to make a statement that I appreciate the work Chairman Keiser has done. This is the first time I have worked with him on a committee and he is a very good chairman and I appreciate his leadership and guidance. I think most of you know I have had some heartburn along the way with this bill and I still do. At our interim committee meetings I did address some of those issues. I just want the committee to know that I am not going to support the bill on the floor. I gave Chairman Keiser my reasons. I want the committee to be aware of that.

**Rep. Kaldor:** I too Mr. Chairman will be leaving and maybe you will still be here when I get back, but I doubt it. I want to echo the comments made as far as working with this committee. I think this has been a very good experience. I'm not going to make any comments on how I am going to vote.

**Rep. Keiser:** Opened the hearing on HB 1476 and roll was taken.

**Rep. Kasper:** After the roll, my question is, are we going to have a quorum.

**Rep. Keiser:** We will see. We do have a quorum. I don't think we have any Senators here. They are still in and I know they are doing redistricting. Even though we have the required number, I think we will just adjourn the hearing and meet with management and get back. I think we need the Senate to weigh in on this issue as they are an integral part of the committee. We will come back. We do have a set of amendments distributed by Senator Mathern and I know he would like to address those to the committee. We will re-schedule and let you know when we are coming back. Thank you.

Hearing adjourned.

# 2011 SPECIAL SESSION
# JOINT COMMITTEE MINUTES
## JOINT HEALTH CARE REFORM
Roughrider Room, State Capitol

HB 1476
November 9, 2011
16952

☐ Conference Committee

Committee Clerk Signature Shirley Brenning

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

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

**Minutes:** Attachments # 1 and 2

**Chairman Keiser:** The hearing on HB 1476 was reopened and attendance was taken. Jen Clark, Legal Counsel, was introduced to provide an overview of the bill that came out of this committee.

**Jennifer Clark:** My testimony here is neutral. The bill before you, 1476, came to you because a provision of the Affordable Care Act addressed external review processes that are required of insurance carriers. During the interim you received testimony that our state law addressing external review did not meet the federal requirements. It was indicated that as a consequence of that our insurance carriers and individuals covered by our North Dakota policies are required to follow the federal external review policy. That policy comes in to play if there is an uncovered claim or denial. Internal review has been completed moving on to external review and have an independent review organization look at that claim. HB 1127 was enacted during the 2011 session and that was the external appeals process that was found to be noncompliant with the federal government. This bill amends that law specifically it provides that subsection that has definitions, PP 1-2 on down to line 17 that is in effect today. It is being revised to state that this law is intended to be either substantially equivalent to the federal law or parallel. Substantially equivalent means that you are following the 16 points that the Feds. require. The testimony received during committee was that this may well meet those 16 points. Page 3 is where you go over the requirements for the insurer's external review process. Page 6 contains a reference to what it takes to be culturally and linguistically appropriate regarding notices that the insurer sends out. The effective date is December 1, 2011.

**Chairman Keiser:** Are there any questions from committee members? Is there anyone else to testify in support of HB 1476?

**Rod St. Aubyn, Representing Blue Cross and Blue Shield of North Dakota:** Provided testimony, see Attachment # 1. Stating that his testimony is similar to what Jennifer Clark stated. Two proposals had been offered because it was unclear whether it could be assigned by the insurer or not. Senator Judy Lee had a conversation with Health and

Human Services (HHS) and got confirmation. Some of the things that they said is that if the State did not have an effective external review law the insurers would still have to do one of the following processes until 2014. See PP. 1 of testimony. Adopter requirement like the self funded plans and contract with three Independent Review Organizations (IRO) and assign them on a random or rotational basis. Continuing with testimony P. 2. And discussing how the process will work. All the insurers supported this and are in compliance with the law as it is right now

**Senator Mathern:** From the consumer perspective, when we say this would bring us into compliance and you are in compliance. With passage of the bill the way it is will the consumer see the process with both internal and external review as being within the same system or would they experience one as state system and one as a federal system.

**St. Aubyn:** Initially it is like the internal process and that would all be identified within the benefit books. They are notified of their rights if they wish to appeal an internal claim. It would be similar all the way up to the external review, they would be notified and would be informed of their right.

**Senator Mathern:** With the external review would the consumer see it still as going through the insurance department or would they see that entity as going through the federal government? Would they see that as being the insurance commissioner's office or some federal entity?

**St. Aubyn:** This would be a state run program.

**Senator Mathern:** They would experience it as something within the insurance commissioners office, whether it be internal or external regulations.

**St. Aubyn:** Ultimately the insurance department has authority over all insurers. Insurers have to establish a process that meets all of those minimum requirements. This is dealing only with external reviews. For anything that goes beyond and someone is requesting an external review, HHS has made it very clear that the insurance company itself cannot have any authority over the selection or contracting or assignment of an independent reviewer. That is different from what happens in our self funded business where the insurer has to contract with three IROs and we have to assign if one of the members should happen to request an external review than the insurer can assign a self funded. In an insured market those would all go through the insurance department.

**Senator Mathern:** Should the consumer need some help with the passage of the bill we have before us and they want assistance outside of the insurance company for either the internal or external review could they get that help from the insurance commissioner's office or would they be required to go to HHS for help with the external review process?

St. Aubyn: The state only regulates fully insured products. Unless you have some state law the insurance department would not have the authority to deal with complaints. With this law, it is very clear that the insurance department has the authority.

**Chairman Keiser:** Senator Mathern is touching on a very important point because the bill was rejected now if a consumer called the insurance with a complaint would the consumer be referred to the federal HHS and have them assign the external reviewer? If this law were to pass and the same consumer called the insurance department would be the difference in the way the insurance department would manage this given the current state of the law versus if this were passed?

**St. Aubyn:** Right now, without this law they would go to the insurer and the insurer would assign an external reviewer.

**Chairman Keiser:** If they call the insurance department, they would refer them to you.

**St. Aubyn:** They would. HHS does not assign, it is the same way as in the self funded.

**Chairman Keiser:** If this law was to pass as written and they call the insurance department, what would happen?

**St. Aubyn:** The process would identify what they have to do if they want an external review and the external review will be handled through the insurance department. And they would assign the IRO on a random or rotational basis.

**Senator Klein:** Are there a lot of external reviews done?

**St. Aubyn:** No.

**Chairman Keiser:** Further questions. In the additional law we indicated that because the federal government had not fully promulgated their rules relative to external review, our law said whatever their rules were that is what we would do. They rejected that. Now we have language in this bill that adds the external review procedures, we have clarified that the insurance department will handle the external reviewers and will assign the external reviewers. Referring to page 2 of HB 1476 we make the statement that our legislation will be parallel and substantially equivalent. That is what we thought we were doing the first time around. Have we added enough to this bill and with the clarification and "substantial equivalent" in the opinion of your attorneys that we now will pass muster with the federal government?

