

Article 50.

General Accident and Health Insurance Regulations.

Part 1. Miscellaneous Provisions.

§ 58-50-1. Waiver by insurer.

The acknowledgment by any insurer of the receipt of notice given under any policy covered by Articles 49, 50 through 55, 65, or 67 of this Chapter, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim under the policy, shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy. (1913, c. 91, s. 7; C.S., s. 6484; 1991, c. 720, s. 28; 1999-244, s. 10; 2000-140, s. 16.)

§ 58-50-5. Application.

(a) On and after January 1, 1956, each individual or family accident, health, hospitalization policy, certificate or service plan of hospital service corporations shall be issued only on application in writing signed by the insured or the head of the household or guardian. Any application or enrollment form that is taken by a resident insurance producer shall also contain the certificate of the insurance producer that the insurance producer has truly and accurately recorded on the application or enrollment form the information supplied by the insured. Every policy subject to the provisions of this section shall contain the original or a reproduction of the application required by this section. This section shall not apply to travel or dread disease policies or to policies issued pursuant to a group insurance conversion privilege. If any policy to which this section applies delivered or issued for delivery to any person in this State shall be reinstated or renewed, and the insured or the beneficiary or assignee of the policy shall make written request to the insurer for a copy of the application for the reinstatement or renewal, then the insurer shall within 15 days after the receipt of that request at the insurer's home office or any branch office of the insurer, deliver or mail to the person making the request, a copy of the requested application. If the copy shall not be so delivered or mailed, the insurer shall be precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.

(b) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(c) The falsity of any statement in the application for any policy covered by Articles 50 through 55 of this Chapter may not bar the right to recover thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer. (1913, c. 91, s. 8; C.S., s. 6485; 1953, c. 1095, s. 9; 1955, c. 850, s. 6; 1961, c. 1149; 1985, c. 484, s. 4.2; 1991, c. 720, s. 29; 2021-169, s. 6(a); 2022-46, s. 14(sss).)

§ 58-50-10: Repealed by Session Laws 1993, c. 529, s. 4.1.

§ 58-50-15. Conforming to statute.

(a) Other Policy Provisions. – No policy provision which is not subject to G.S. 58-51-15 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to Articles 50 through 55 of this Chapter.

(b) Policy Conflicting with Articles 50 through 55 of this Chapter. – A policy delivered or issued for delivery to any person in this State in violation of Articles 50 through 55 of this Chapter

shall be held valid but shall be construed as provided in Articles 50 through 55 of this Chapter. When any provision in a policy subject to Articles 50 through 55 of this Chapter is in conflict with any provision of Articles 50 through 55 of this Chapter, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of Articles 50 through 55 of this Chapter. (1913, c. 91, s. 9; C.S., s. 6486; 1953, c. 1095, s. 10; 1991, c. 720, s. 29.)

§ 58-50-20. Age limit.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. (1953, c. 1095, s. 11.)

§ 58-50-25. Nurses' services.

(a) No agency, institution or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied such payment or reimbursement on account of the fact that such services were rendered through a registered nurse acting under authority of rules and regulations adopted by the North Carolina Medical Board and the Board of Nursing pursuant to G.S. 90-6 and 90-171.23.

(b) A licensed registered nurse who has successfully completed a program established under G.S. 90-171.38(b) may receive direct payment for conducting medical examinations or medical procedures for the purpose of collecting evidence from victims of offenses described in that subsection if the payment would have otherwise been permitted. (1973, c. 437; 1991, c. 720, s. 37; 1993, c. 347, s. 1; 1995, c. 94, s. 2; 1997-197, s. 1; 1997-375, s. 3.)

§ 58-50-26. Physician services provided by physician assistants.

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1. (1999-210, s. 1.)

§ 58-50-30. Right to choose services of certain providers.

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a provider listed in subsection (b) of this section, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in subsection (b) of this section, notwithstanding any provision contained in the plan or policy

limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

- (1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and
- (2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a provider listed in subsection (b) of this section, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in subsection (b) of this section, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) This section applies to the following provider types:

- (1) A duly licensed optometrist.
- (2) A duly licensed dentist.
- (3) A duly licensed podiatrist.
- (4) A duly licensed chiropractor.
- (5) An advanced practice registered nurse, subject to subsection (d) of this section. For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.
- (6) A psychologist who is one of the following:
 - a. A licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.
 - b. A licensed psychological associate who holds permanent licensure.
- (7) A licensed clinical social worker, as defined in G.S. 90B-3(2) who is licensed by the North Carolina Social Work Certification and Licensure Board pursuant to Chapter 90B of the General Statutes.

