CHAPTER 26.1-47
PREFERRED PROVIDER ORGANIZATIONS

26.1-47-01. Definitions.

As used in this chapter, unless the context indicates otherwise:

1. "Air ambulance" means a specially equipped aircraft licensed by the department of health and human services for transporting patients.
2. "Air ambulance provider" means a publicly or privately owned organization that is licensed or applies for licensure by the department of health and human services to provide transportation and care of patients by air ambulance.
3. "Authorized representative" means:
   a. A person to which a covered person has given express written consent to represent the covered person;
   b. A person authorized by law to provide substituted consent for a covered person; or
   c. If a covered person is unable to provide consent, the covered person's treating health care professional or a family member of the covered person.
4. "Balance billing" means the practice of an air ambulance provider billing for the difference between the air ambulance provider's charge and the health care insurer's allowed amount.
5. "Commissioner" means the insurance commissioner of the state of North Dakota.
6. "Covered person" means an individual on whose behalf the health care insurer is obligated to pay for or provide health care services.
7. "Facility" means an institution or other immobile health care setting providing physical, mental, or behavioral health care services.
8. "Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the services covered.
9. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.
10. "Health care provider" means licensed providers of health care services in this state.
11. "Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes hospital, medical, surgical, dental, vision, chiropractic, and pharmaceutical services or products.
12. "Network" means a group of preferred providers providing services under a network plan.
13. "Network 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 by, owned by, under contract with, or employed by the health care insurer.
14. "Out-of-network" means a provider that is not providing the service under a network plan.
15. "Preferred provider" means a duly licensed health care provider or group of providers who have contracted with the health care insurer, under this chapter, to provide health care services to covered persons under a health benefit plan.
16. "Preferred provider arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter.
17. "Prior authorization" means confirmation by the covered person's health care insurer that the air ambulance services sought to be provided by the air ambulance provider meet the criteria for coverage under the covered person's health benefit plan as defined by the provisions of the covered person's health benefit plan.

26.1-47-02. Preferred provider arrangements.

Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:
   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.
   b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care services and establish a procedure for determining whether health care services rendered are medically necessary.
   c. Include mechanisms which are designed to preserve the quality of health care.
   d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.
   e. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.
   f. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.
   g. Provide that either party terminating the contract without cause provide the other party at least sixty days' advance written notice of the termination.
2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.
3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.
4. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.
5. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.
6. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer which jeopardizes patient health or welfare.

26.1-47-02.1. Fees for dental services - Prohibition.

1. As used in this section, "covered services" means dental care services for which a reimbursement is available under an enrollee's plan or for which a reimbursement would be available but for the application of a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, or frequency limitation.
2. Except for fees for covered services, a preferred provider arrangement for a dental plan may not directly or indirectly set or otherwise regulate the fees charged by the preferred provider for dental care services.

26.1-47-02.2. Dental networks.

1. As used in this section:
   a. "Affiliate" means a person that directly or indirectly through one or more intermediaries controls, or is under the control of, or is under common control with, the person specified.
   b. "Contracting entity" means a person that enters a direct contract with a dental provider for the delivery of dental services.
   c. "Network" means a group of preferred dental providers providing services under a network plan.
   d. "Network plan" means a dental benefit plan that requires a covered individual to use, or creates incentives, including financial incentives, for a covered individual to use a dental provider managed by, owned by, under contract with, or employed by the dental insurer.
   e. "Third party" means an entity that is not a party to a contracting entity's dental provider network.
2. A contracting entity may grant a third party access to a dental provider network contract, or a provider's dental services or contractual discounts provided pursuant to a dental provider network contract, if all of the following are met:
   a. The contract specifically states the contracting entity may enter an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.
   b. If the contracting entity is a dental insurer, the dental provider may opt out of the third-party access at the time the dental provider network contract was entered or renewed.
   c. The contracting entity identifies, in writing or electronic form to the dental provider, all third parties in existence as of the date the contract is entered or renewed.
   d. The contracting entity notifies dental network providers that a new third party is leasing or purchasing the network at least thirty days in advance of the relationship taking effect.
   e. The contracting entity makes available a copy of the dental provider network contract relied on in the adjudication of a claim to a participating dental provider within thirty days of a request from the dental provider.
3. A dental provider's refusal to agree in writing to the third-party access to the dental provider network does not permit the contracting entity to end the contractual relationship with the dental provider.
4. The provisions of this section do not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity.