**St. Aubyn:** From our perspective, yes. First we have to submit to the insurance department what our process is. When we change our benefit books we have to receive approval from the insurance department. If it does not meet the minimum federal requirements, they have the authority to reject our filing and say that specific changes need to be made. This does go into the detail of what has to be in there.

**Chairman Keiser:** Further questions.

**St. Aubyn:** Our legal counsel is here and would be available for questions.

**Chairman Keiser:** Is there anyone who wishes to speak in support of HB 1476? Seeing on one, is there anyone here to speak in opposition to HB 1476? Seeing no one, is there

anyone in a neutral position on HB 1476? Committee members, we will close the accepting testimony part but I know there are some amendments and if anyone in the audience would have an amendment they could bring it forward and we would recognize it. Introducing Senator Mathern.

**Senator Mathern:** I am handing out an email that I received from the Insurance Commissioner's office; see Attachment # 2 and Amendment # .02001. I attempted to draft an amendment that would express the concerns that the Insurance Commissioner's office had last session and again during the interim saying that our law was not adequate to meet federal standards. The proposal that we made was not accepted by HHS which then brought us back to this session to try to get a proposal that would be acceptable. Instead of going through the details of the 68 page amendment, some confirmation about the Amendment some confirmation from the insurance commissioner's office would suffice. As mentioned in the memo, the language would put into one place the laws related to utilization review, grievance procedures and external review. Should we pass the amendments, the HHS would likely find our review process acceptable and these amendments are the same as the other amendments we had in the past. The rational is to try to meet all of the requirements that are part of 2014 in terms of this process. There are some 16 indicators and the goal is to try to meet all of those indicators so this process for a citizen within the state. I have comfort that we are closer to meeting the federal requirements and I think we are still at some risk though less risk. These amendments are for your edification and I do not plan to offer them.

**Chairman Keiser:** Calling on someone from the insurance department to address the committee relative to the amendment, specifically review the 16 points and with prior approval make certain that should a company apply for review would meet those requirements.

**Melissa Hauer, Insurance Department General Counsel:** Do you want me go through what I went through last time?

**Chairman Keiser:** If you can summarize it. We have done one of the 16 here in identifying that the insurance department would hire the IROs and assign complaint to them. On the other 15, does the insurance department have adequate authority without a 68 page amendment to implement those either through rule or the prior approval process to make certain that companies meeting the 16 required elements of Parent Protection Affordable Care Act (PPACA).

**Hauer:** The bill says that "if the federal laws or the rules relating to external review are amended, repealed or otherwise changed the commissioner shall track such changes to the federal external review." We only do rule making if something at the federal level is changing. If HHS were to look at this bill if it passes and say that it is deficient in some area, by rule we cannot fill in that gap. This bill seems to say the legislature only want us to do rule making if federal laws or rules have changed.

**Senator Mathern:** Are you saying this would not be adequate or maybe you don't even have the tools to make changes to address concerns that might come forward. Is there

something short of the 68 pages of amendments to address this concern? Is there something more than tracking authority but authority to move forward?

**Hauer:** There are some areas where we are not sure. We are not saying that HHS won't accept this but it seemed that there were a few areas where there was lacking a little detail and that HHS may have a concern about that. It may be possible to beef this up without going to 68 pages.

**Chairman Keiser:** Are there any more questions for Melissa? So if we were to propose an amendment to allow you to develop rules for any area that they may reject and leave it until we go back into session would that give some level of comfort to the insurance department?

**Hauer:** That would give us an avenue with a specific statement by the legislature that we are being granted authority to fill in those gaps.

**Senator Mathern:** I think this is a delicate process. What the insurance department has told us in terms of the direction it would go is pretty clear in light of the amendments that I have handed out. They are the direction the insurance would have gone. We should provide some further ability on their part. To decrease the chances we are in this situation again. People could be working on this until we get back to the next session. I would hope to provide some sort of amendment to the present bill to provide leeway to more ahead until the next session.

**Senator Lee:** Is there anything in here that would prevent the insurance department from promulgating rules? Looking on P. 2, line 26 about the "insurance commissioners shall track such changes……."? I am not saying that they can't do it. But if there is some concern that they can't do it. Maybe we should consider saying "Shall track such changes and may promulgate rules to insure the external review."

**Chairman Keiser:** The attorney general reads what the word says we pass legislation and it does the interpretation, not based on what we intended. It has to be clear that they can promulgate a rule. We need to make sure not to default to the federal government.

**St. Aubyn:** The insurance department makes it clear that they cannot (default to the federal government). Replace "track" with "adopt" p. 2, line 26 of the bill.

**Senator Mathern:** I think that does address the issue and I would **move on line 26 of page two to remove the overstrike on the word "adopt" and remove the word "track".**

**Senator Lee: Second**

**Chairman Keiser:** Further discussion?

**Representative Winrich**: Did we hear Melissa's opinion?

**Chairman Keiser:** She was on her way up.

**Hauer:** I appreciate what you are trying to do. I think it helps but adopt and track, that is not the problem language in here. The department only adopts rules to insure that we are incorporating changes. It is still saying that if the federal rules are amended, repealed or otherwise changed. What you are talking about is not a change. The department has general rule making authority but there is a bill that is defeated and we would try to come in and do rules knowing that that bill had been defeated, that puts us in a difficult position to do by rule what the legislature has said it is not going to do in legislation. I would want clarity that it is okay when we can and when we cannot make rules.

**Senator Mathern:** What words and changes would provide you the authority to do what you have just described?

**Hauer:** Some general rule making authority to ensure that the external appeals and rules processes are in compliance with federal laws and regulations could be added.

**Senator Mathern:** Would that wording be in addition to this. Might you also want the word adopt to get you out of the difficulty about when you would start acting? You need a change from "tract" to "adopt" in addition so you have some policy direction.

**Chairman Keiser:** On line 26, if we remove the overstrike on adopt then .....reading from line 26. It needs to be both ways.

**Representative Winrich:** On lines 23 and 24 there is a line that is struck out. Reading from lines 23 and 24. Should that strike out be removed?

**Chairman Keiser:** I think you might find more support for limiting it to the 16 provisions rather than opening it.

**Senator Lee:** A majority of our discussions about this is 1127 was that we didn't want to open up the process to that 93 page bill. I am not interested in hearing that the department is coming to administrative rules to try to implement all that we rejected. There is a comfort level that comes from everybody recognizing that we want to do what the minimum is that the feds require. We want to do what the insurance department to be able to do that. Let's not upon it all up again.

**Senator Dever:** during the session we passed a bill that would be accepted but it was rejected now we are considering another bill. Is it not possible to send a bill to them in advance and ask their approval?

**Chairman Keiser:** I think the insurance department will be happy to address that because they are in contact with legislation that is brought forward and whether or not they feel that they have a receptive ear in HHS. Any comment from the insurance department?