- (8) A duly licensed pharmacist, subject to the provisions of subsection (e) of this section.
- (9) A fee-based practicing pastoral counselor certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.
- (10) A substance abuse professional certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.
- (11) A physician assistant, as defined by G.S. 90-18.1 and subject to subsection (f) of this section.
- (12) A clinical mental health counselor licensed by the North Carolina Board of Licensed Clinical Mental Health Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.
- (13) A marriage and family therapist licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C of Chapter 90 of the General Statutes.
- (14) A physical therapist licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18E of Chapter 90 of the General Statutes.
- (15) A hearing aid specialist licensed by the North Carolina State Hearing Aid Dealers and Fitters Board under Chapter 93D of the General Statutes to engage in fitting or selling hearing aids. For purposes of this subdivision, the term "fitting and selling hearing aids" has the same meaning as defined in G.S. 93D-1.
- (16) An occupational therapist licensed by the North Carolina Board of Occupational Therapy pursuant to Article 18D of Chapter 90 of the General Statutes.

- (c) Recodified as G.S. 58-50-30(b)(7).
- (c1) Recodified as G.S. 58-50-30(b)(9).
- (c2) Recodified as G.S. 58-50-30(b)(10).
- (c3) Recodified as G.S. 58-50-30(b)(12).
- (c4) Recodified as G.S. 58-50-30(b)(13).
- (c5) Recodified as G.S. 58-50-30(b)(14).

- (d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:
 - (1) The service performed is within the nurse's lawful scope of practice;
 - (2) The policy currently provides benefits for identical services performed by other licensed health care providers;
 - (3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
 - (4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
 - (5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision, unless these plan requirements apply to all providers for that service.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

- (1) The service performed is within the lawful scope of practice of the pharmacist;
- (2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;
- (3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
- (4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

- (1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;
- (2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
- (3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service.

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection (b) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in subsection (b) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection (b) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected.

(h) Nothing in this section shall be construed as expanding the scope of practice of any duly licensed physician or provider listed in subsection (b) of this section. (1913, c. 91, s. 11; C.S., s. 6488; 1965, c. 396, s. 2; c. 1169, s. 2; 1967, c. 690, s. 2; 1969, c. 679; 1973, c. 610; 1977, c. 601, ss. 2, 31/2; 1991, c. 720, s. 29; 1993, c. 347, s. 2; c. 375, s. 3; c. 464, s. 2; c. 554, s. 1; 1995, c. 193, s. 41, c. 223, s. 1; c. 406, s. 3; 1997-197, ss. 1, 2; 1999-186, s. 1; 1999-199, s. 1; 1999-210, s. 2; 2001-297, s. 1; 2001-446, s. 1.7; 2001-487, s. 40(g); 2003-117, s. 1; 2003-368, s. 1; 2005-276, s. 6.29; 2005-345, ss. 3(a), 3(b); 2007-24, s. 1; 2012-129, s. 1; 2013-296, s. 1; 2017-24, s. 1; 2019-240, s. 3(f).)

§ 58-50-35. Notice of nonpayment of premium required before forfeiture.

No insurance company doing business in this State and issuing health and/or accident insurance policies, other than contracts of group insurance or disability and/or accidental death benefits in connection with policies of life insurance, the premium for which is to be collected in weekly, monthly, or other periodical installments by authority of a payroll deduction order executed by the assured and delivered to such insurance company or the assured's employer authorizing the deduction of such premium installments from the assured's salary or wages, shall, during the period for which such policy is issued, declare forfeited or lapsed any such policy hereafter issued or renewed until and unless a written or printed notice of the failure of the employer to remit said premium or installment thereof stating the amount or portion thereof due on such policy and to whom it must be paid, has been duly addressed and mailed to the person who is insured under such policy at least 15 days before said policy is canceled or lapsed. (1909, c. 884; C.S., s. 6465; 1929, c. 308, s. 1; 1931, c. 317; 1945, c. 379.)