26.1-47-02.3. Postpayment of dental claims - Payment recovery limitations.

1. As used in this section, "dental care provider" means a licensed provider of dental care services in this state.
2. Other than recovery for duplicate payments, a dental insurer, if engaging in overpayment recovery efforts, shall provide written notice to the dental care provider which identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.
3. A dental insurer shall provide a dental care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for a dental care provider to follow to challenge an overpayment recovery.
4. A dental insurer may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made. This time limit does not apply to overpayment recovery efforts that are:
   a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

b. Required by, or initiated at the request of, a self-insured plan; or
c. Required by a state or federal government plan.

26.1-47-03. Health benefits plans.

1. Health care insurers may issue policies or subscriber agreements which provide for incentives for covered persons to use the health care services of preferred providers. These policies or subscriber agreements must contain all of the following provisions:
   a. A provision that if a covered person receives emergency care and cannot reasonably reach a preferred provider that care will be reimbursed as though the covered person had been treated by a preferred provider.
   b. A provision that if covered services are not available through a preferred provider, reimbursement for those services will be made as though the covered person had been treated by a preferred provider.
   c. A provision which clearly discloses differentials between benefit levels for health care services of preferred providers and benefit levels for health care services of other providers.
   d. A provision that entitles the covered person, if any health care services covered under the health benefit plan are not available through a preferred provider within fifty miles [80.47 kilometers] of the policyholder's legal residence, to the provision of those covered services under the health benefit plan by a health care provider not under contract with the health care insurer and located within fifty miles [80.47 kilometers] of the policyholder's legal residence. For the covered person to be eligible for benefits under this subdivision, the health care provider not under contract with the health care insurer must furnish the health care services at the same cost or less that would have been incurred had the covered person secured the health care services through a preferred provider.
2. If the policy or subscriber agreement provides differences in benefit levels payable to preferred providers compared to other providers, the differences may not unfairly deny payment for covered services and may be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

26.1-47-04. Preferred provider participation requirements.

Health care insurers may place reasonable limits on the number of classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against any providers on the basis of religion, race, color, national origin, age, sex, or marital status, and further provided that selection of preferred providers is made on the combined basis of least cost and highest quality of service.

26.1-47-04.1. Maintenance of certification.

1. As used in this section, the terms "continuing medical education", "maintenance of certification", "physician", and "specialty medical board certification" have the same meaning as provided under section 23-16-18.
2. A health care insurer may not deny reimbursement to or prevent a physician from being a preferred provider based solely on a physician's decision to not participate in maintenance of certification, including basing a physician's network participation on any form of maintenance of certification participation or status.
3. A health care insurer may not discriminate with respect to reimbursement levels based solely on a physician's decision to not participate in any form of maintenance of certification.

26.1-47-05. General requirements.

Health care insurers complying with this chapter are subject to all other applicable laws, rules, and regulations of this state.

26.1-47-06. Rules.

The commissioner may adopt rules necessary to enforce and administer this chapter.

26.1-47-07. Penalty.

The commissioner may levy an administrative penalty not to exceed ten thousand dollars for a violation of this chapter.

26.1-47-08. Air ambulance subscription agreements - Prohibition.

An air ambulance provider, or an agent of an air ambulance provider, may not sell, solicit, or negotiate a subscription agreement or contract relating to services or the billing of services provided by an air ambulance provider. An air ambulance provider, or agent of an air ambulance provider, which violates this section is subject to a civil fine in an amount not to exceed ten thousand dollars for each violation. The fine may be collected and recovered in an action brought in the name of the state.

26.1-47-09. Air ambulances.