**Hauer:** We have been in contact with HHS and we can do that if you would like us to.

**Senator Lee:** Chairman, I would ask that you be a part of that discussion.

**Senator Mathern:** I think we have a motion on the table with a friendly amendment.

**Chairman Keiser:** I don't believe we have a friendly amendment.

**Senator Mathern:** I heard you state it.

**Chairman Keiser:** We have a motion.

**Senator Mathern:** Is what Senator Dever is saying in context with that being adopted or with that not being adopted?

**Senator Dever:** I would rather not adopt the amendment and have that conversation with HHS and see where we are.

**Chairman Keiser:** The motion can be withdrawn.

**Senator Mathern:** Agrees.

**Chairman Keiser:** It is possible to do it today yet. It is not a bad suggestion because this committee always has wanted the state to be in charge of and involved in this process. We always wanted to do the minimum amount necessary to meet the necessary requirements established. We can have that discussion. Leadership will not be happy but we will withdraw the amendment and try to get a call in immediately. We will meet back here at 11:30. Senator Lee, Senator Mathern and other House members be in attendance at the call.

**Senator Lee:** While that is going on, the language that you were talking about, if we could have that crafted and have it ready.

**Chairman Keiser:** Adjourn until 11:30.

**Recess**

**Chairman Keiser:** Introducing students from Dickinson who are visiting. Conversation with legislators ensues. Calling the session to order. We were unable to make contact so what we are going to do is take the draft from her computer and read it to us.

**Clark:** Asking members to turn to page 2 of the bill draft and go to line 23 and reading, "The insurance commissioner shall adopt rules as necessary to ensure compliance with this section and the minimum consumer protection standards." That is the general direction that they need to adopt rules as necessary to comply with the federal law as it exists. Continuing, "If federal laws or rules relating to external review are amended, repealed or otherwise changed the insurance commissioner shall adopt rules that track such changes to the federal external review rules to ensure the external rules procedures set forth in this section is substantively equivalent and parallel to the federal requirements."

**Chairman Keiser:** You may not have the exact language in front of you but you have the general concept.

**Senator Mathern:** I suggest we adopt that amendment and then I hope that the department would continue in trying to have the communication with the federal government and if there is feedback maybe that could still be addressed by a shorter procedure. I think getting the bill out with this amendment would be a positive thing. **I so Move.**

**Representative Johnson: Second**

**Chairman Keiser:** Any further questions?

**Representative Johnson:** It identifies that it only applies to the external review process because it says "this section" so it is limited to that area?

**Clark:** My position is that the insurance commissioner has general authority to adopt rules. We are not taking that away. The reality is given the legislative history of this body of law, the insurance commissioner is hesitating to address this through rules without a clear directive. We are giving him that directive. We have an expectation that rules be adopted as necessary to comply with the federal law. I want to be clear that we have taken away his authority as it may relate to internal review. He still has general authority. You may want to speak to the insurance commissioner's office to find out whether they think they need a clear directive in order to pursue that.

**Senator Dever:** Is there precedence where we promulgate rules based on federal law instead of state law?

**Chairman Keiser:** I defer that question to Senator Klein who has experience with this.

**Senator Klein:** The issue happens quite often as it relates to the federal ilk of rules, we have to adopt them as proposed by the federal government. We do that every biennium and there is also the security commissioner where there are national rules that get set down and we adopt them. There are some things that are adopted but only because the federal government requires us to adopt them. Generally, rules are laid out, they are sent out for publication, for review, for input and then the committee takes the information and reviews it at the quarterly meeting and determines whether or not it falls within the guidance of what we as a legislature set forth.

**Chairman Keiser:** We have had several occasions where the federal government has promulgated their rules or law and in establishing rules with the state, we have made sure to restrict our rules to not exceed the regulatory requirements within the federal law.
Any additional questions?
We have the motion and a second before us putting in the express language of what we want to have happen relative to the subject. The department presently has the authority to promulgate rules. The language as it exists in this bill does require them to promulgate rules. So the first half is "they may promulgate rules currently." The language that is currently in the bill is "they must promulgate rules if the federal government makes any changes relative to these areas." The amendment is now maintaining the requirement that if changes are made, they have to promulgate rules. It is also giving clear authority to them that they can do what they can do is promulgate rules. Clerk, take the role on the amendment.

**Vote Taken: 12 yes, 3 no, 4 absent. Motion carries.**

**Chairman Keiser:** The amendment is on the bill and we have the bill as amended before us. Do we have a motion on the bill?
**Representative Johnson: I move a do Pass on bill 1476 as amended.**

**Senator Dever: Second.**

**Vote Taken: 17 yes, 0 no, 2 absent. Motion carries.**

**Chairman Keiser:** This bill will be expedited on the floor.

**Representative Johnson:** Requesting Clark to email the amendment.

**Chairman Keiser: Meeting adjourned.**

VR
11/9/11

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Prepared by the Legislative Council staff for
the Joint Health Care Reform Committee
November 9, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1476

Page 2, line 23, remove the overstrike over "~~The insurance~~"

Page 2, line 24, remove the overstrike over "~~commissioner~~"

Page 2, line 24, after "~~steps~~" insert "shall adopt rules as"

Page 2, line 24, remove the overstrike over "~~necessary to ensure compliance with this section~~" and insert immediately thereafter "and the federal minimum consumer protection standards"

Page 2, line 24, remove the overstrike over the overstruck period

Page 2, line 26, remove the overstrike over "~~adopt~~" and insert immediately thereafter "rules that"

Renumber accordingly

Date: 11-9-11
Roll Call Vote #: 1

**2011 SPECIAL SESSION JOINT HEALTH CARE REFORM COMMITTEE**
**ROLL CALL VOTES**
**BILL/RESOLUTION NO.** 1476

House Health Care Reform Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS

Motion Made By Sen. MATHERN Seconded By Rep. N. Johnson

| Senators | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chairman Keiser | ✓ | | Representative Clark | ✓ | |
| Vice Chairman Klein | ✓ | | Representative Frantsvog | ✓ | |
| | | | Representative Glassheim | A | |
| Senator Berry | ✓ | | Representative N. Johnson | ✓ | |
| Senator Dever | ✓ | | Representative Kaldor | A | |
| Senator Lee | ✓ | | Representative Kasper | ✓ | |
| Senator Mathern | ✓ | | Representative Kreidt | A | |
| | | | Representative Meier | | ✓ |
| | | | Representative Metcalf | A | |
| | | | Representative M. Nelson. | ✓ | |
| | | | Representative Rohr | | ✓ |
| | | | Representative Weisz | | ✓ |
| | | | Representative Winrich | ✓ | |
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Total (Yes) 12 (No) 3

Absent 4

Floor Assignment _____

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

adopt amendments

Date: 11-9-11
Roll Call Vote #: 2

**2011 SPECIAL SESSION JOINT HEALTH CARE REFORM COMMITTEE**
**ROLL CALL VOTES**
**BILL/RESOLUTION NO.**

House HEALTH CARE REFORM Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS

Motion Made By Rep. N. Johnson Seconded By Sen. Dever

| Senators | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chairman Keiser | ✓ | | Representative Clark | ✓ | |
| Vice Chairman Klein | ✓ | | Representative Frantsvog | ✓ | |
| | | | Representative Glassheim | ✓ | |
| Senator Berry | ✓ | | Representative N. Johnson | ✓ | |
| Senator Dever | ✓ | | Representative Kaldor | A | |
| Senator Lee | ✓ | | Representative Kasper | ✓ | |
| Senator Mathern | ✓ | | Representative Kreidt | A | |
| | | | Representative Meier | ✓ | |
| | | | Representative Metcalf | ✓ | |
| | | | Representative M. Nelson. | ✓ | |
| | | | Representative Rohr | ✓ | |
| | | | Representative Weisz | ✓ | |
| | | | Representative Winrich | ✓ | |
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Total (Yes) 17 (No) 0

Absent 2

Floor Assignment Rep. Keiser

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

vote on amended bill

**REPORT OF STANDING COMMITTEE**

**HB 1476: Joint Health Care Reform Committee (Rep. Keiser, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (17 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1476 was placed on the Sixth order on the calendar.