§ 58-50-40. Willful failure to pay group insurance premiums; willful termination of a group health plan; notice to persons insured; penalty; restitution; examination of insurance transactions.

(a) As used in this section and in G.S. 58-50-45:

- (1) "Group health insurance" means any policy described in G.S. 58-51-75, 58-51-80, or 58-51-90; any group insurance certificate or group subscriber contract issued by a service corporation pursuant to Articles 65 and 66 of this Chapter; any health care plan provided or arranged by a health maintenance organization pursuant to Article 67 of this Chapter; or any multiple employer welfare arrangement as defined in G.S. 58-50A-1.
- (2) "Group health plan" means a single employer self-insured group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1167(1), as amended.
- (3) "Insurance fiduciary" means any person, employer, principal, agent, trustee, or third-party administrator who is responsible for the payment of group health or group life insurance premiums or who is responsible for funding a group health plan.
- (4) "Premiums" includes contributions to a group health plan or to a multiple employer welfare arrangement.

(b) No insurance fiduciary shall:

- (1) Cause the cancellation or nonrenewal of group health or group life insurance and the consequential loss of the coverages of the persons insured by willfully failing to pay such premiums in accordance with the terms of a group health or

group life insurance contract; or, in the case of a group health plan to which there are no premiums contributed, terminate the plan by willfully failing to fund the plan; and

(2) Willfully fail to deliver, at least 45 days before the termination of the group health or group life insurance or group health plan, to all persons covered by the group policy or group health plan a written notice of the insurance fiduciary's intention to stop payment of premiums for the group life or health insurance or the insurance fiduciary's intention to cease funding of a group health plan.

(c) Any insurance fiduciary who violates subsection (b) of this section shall be guilty of the following felony offense:

- (1) If the total value of losses suffered as a result of an insurance fiduciary's violation of subsection (b) of this section is one hundred thousand dollars (\$100,000) or more, the violation is a Class F felony.
- (2) If the total value of losses suffered as a result of an insurance fiduciary's violation of subsection (b) of this section is less than one hundred thousand dollars (\$100,000), the violation is a Class H felony.

(d) Repealed by Session Laws 1991, c. 644, s. 37.

(e) Upon conviction under subsection (c) of this section the court shall order the insurance fiduciary to make full restitution to persons insured who incurred expenses that would have been covered by the group health insurance or group health plan or full restitution to beneficiaries of the group life insurance for death benefits that would have been paid if the coverage had not been terminated.

(f) Insurance fiduciaries subject to this section shall be subject to the provisions of G.S. 58-2-200 with respect only to transactions involving group health or life insurance.

(g) In the notice required by subsection (b) of this section, the insurance fiduciary shall also notify those persons of their rights to health insurance conversion policies under Article 53 of this Chapter and their rights to purchase individual policies under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, and Article 68 of this Chapter.

(h) In the event of the insolvency of an employer or insurance fiduciary who has violated this section, any person specified in subsection (e) of this section shall have a lien upon the assets of the employer or insurance fiduciary for the expenses or benefits specified in subsection (e) of this section. With respect to personal property within the estate of the insolvent employer or insurance fiduciary, the lien shall have priority over unperfected security interests.

(i) Upon the termination of a group health insurance contract by the insurer, the insurer shall notify every subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided under G.S. 58-68-30(e). Upon the termination of a group health insurance contract by the insurance fiduciary, the insurance fiduciary shall notify every subscriber and certificate holder under the contract of the termination of the contract along with the certification required to be provided under G.S. 58-68-30(e).

(j) This section shall not apply to the cessation of individual contributions made by any person covered by a group health or group life insurance policy or group health plan. (1985, c. 507, s. 1; 1989, c. 485, s. 51; 1989 (Reg. Sess., 1990), c. 1055, ss. 2, 3.1; 1991, c. 644, s. 37; 1993, c. 539, s. 1274; 1994, Ex. Sess., c. 24, s. 14(c); 2001-422, s. 1; 2006-105, s. 1.8; 2016-78, s. 3.1; 2019-202, s. 8; 2020-69, s. 3(b).)

§ 58-50-45. Group health or life insurers to notify insurance fiduciaries of obligations.

(a) Upon the issuance or renewal of any policy, contract, certificate, or evidence of coverage of group health or life insurance, the insurer, corporation, or health maintenance organization shall give written notice to the insurance fiduciary of the provisions of G.S. 58-50-40.