1. A health benefit plan may not be issued in this state unless the plan provides the reimbursement rate for out-of-network air ambulance provider services is equal to the average of the insurer's in-network rates for air ambulance providers in the state.
2. An insurer may not use the average of an insurer's in-network rates for air ambulance providers in the state in order to decrease current or future contractual rates between an insurer and an air ambulance provider.
3. For purposes of settling a claim made by the insured for air ambulance services, a payment made by an insurer under the plan in compliance with this section is deemed to be the same as an in-network payment and is considered a full and final payment by the insured for out-of-network air ambulance services billed to the insured.
4. This section does not apply to a policy or certificate of insurance, whether written on a group or individual basis, which provides coverage limited to:
   a. A specified disease, a specified accident, or accident-only coverage;
   b. Credit;
   c. Dental;
   d. Disability;
   e. Hospital;
   f. Long-term care insurance as defined by chapter 26.1-45;
   g. Vision care or any other limited supplemental benefit;
   h. A Medicare supplement policy of insurance, as defined by the commissioner by rule or coverage under a plan through Medicare;
   i. Medicaid;
   j. The federal employees health benefits program and any coverage issued as a supplement to that coverage;
   k. Coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; or
   l. Automobile medical payment insurance.

26.1-47-10. Preferred provider arrangements - Requirements for accessing air ambulance providers.

1. In addition to the other preferred provider arrangement requirements under this chapter, a preferred provider arrangement must require the health care insurer and health care provider comply with this section.
2. Except as otherwise provided under this section, before a health care provider arranges for air ambulance services for an individual the health care provider knows to be a covered person, the health care provider shall request a prior authorization from the covered person's health care insurer for the air ambulance services to be provided to the covered person. If the health care provider is unable to request or obtain prior authorization from the covered person's health care insurer:

a. The health care provider shall provide the covered person or the covered person's authorized representative an out-of-network services written disclosure stating the following:
   (1) Certain air ambulance providers may be called upon to render care to the covered person during the course of treatment;
   (2) These air ambulance providers might not have contracts with the covered person's health care insurer and are, therefore, considered to be out of network;
   (3) If these air ambulance providers do not have contracts with the covered person's health care insurer, the air ambulance services will be provided on an out-of-network basis;
   (4) A description of the range of the charges for the out-of-network air ambulance services for which the covered person may be responsible;
   (5) A notification the covered person or the covered person's authorized representative may agree to accept and pay the charges for the out-of-network air ambulance services, contact the covered person's health care insurer for additional assistance, or rely on other rights and remedies that may be available under state or federal law; and
   (6) A statement indicating the covered person or the covered person's authorized representative may obtain a list of air ambulance providers from the covered person's health care insurer which are preferred providers and the covered person or the covered person's representative may request those participating air ambulance providers be accessed by the health care provider.

b. Before air ambulance services are accessed for the covered person, the health care provider shall provide the covered person or the covered person's authorized representative the written disclosure, as outlined by subdivision a and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging the covered person or the covered person's authorized representative received the disclosure document before the air ambulance services were accessed. If the health care provider is unable to provide the written disclosure or obtain the signature required under this subdivision, the health care provider shall document the reason, which may include the health and safety of the patient. The health care provider documentation satisfies the requirement under this subdivision.

3. The rights and remedies provided under this section to covered persons are in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.
4. The department shall enforce this section and shall report a violation of this section by a facility to the department of health and human services.
5. This section does not apply to a policy or certificate of insurance, whether written on a group or individual basis, which provides coverage limited to:
   a. A specified disease, a specified accident, or accident-only coverage;
   b. Credit;
   c. Dental;
   d. Disability;
   e. Hospital;
   f. Long-term care insurance as defined by chapter 26.1-45;
   g. Vision care or any other limited supplemental benefit;
   h. A Medicare supplement policy of insurance, as defined by the commissioner by rule or coverage under a plan through Medicare;
   i. Medicaid;
   j. The federal employees health benefits program and any coverage issued as a supplement to that coverage;
   k. Coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; or

l. Automobile medical payment insurance.

6. A health care provider is exempt from complying with this section if the health care provider determines and documents that due to emergency circumstances, compliance might jeopardize the health or safety of the patient.
7. The commissioner may adopt rules to implement this section.

26.1-47-11. Rules - Air ambulance.

If an action of Congress, the president of the United States, or a federal agency allows the state to regulate the rates, routes, or services of air ambulance providers, the commissioner may adopt rules consistent with the action taken.