Page 2, line 23, remove the overstrike over "~~The insurance~~"

Page 2, line 24, remove the overstrike over "~~commissioner~~"

Page 2, line 24, after "~~steps~~" insert "shall adopt rules as"

Page 2, line 24, remove the overstrike over "~~necessary to ensure compliance with this section~~" and insert immediately thereafter "and the federal minimum consumer protection standards"

Page 2, line 24, remove the overstrike over the overstruck period

Page 2, line 26, remove the overstrike over "~~adopt~~" and insert immediately thereafter "rules that"

Renumber accordingly

## REPORT OF STANDING COMMITTEE

**HB 1476, as engrossed: Joint Health Care Reform Committee (Sen. Klein, Chairman)** recommends **DO PASS** (17 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1476 was placed on the Fourteenth order on the calendar.

**2011 TESTIMONY**

**HB 1476**

HB 1476
November 9, 2011
Rod St. Aubyn
attachment # 1

**Testimony on HB 1476**
**Joint Health Care Reform Committee**
**November 7, 2011**

Chairmen Keiser and Klein and committee members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota. I appear today to offer support for HB 1476, the External Review Bill. Your committee discussed this and approved this bill earlier in your interim committee.

I will attempt to give you some background concerning this bill. As you will recall, the legislature approved HB 1127 during the 2011 Legislative Session. That bill in essence stated that ND's law on external review, internal review, and utilization review was to be exactly as federal law or regulations in force as on July 1, 2011. The law stipulated that should HHS change or relax their standards on these provisions, the Insurance Department was to make changes via the administrative rules process to ensure that ND's standards were essentially the same. The legislature made it clear that they did not want ND's law any more stringent than the minimum required by the Federal government. HHS determined in late July, 2011, that HB 1127 did not meet their requirements as "effective" for only external review.

At the request of Chairman Keiser, we offered a couple of bill draft options to put more specifics in the external review requirements. Our attorneys drafted the bills based on the actual Federal regulations. However there was a question of interpretation relating to the use of Independent Review Organizations (IRO's). In our self-funded business, the insurer must contract with 3 IRO's and they must be assigned on a rotating or random process. The question was whether insurers could assign the IRO's for fully insured plans as long as they used the same random or rotational basis. Our attorneys offered two bill options:

- The first bill draft made the process the same as that used in our self-funded insurance plans where the insurer would assign the IRO's in a random or rotational basis.
- The second bill draft had the Insurance Department responsible for contracting with the IRO's and assigning them on a random or rotational process.

Senator Judy Lee was able to confirm the following after direct discussions with Ms. Ellen Kuhn from the Center for Consumer Information and Insurance Oversight (CCIIO) within the Department of Health and Human Services:

- If the state did not have an "effective" external review law, the insurers would still have to do one of the following processes until 2014 (I believe that was the date she indicated):
    - Adopt the requirement like the self-funded plans and contract with 3 IRO's and assign them on a random or rotational basis (a private accredited IRO process), or

    - Use a Federally-administer external review process by HHS. Ms. Kuhn indicated that HHS would not use 3 IRO's, but instead would be using 1 IRO.
- The insurer would have to notify HHS of the process they were going to be using.
- For these states (like ND), Ms. Kuhn indicated that the consumer did not have to go through HHS or DOL to request an external review. The simply had to go through the insurer. The insurer would then be required to follow the required steps that would have to be indentified in their benefit books and letters to the consumer.
- If the state was to have an "effective external review law", the IRO "cannot be contracted and assigned" by the insurer. It would have to be contracted and assigned by the state or an independent entity.

As a result of that conversation and information gathered by Sen. Judy Lee, your committee decided to approve your current bill draft based on that second bill draft option previously mentioned.

As you previously heard from your earlier meetings, all the insurers testifying stated that they have already established processes that meet the Federal requirements because they had to do so for their self funded plans which are not regulated by the state Insurance Department.

I would like to briefly discuss how this process will work should this bill be approved. Every insurer must adopt a process that meets the minimum federal requirements. This process must be identified in their benefits books and the right to an external review must be included in any "appeal" letters that are sent to the consumer. The insurer must submit their benefits books and external review process for fully insured plans to the Insurance Department for prior approval to ensure that all State and Federal requirements are met. Should a consumer request an external review, this process would explain that the request would be submitted to the Insurance Department who will assign the request to a contracted nationally recognized accredited IRO on a random or rotational basis. The cost of the IRO would be borne by the insurer.

Should the Federal law or regulations change, the Insurance Department can utilize the administrative rules process to ensure that ND's external review law meets the minimum Federal requirements as required in HB 1127 passed in the 2011 Legislative Session.

Chairmen and committee members, we support HB 1476 and your effort to allow the Insurance Department the authority to enforce the new Federal external review requirements and urge that you pass this bill. I would be willing to try to answer any questions that the committee may have.

HB 1476
November 9, 2011
Senator Mathern
#2

**Mathern, Tim**

**From:** Ternes, Rebecca L.
**Sent:** Sunday, November 06, 2011 11:55 AM
**To:** Mathern, Tim
**Cc:** Hauer, Melissa A.; Clark, Jennifer S.
**Subject:** Amendments to HB1476

Senator Mathern – Thank you for sending us your proposed amendments to HB1476 related to external review of health insurance claims. As I mentioned, we had not planned to testify on the bill but in direct response to your questions I have prepared the following.

The amendments prepared by Legislative Council appear to mimic those the North Dakota Insurance Department prepared during the 2011 session debate of HB1127 and which were agreed to by three insurance carriers. The language would put in one place the laws related to utilization review, grievance procedures and external review on.

Should the state pass the amendments, the US Department of Health and Human Services (HHS) would likely allow North Dakota to regain the responsibility for receiving external review and assigning them to independent review organizations. If passed the amendments would likely be a complete description of the requirements necessary by 2014.

Please let me know if you have any questions.

Rebecca Ternes
Deputy Insurance Commissioner
North Dakota Insurance Department
701.328.2440; www.nd.gov/ndins

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11.0822.02001
Title.