(b) The notice required by subsection (a) of this section shall be printed in 10 point type and shall read as follows:

"UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE." (1985, c. 507, s. 1; 1989 (Reg. Sess., 1990), c. 1055, s. 3; 1991, c. 644, s. 38; 2001-422, s. 2; 2021-169, s. 6(b).)

§ 58-50-46: Recodified as G.S. 108A-55.4 by Session Laws 2006-221, s. 9(a), effective January 1, 2007.

Part 2. PPOs, Utilization Review and Grievances.

§ 58-50-50: Repealed by Session Laws 1997-519, s. 3.17.

§ 58-50-55: Repealed by Session Laws 1997-519, s. 3.17.

§ 58-50-56. Insurers, preferred provider organizations, and preferred provider benefit plans.

(a) Definitions. – As used in this section:

- (1) "Insurer" means an insurer or service corporation subject to this Chapter.
- (2) "Preferred provider" means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services. A "preferred provider" is not a health care provider participating in any prepaid health service or capitation arrangement

implemented or administered by the Department of Health and Human Services or its representatives.

(3) "Preferred provider benefit plan" means a health benefit plan offered by an insurer in which covered services are available from health care providers who are under a contract with the insurer in accordance with this section and in which enrollees are given incentives through differentials in deductibles, coinsurance, or copayments to obtain covered health care services from contracted health care providers.

(4) "Preferred provider organization" or "PPO" means an insurer holding contracts with preferred providers to be used by or offered to insurers offering preferred provider benefit plans.

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice. A preferred provider contract or other cost containment arrangement that is not disapproved by the Commissioner within 90 days of its filing by the insurer shall be deemed to be approved.

(c) At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. G.S. 58-50-30 applies to preferred provider benefit plans.

(d) Any provision of a contract between an insurer offering a preferred provider benefit plan and a health care provider that restricts the provider's right to enter into preferred provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(e) Repealed by Session Laws 2018-120, s. 4.6(b), effective June 28, 2018.

(f) Every insurer offering a preferred provider benefit plan and contracting with a PPO shall require by contract that the PPO shall provide all of the preferred providers with whom it holds contracts information about the insurer and the insurer's preferred provider benefit plans. This information shall include for each insurer and preferred provider benefit plan the benefit designs and incentives that are used to encourage insureds to use preferred providers.

(g) The Commissioner may adopt rules applicable to insurers offering preferred provider benefit plans under this section. These rules shall provide for:

- (1) Accessibility of preferred provider services to individuals within the insured group.
- (2) The adequacy of the number and locations of health care providers.
- (3) The availability of services at reasonable times.
- (4) Financial solvency.

(h) Each insurer offering a preferred provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall disclose annually the following information:

- (1) The name by which the preferred provider benefit plan is known and its business address.
- (2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.
- (3) The terms of the agreements entered into by the insurer with preferred providers.
- (4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(i) A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan. In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products.

(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician.

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers. (1997-443, s. 11A.122; 1997-519, s. 3.1; 1998-211, s. 2; 1999-210, s. 3; 2001-297, s. 3; 2001-334, s. 2.1; 2018-120, ss. 4.6(a), (b).)

§ 58-50-56.1. Exclusive provider organizations, exclusive provider benefit plans.

(a) Definitions. – The following definitions apply in this section:

- (1) Exclusive provider benefit plan. – A health benefit plan offered by an insurer in which insureds must receive covered services from health care providers who are under a contract with the insurer and under which there is no requirement of coverage for care received from a health care provider who is not under contract with the insurer, except for emergency services as required by G.S. 58-3-190 and medically necessary covered services as required by G.S. 58-3-200(d).
- (2) Exclusive provider organization or EPO. – An insurer holding contracts with providers to be used by or offered to insurers offering exclusive provider benefit plans.
- (3) Insurer. – An insurer or service corporation subject to this Chapter.
- (4) Participating provider. – A health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services; however, a participating provider is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Health and Human Services or its representatives.

(b) Insurers may enter into contracts for an exclusive provider organization with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice. A contract for an exclusive provider organization that is not disapproved by the Commissioner within 90 days of its filing by the insurer shall be deemed to be approved.