Prepared by the Legislative Council staff for
Senator Mathern
November 4, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1476

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 repeal sections 26.1-36-46 and 26.1-36-47 of the North Dakota Century Code, relating to external appeal procedures and internal claims and appeals procedures for health insurance; to provide a penalty; and to provide an effective date.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Chapter 26.1-36.6 of the North Dakota Century Code is created and enacted as follows:

**26.1-36.6-01. Definitions.**

For purposes of this chapter:

1. "Adverse determination" means:

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

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

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

   d. A rescission of coverage determination.

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

3. "Authorized representative" means:

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

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

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

4. "Best evidence" means evidence based on:

a. Randomized clinical trials;

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

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

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

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

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

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

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

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

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

11. "Commissioner" means the insurance commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27. "Health carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness

and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

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

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

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

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

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

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

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

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

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

    d. The following standard reference compendia:

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

        (2) Drug facts and comparisons;

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

        (4) The United States pharmacopoeia-drug information;

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

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

        (2) The national institutes of health;

(3) The national cancer institute;

(4) The national academy of sciences;

(5) The centers for medicare and medicaid services;

(6) The federal food and drug administration; and

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

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

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

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

33. "Protected health information" means health information:

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

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

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

35. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

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

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

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

**26.1-36.6-02. Applicability and scope.**

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

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

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

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

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

   (2) A final adverse determination.

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

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

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

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

(a) If the covered person has a medical condition and the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in section 26.1-36.8-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 26.1-36.6-07 or 26.1-36.6-08 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-08, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

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

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

(a) If the covered person has a medical condition and the timeframe for completion of a standard external review

pursuant to section 26.1-36.6-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to section 26.1-36.6-07; or

(b) If the final adverse determination concerns:

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

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

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

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

**26.1-36.6-04. Request for external review.**

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

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

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

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

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

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

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

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

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

2. a. (1) At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-06, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

      (a) Under section 26.1-36.6-07 if the covered person has a medical condition and the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in section 26.1-36.8-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

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

(2) Upon receipt of a request for an expedited external review under paragraph 1, the independent review organization conducting the external review in accordance with the provisions of section 26.1-36.6-07 or 26.1-36.6-08 shall determine whether the covered person shall be required to complete the expedited review process set forth in section 26.1-36.8-06 before it conducts the expedited external review.

(3) Upon a determination made pursuant to paragraph 2 that the covered person must first complete the expedited grievance review process set forth in section 26.1-36.8-06, the independent review organization immediately shall notify the covered person and the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in section 26.1-36.6-07 until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

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

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

**26.1-36.6-06. Standard external review.**

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

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

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

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

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

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

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

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

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

(1) The request is complete; and

(2) The request is eligible for external review.

b. If the request:

(1) Is not complete, the health carrier shall inform the covered person and the covered person's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall inform the covered person and the covered person's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(2) The notice of initial determination shall include a statement informing the covered person and the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under section 26.1-36.6-06 notwithstanding a

health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

4. a. Whenever the commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection 3, within one business day after the date of receipt of the notice, the commissioner shall:

(1) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10 to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(2) Notify in writing the covered person and the covered person's authorized representative of the request's eligibility and acceptance for external review.

b. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in chapter 26.1-36.8.

c. The commissioner shall include in the notice provided to the covered person and the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision a additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

5. a. Within five business days after the date of receipt of the notice provided pursuant to subdivision a of subsection 4, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

b. Except as provided in subdivision c, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subdivision a shall not delay the conduct of the external review.

c. (1) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subdivision a, the assigned independent review organization

may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(2) Within one business day after making the decision under paragraph 1, the independent review organization shall notify the covered person and the covered person's authorized representative, the health carrier, and the commissioner.

6. a. The assigned independent review organization shall review all of the information and documents received pursuant to subsection 5 and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision c of subsection 4.

b. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision c of subsection 4, the assigned independent review organization shall within one business day forward the information to the health carrier.

7. a. Upon receipt of the information, if any, required to be forwarded pursuant to subdivision b of subsection 6, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

b. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision a shall not delay or terminate the external review.

c. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

d. (1) Within one business day after making the decision to reverse its adverse determination or final adverse determination, as provided in subdivision c, the health carrier shall notify the covered person and the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(2) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to paragraph 1.

8. In addition to the documents and information provided pursuant to subsection 5, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's medical records;

b. The attending health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

e. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions a through f to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

9. a. Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(1) The covered person;

(2) If applicable, the covered person's authorized representative;

(3) The health carrier; and

(4) The commissioner.

b. The independent review organization shall include in the notice sent pursuant to subdivision a:

(1) A general description of the reason for the request for external review;

(2) The date the independent review organization received the assignment from the commissioner to conduct the external review;

(3) The date the external review was conducted;

(4) The date of its decision;

(5) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(6) The rationale for its decision; and

(7) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

c. Upon receipt of a notice of a decision pursuant to subdivision a reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

10. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to section 26.1-36.6-11.

**26.1-36.6-07. Expedited external review.**

1. Except as provided in subsection 5, a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner at the time the covered person receives:

   a. An adverse determination if:

      (1) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in section 26.1-36.8-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

      (2) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in section 26.1-36.8-06; or

   b. A final adverse determination:

      (1) If the covered person has a medical condition and the timeframe for completion of a standard external review pursuant to section 26.1-36.6-06 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

      (2) If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

2. a. Upon receipt of a request for an expedited external review, the commissioner immediately shall send a copy of the request to the health carrier.

   b. Immediately upon receipt of the request pursuant to subdivision a, the health carrier shall determine whether the request meets the reviewability requirements set forth in section 26.1-36.6-06. The

health carrier shall immediately notify the commissioner and the covered person and the covered person's authorized representative of its eligibility determination.

c. (1) The commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(2) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

d. (1) The commissioner may determine that a request is eligible for external review under section 26.1-36.6-06 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under paragraph 1, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

e. Upon receipt of the notice that the request meets the reviewability requirements, the commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 26.1-36.6-10. The commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

f. In reaching a decision in accordance with subsection 5, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in chapter 26.1-36.7 or the health carrier's internal grievance process as set forth in 26.1-36.8.

3. Upon receipt of the notice from the commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subdivision e of subsection 2, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

4. In addition to the documents and information provided or transmitted pursuant to subsection 3, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

a. The covered person's pertinent medical records;

b. The attending health care professional's recommendation;

c. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

d. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

e. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

f. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

g. The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions a through f to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

5. a. As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in section 26.1-36.6-06, the assigned independent review organization shall:

(1) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(2) Notify the covered person and the covered person's authorized representative, the health carrier, and the commissioner of the decision.

b. If the notice provided pursuant to subdivision a was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall:

(1) Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative the health carrier, and the commissioner; and

(2) Include the information set forth in subdivision b of subsection 9 of section 26.1-36.6-06.

c. Upon receipt of the notice of a decision pursuant to paragraph 1 reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

6. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

7. The assignment by the commissioner of an approved independent review organization to conduct an external review in accordance with this section

shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection 4 of section 26.1-36.6-11.

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

1. a. Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 26.1-36.6-03 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the commissioner.

   b. (1) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subdivision a if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

   (2) Upon receipt of a request for an expedited external review, 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.**

As authorized under chapter 28-32, the commissioner may adopt rules to implement this chapter.

**26.1-36.6-17. Confidentiality.**

Any protected health information that the commissioner receives pursuant to this chapter is confidential.

**SECTION 2.** Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

**26.1-36.7-01. Definitions.**

As used in this chapter:

1. "Adverse determination" means:
   a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
   b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;
   c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit; or
   d. A rescission of coverage determination.
2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.
3. "Authorized representative" means:
   a. A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;
   b. A person authorized by law to provide substituted consent for a covered person;

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

d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

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

5. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

6. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

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

8. "Commissioner" means the insurance commissioner.

9. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

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

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

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

13. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's

health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

14. "Emergency services" means, with respect to an emergency medical condition:

    a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

    b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

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

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

    b. "Health benefit plan" includes short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

    c. "Health benefit plan" does not include:

        (1) Coverage only for accident or disability income insurance, or any combination thereof;

        (2) Coverage issued as a supplement to liability insurance;

        (3) Liability insurance, including general liability insurance and automobile liability insurance;

        (4) Workers' compensation or similar insurance;

        (5) Automobile medical payment insurance;

        (6) Credit-only insurance;

        (7) Coverage for onsite medical clinics; and

        (8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191], under which benefits for medical care are secondary or incidental to other insurance benefits.

    d. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].

e. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

f. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (civilian health and medical program of the uniformed services (CHAMPUS)); or

(3) Similar supplemental coverage provided to coverage under a group health plan.

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

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

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

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

21. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives,

for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

22. "Network" means the group of participating providers providing services to a managed care plan.

23. "Participating provider" means a provider who under a contract with the health carrier or with its contractor or subcontractor has agreed to provide health care services to covered persons with an expectation of receiving payment other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

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

25. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

26. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under a health benefit plan if:

    a. The cancellation or discontinuance of coverage has only a prospective effect; or

    b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

27. a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

    b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

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

29. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

30. a. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

b. (1) Except as provided in paragraph 2, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(2) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision a must be treated as an urgent care request.

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

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

**26.1-36.7-02. Applicability and scope.**

This chapter shall apply to a health carrier offering health benefit plans that provides or performs utilization review services, to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf, and to a health carrier or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations regarding coverage provided under a nongrandfathered health benefit plan. For purposes of this chapter, "nongrandfathered health benefit plan" means a health benefit plan that is not exempt from the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] and the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] because it failed to achieve or lost grandfathered health plan status. For purposes of this chapter, "grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

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

A health carrier shall be responsible for monitoring all utilization review activities carried out by or on behalf of the health carrier and for ensuring that all requirements of this chapter and

applicable rules are met. The health carrier also shall ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

**26.1-36.7-04. Contracting.**

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by this chapter or applicable rules, the commissioner shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of this chapter and applicable rules are met.

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

1. a. A health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and nondelegated for:

   (1) The filing of benefit requests;

   (2) The notification of utilization review and benefit determinations; and

   (3) The review of adverse determinations in accordance with chapter 26.1-36.8.

   b. The program document shall describe the following:

   (1) Procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

   (2) Data sources and clinical review criteria used in decisionmaking;

   (3) Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

   (4) Data collection processes and analytical methods used in assessing utilization of health care services;

   (5) Provisions for assuring confidentiality of clinical and proprietary information;

   (6) The organizational structure, such as a utilization review committee, quality assurance, or other committee, that periodically assesses utilization review activities and reports to the health carrier's governing body; and

   (7) The staff position functionally responsible for day-to-day program management.

2. a. A health carrier shall file an annual summary report of its utilization review program activities with the commissioner in the format approved by the commissioner.

b. (1) In addition to the summary report, a health carrier shall maintain records for a minimum of six years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with sections 26.1-36.7-07 and 26.1-36.7-08.

(2) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agencies upon request.

**26.1-36.7-06. Operational requirements.**

1. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to the commissioner.

2. Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

3. a. A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of sections 26.1-36.7-07 and 26.1-36.7-08.

b. (1) Whenever a health carrier fails to strictly adhere to the requirements of sections 26.1-36.7-07 or 26.1-36.7-08 with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this chapter and may take action under paragraph 2 regardless of whether the health carrier asserts that it substantially complied with the requirements of sections 26.1-36.7-07 or 26.1-36.7-08, as applicable, or that any error it committed was de minimis.

(2) (a) A covered person may file a request for external review in accordance with the procedures outlined in chapter 26.1-36.6.

(b) In addition, a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

4. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria consistently in conducting utilization review.

5. A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

6. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

7. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which must include:

   a. A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

   b. Evidence of formal approval of the utilization review organization program by the health carrier; and

   c. A process by which the health carrier evaluates the performance of the utilization review organization.

8. The health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

9. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

10. When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

11. a. In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

    b. In ensuring the independence and impartiality of individuals involved in making the utilization review or benefit determination, the health carrier may not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

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

1. A health carrier shall maintain written procedures pursuant to this section for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified timeframes required under this section.

2. a. (1) Subject to paragraph 2, for prospective review determinations, a health carrier shall make the determination and notify the covered person or the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition but in no event later than fifteen days after the date the health carrier receives the request.

Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with subsection 6.

(2) The time period for making a determination and notifying the covered person or the covered person's authorized representative of the determination pursuant to paragraph 1 may be extended one time by the health carrier for up to fifteen days, provided the health carrier:

(a) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(b) Notifies the covered person or the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(3) If the extension under paragraph 2 is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(a) Specifically describe the required information necessary to complete the request; and

(b) Give the covered person or the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

b. (1) Whenever the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request.

(2) (a) The notice required under paragraph 1 shall be provided as soon as possible but in no event later than five days following the date of the failure.

(b) The health carrier may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing.

(3) The provisions of this paragraph apply only in the case of a failure that:

(a) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(b) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which certification is being requested.

3. a. For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and

(2) The health carrier shall notify the covered person of the adverse determination in accordance with subsection 6 at a time sufficiently in advance of the reduction or termination to allow the covered person or the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to chapter 26.1-36.8 and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

b. The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the health carrier with respect to the internal review request made pursuant to chapter 26.1-36.8.

4. a. (1) For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time but in no event later than thirty days after the date of receiving the benefit request.

(2) If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or the covered person's authorized representative in accordance with subsection 6.

b. (1) The time period for making a determination and notifying the coveted person or the covered person's authorized representative of the determination pursuant to subdivision a may be extended one time by the health carrier for up to fifteen days, provided the health carrier:

(a) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(b) Notifies the covered person or the covered person's authorized representative prior to the expiration of the initial thirty-day time period of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(2) If the extension under paragraph 1 is necessary due to the failure of the covered person or the covered person's authorized

representative to submit information necessary to reach a determination on the request, the notice of extension shall:

(a) Specifically describe the required information necessary to complete the request; and

(b) Give the covered person or the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

5. a. For purposes of calculating the time periods within which a determination is required to be made under subsections 2 and 4, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.7-05 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

b. (1) If the time period for making the determination under subsection 2 or 4 is extended due to the covered person's or the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or the covered person's authorized representative until the earlier of:

(a) The date on which the covered person or the covered person's authorized representative responds to the request for additional information; or

(b) The date on which the specified information was to have been submitted.

(2) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection 2 or 4, the health carrier may deny the certification of the requested benefit.

6. a. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

(2) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(3) Reference to the specific plan provisions on which the determination is based;

(4) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;

(5) A description of the health carrier's grievance procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures;

(6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(7) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(8) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination; or

(9) The written statement of the scientific or clinical rationale for the adverse determination; and

(10) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under chapter 26.1-36.8, to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. If the adverse determination is a rescission, the health carrier shall provide in the advance notice of the rescission determination required to be provided under applicable state or federal law or regulation related to the advance notice requirement of a proposed rescission, in addition to any applicable disclosures required under subdivision a:

(1) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of a material fact;

(2) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to chapter 26.1-36.8;

(4) A description of the health carrier's grievance procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures; and

(5) The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

d. A health carrier may provide the notice required under this section in writing or electronically.

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

1. a. A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

b. (1) As part of the procedures required under subdivision a, a health carrier shall provide that in the case of a failure by a covered person or the covered person's authorized representative to follow the health carrier's procedures for filing an urgent care request the covered person or the covered person's authorized representative shall be notified of the failure and the proper procedures to be following for filing the request.

(2) A health carrier shall provide the notice required under paragraph 1:

(a) To the covered person or the covered person's authorized representative as soon as possible but not later than twenty-four hours after receipt of the request; and

(b) Orally unless the covered person or the covered person's authorized representative requests the notice in writing.

(3) The provisions of this paragraph apply only in the case of a failure that:

(a) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(b) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which approval is being requested.

2. a. (1) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or the covered person's authorized representative of the health carrier's determination with respect to the request, whether the determination is an adverse determination as soon as possible taking into account the medical condition of the covered person but in no event later than twenty-four hours after the receipt of the request by the health carrier.

(2) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

b. (1) If the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible but in no event later than twenty-four hours after receipt of the request.

(2) The health carrier shall provide the covered person or the covered person's authorized representative a reasonable period of time to submit the necessary information taking into account the circumstances but in no event less than forty-eight hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in paragraph 1.

(3) The health carrier shall notify the covered person or the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible but in no event more than forty-eight hours after the earlier of:

(a) The health carrier's receipt of the requested specified information; or

(b) The end of the period provided for the covered person or the covered person's authorized representative to submit the requested specified information.

(4) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in paragraph 2, the health carrier may deny the certification of the requested benefit.

(5) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

3. a. For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible taking into account the covered person's medical condition but in no event more than twenty-four hours after the health carrier's receipt of the request.

b. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with subsection 5.

4. For purposes of calculating the time periods within which a determination is required to be made under subsection 2 or 3, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.7-05 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5. a. A notification of an adverse determination under this section shall in a manner calculated to be understood by the covered person set forth:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(2) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well

as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

(3) Reference to the specific plan provisions on which the determination is based;

(4) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(5) A description of the health carrier's internal review procedures established pursuant to chapter 26.1-36.8, including any time limits applicable to those procedures;

(6) A description of the health carrier's expedited review procedures established pursuant to section 26.1-36.8-06;

(7) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(8) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(9) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with paragraph 7; or

(b) The written statement of the scientific or clinical rationale for the adverse determination in accordance with paragraph 8; and

(10) A statement explaining the availability of and right of the covered person to contact the commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under chapter 26.1-36.8, to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. If the adverse determination is a rescission, the health carrier shall provide, in addition to any applicable disclosures required:

(1) Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) The date the health carrier made the decision to rescind the coverage; and

(4) The date when the advance notice of the health carrier's decision to rescind the coverage ends.

d. (1) A health carrier may provide the notice required under this section orally, in writing, or electronically.

(2) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

**26.1-36.7-09. Emergency services.**

1. When conducting utilization review or making a benefit determination for emergency services, a health carrier that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

2. A health carrier shall cover emergency services to screen and stabilize a covered person in the following manner:

a. Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical

condition existed even if the emergency services are provided on an out-of-network basis;

b. Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;

c. If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

d. If the emergency services are provided out of network, by complying with the cost-sharing requirements of subsection 3; and

e. Without regard to any other term or condition of coverage, other than:

(1) The exclusion of or coordination of benefits;

(2) An affiliation or waiting period as permitted under section 2704 of the Public Health Service Act; or

(3) Applicable cost-sharing, as provided in subsection 3.

3. a. For in-network emergency services, coverage of emergency services shall be subject to applicable copayments, coinsurance, and deductibles.

b. (1) For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in network.

(2) Notwithstanding paragraph 1, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this subparagraph.

(3) A health carrier complies with the requirements of this paragraph if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

(a) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(b) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-town network cost-sharing provisions; or

(c) The amount that would be paid under medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

(4) (a) For capitated or other health benefit plans that do not have a negotiated per service amount for in-network providers, subparagraph a of paragraph 3 does not apply.

(b) If a heath benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subparagraph a of paragraph 3 is the median of these negotiated amounts.

c. (1) Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out of network benefits.

(2) A deductible may be imposed with respect to out of network emergency services only as part of a deductible that generally applies to out of network benefits.

(3) If an out-of-pocket maximum generally applies to out of network benefits, that out-of-network maximum must apply to out of network emergency services.

4. For immediately required postevaluation or poststabilization services, a health carrier shall provide access to a designated representative twenty-four hours a day seven days a week to facilitate review or shall otherwise provide coverage with no financial penalty to the covered person.

**26.1-36.7-10. Confidentiality requirements.**

A health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

**26.1-36.7-11. Disclosure requirements.**

1. In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations and a statement of rights and responsibilities of covered persons with respect to those procedures.

2. A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

**26.1-36.7-12. Rulemaking.**

As authorized under chapter 28-32, the commissioner may adopt rules to implement 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 3.** Chapter 26.1-36.8 of the North Dakota Century Code is created and enacted as follows:

**26.1-36.8-01. Definitions.**

As used in this chapter:

1. "Adverse determination" means:

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

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

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

   d. A rescission of coverage determination.

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

3. "Authorized representative" means:

   a. A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;

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

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

   d. A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

e. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

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

5. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and based on the information provided satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

6. "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

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

8. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

9. "Commissioner" means the insurance commissioner.

10. "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

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

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

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

14. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

15. "Emergency services" means, with respect to an emergency medical condition:

a. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

b. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

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

17. "Final adverse determination" means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under section 26.1-36.8-05 or 26.1-36.8-06 or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 26.1-36.8-04.

18. "Grievance" means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

a. Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

b. Claims payment, handling, or reimbursement for health care services; or

c. Matters pertaining to the contractual relationship between a covered person and a health carrier.

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

b. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

c. "Health benefit plan" does not include:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191], under which benefits for medical care are secondary or incidental to other insurance benefits.

d. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191].

e. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

f. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (civilian health and medical program of the uniformed services (CHAMPUS)); or

(3) Similar supplemental coverage provided to coverage under a group health plan.

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

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

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

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

24. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

25. a. "Managed care plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

b. "Managed care plan" includes:

(1) A closed plan, as defined in subsection 8; and

(2) An open plan, as defined in subsection 27.

26. "Network" means the group of participating providers providing services to a managed care plan.

27. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

28. "Participating provider" means a provider who under a contract with the health carrier or with its contractor or subcontractor has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

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

30. "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

31. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under a health benefit plan if:

a. The cancellation or discontinuance of coverage has only a prospective effect; or

b. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

32. a. "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

b. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

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

34. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

35. a. "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

b. (1) Except as provided in paragraph 2, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(2) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision a must be treated as an urgent care request.

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

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

**26.1-36.8-02. Applicability and scope.**

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

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

1. a. A health carrier shall maintain a written register to document all grievances received, including the notices and claims associated with the grievances, during a calendar year.

   b. (1) Notwithstanding the provisions under subsection 6, a health carrier shall maintain the records required under this section for at least six years related to the notices provided under sections 26.1-36.8-05 and 26.1-36.8-06.

   (2) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.

2. A health carrier shall process a request for a 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. For each grievance the register must contain, at a minimum, the following information:

   a. A general description of the reason for the grievance;

   b. The date received;

   c. The date of each review or review meeting;

   d. Resolution at each level of the grievance;

   e. Date of resolution at each level; and

   f. Name of the covered person for whom the grievance was filed.

4. A health carrier shall maintain the register in a manner that is reasonably clear and accessible to the commissioner.

5. a. Subject to the provisions of subsection 1, a health carrier shall retain the register compiled for a calendar year for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

   b. (1) A health carrier shall submit to the commissioner at least annually a report in the format specified by the commissioner.

   (2) The report shall include for each type of health benefit plan offered by the health carrier:

(a) The certificate of compliance required by section 26.1-36.8-04;

(b) The number of covered lives;

(c) The total number of grievances;

(d) The number of grievances resolved at each level and their resolution;

(e) The number of grievances appealed to the commissioner of which the health carrier has been informed;

(f) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(g) A synopsis of actions being taken to correct problems identified.

**26.1-36.8-04. Grievance review procedures.**

1. a. Except as specified in section 26.1-36.8-06, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in section 26.1-36.8-05.

b. (1) Whenever a health carrier fails to strictly adhere to the requirements of section 26.1-36.8-05 or 26.1-36.8-06 with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this chapter and may take action under paragraph 2 regardless of whether the health carrier asserts that it substantially complied with the requirements of section 26.1-36.8-05 or 26.1-36.8-06, as applicable, or that any error it committed was de minimis.

(2) (a) A covered person may file a request for external review in accordance with the procedures outlined in chapter 26.1-36.6.

(b) In addition, a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

2. a. A health carrier shall file with the commissioner a copy of the procedures required under subsection 1, including all forms used to process requests made pursuant to section 26.1-36.8-05. A health carrier shall file with the commissioner any subsequent material modifications to the documents.

b. The commissioner may disapprove a filing received in accordance with subdivision a that fails to comply with this chapter or applicable rules.

3. In addition to subsection 2, a health carrier shall file annually with the commissioner as part of its annual report required by section 26.1-36.8-03 a certificate of compliance stating that the health carrier has established

and maintains for each of its health benefit plans grievance procedures that fully comply with the provisions of this chapter.

4. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

5. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office or ombudsman's office for assistance at any time. The statement shall include the telephone number and address of the commissioner's or ombudsman's office.

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

1. Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to chapter 26.1-36.7, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a 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 a voluntary review is offered by the health carrier;

(2) The written procedures governing the voluntary review, including any required timeframe for the review;

(3) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to chapter 26.1-36.6 if the covered person decides not to file for an additional voluntary review of the first-level review decision involving an adverse determination; and

(4) The covered person's right to bring a civil action in a court of competent jurisdiction;

h. If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

i. Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

9. a. A health carrier shall provide the notice required under subsection 8 in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

b. If a health carrier is required to provide the notice required under this subsection in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(1) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(2) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(3) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

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

1. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

2. In addition to subsection 1, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility.

3. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

4. A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers may not have been involved in making the initial adverse determination.

5. In an expedited review all necessary information, including the health carrier's decision shall be transmitted between the health carrier and the covered person or the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

6. a. An expedited review decision shall be made and the covered person or the covered person's authorized representative shall be notified of the decision in accordance with subsection 8 as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the receipt of the request for the expedited review.

   b. If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

7. For purposes of calculating the time periods within which a decision is required to be made under subsection 6, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 26.1-36.8-04 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

8. a. A notification of a decision under this section must set forth in a manner calculated to be understood by the covered person or the covered person's authorized representative:

   (1) The titles and qualifying credentials of the reviewers participating in the expedited review process;

   (2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

   (3) A statement of the reviewers' understanding of the covered person's grievance;

   (4) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

   (5) A reference to the evidence or documentation used as the basis for the decision; and

   (6) If the decision involves a final adverse determination, the notice shall provide:

(a) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(b) Reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(f) If applicable, instructions for requesting:

[1] A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with subparagraph d; or

[2] The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph e;

(g) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to chapter 26.1-36.6;

(h) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

(i) The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(j) A notice of the covered person's right to contact the commissioner's office or ombudsman's office for

assistance with respect to any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

b. (1) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner if required in accordance with federal regulations.

(2) If a health carrier is required to provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations, the health carrier shall:

(a) Include a statement in the English version of the notice, prominently displayed in the non-English language, offering the provision of the notice in the non-English language;

(b) Once a utilization review or benefit determination request has been made by a covered person, provide all subsequent notices to the covered person in the non-English language; and

(c) To the extent the health carrier maintains a consumer assistance process, such as a telephone hotline that answers questions or provides assistance with filing claims and appeals, the health carrier shall provide this assistance in the non-English language.

c. (1) A health carrier may provide the notice required under this section orally, in writing, or electronically.

(2) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

**26.1-36.8-07. Rulemaking.**

As authorized under chapter 28-32, the commissioner may adopt rules to implement this chapter.

**26.1-36.8-08. Penalties.**

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

**SECTION 4. REPEAL.** Sections 26.1-36-46 and 26.1-36-47 of the North Dakota Century Code are repealed.

**SECTION 5. EFFECTIVE DATE.** This Act becomes effective December 1, 2011."

Renumber accordingly