(c) Any provision of a contract between an insurer offering an exclusive provider benefit plan and a health care provider that restricts the provider's right to enter into provider contracts with other persons is prohibited, is void ab initio, and is not enforceable. The existence of that restriction does not invalidate any other provision of the contract.

(d) Every insurer offering an exclusive provider benefit plan and contracting with an EPO shall require by contract that the EPO provide all of the participating providers with whom it holds contracts information about the insurer and the insurer's exclusive provider benefit plans. This information shall include for each insurer and participating provider benefit plan the benefit designs and incentives that are used to encourage insureds to use participating providers.

(e) The Commissioner's rules adopted and applicable for preferred provider organizations related to provider accessibility for the insured group, adequacy of providers, availability of services at reasonable times, and financial solvency shall apply for exclusive provider organizations.

(f) Each insurer offering an exclusive provider benefit plan shall provide the Commissioner with summary data about the financial reimbursements offered to health care providers. All such insurers shall annually disclose the following information:

- (1) The name by which the exclusive provider benefit plan is known and its business address.
- (2) The name, address, and nature of any separate organization that administers any preferred provider benefit plan for the insurer.
- (3) The terms of the agreements entered into by the insurer with providers in an exclusive provider organization.
- (4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

(g) Each insurer shall include a clear statement in any application and any benefit booklets for exclusive provider benefit plans that out-of-network coverage for insureds in the exclusive provider benefit plan only applies for (i) emergency services and (ii) medically necessary covered services when an in-network provider is not reasonably available.

(h) Any provisions of this Chapter that apply to preferred provider benefit plans or preferred provider organizations as of July 1, 2021, shall also apply to exclusive provider benefit plans or exclusive provider organizations. (2021-151, s. 1.)

§ 58-50-56.2. Exclusive provider organization continuity of care.

(a) Definitions. – The following definitions apply in this section:

- (1) Ongoing special condition. – One of the following conditions:
 - a. An acute illness that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
 - b. A chronic illness, disease, or condition that is life-threatening, degenerative, or disabling and that requires medical care or treatment over a prolonged period of time.
 - c. Pregnancy from the start of the second trimester.
 - d. A terminal illness for which an individual has a medical prognosis of a life expectancy of six months or less.

(2) Terminated or termination. – The expiration or nonrenewal of a contract. The term does not include an ending of the contract by an insurer for failure to meet applicable quality standards or for fraud.

(b) Termination of a Provider. – If (i) a contract between an insurer and a health care provider offering an exclusive provider benefit plan is terminated by the provider or by the insurer, or benefits or coverage provided by the insurer are terminated because of a change in the terms of provider participation in an insurer's exclusive provider benefit plan and (ii) an insured is undergoing treatment from the provider for an ongoing special condition on the date of termination, then the following shall apply:

- (1) Upon termination of the contract by the insurer or upon receipt by the insurer of written notification of termination by the provider, the insurer shall notify the insured on a timely basis of the termination and of the insured's right to elect continuation of coverage of treatment by the provider. This subdivision shall apply only if the insured has a claim with the insurer for services provided by the terminated provider or the insured is otherwise known by the insurer to be a patient of the terminated provider.
- (2) Subject to subsection (h) of this section, the insurer shall permit an insured to elect to continue to be covered with respect to the treatment by the terminated provider for the ongoing special condition during a transitional period, as provided under this section.

(c) Newly Covered Insured. – Each exclusive provider benefit plan offered by an insurer shall provide transition coverage to individuals who (i) are newly covered under an exclusive provider benefit plan because the individual's employer has changed benefit plans and (ii) are undergoing treatment from a provider for an ongoing special condition. On the date of enrollment, an insurer shall notify the newly covered insured of (i) the right to elect continuation of coverage of treatment by a provider that is not contracted with the exclusive provider benefit plan and (ii) the method and time line by which the insured should contact the insurer. Subject to subsection (h) of this section, the insurer shall permit the newly covered insured to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period, as provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in this section, the length of a transitional period provided under this subsection shall be determined by the treating health care provider, so long as it does not exceed 90 days after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual, or if the individual was on an established waiting list for surgery, organ transplantation, or other inpatient care, before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment described in subsection (c) of this section, then the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend through the date of discharge of the individual after completion of the surgery, transplantation, or other inpatient care, and through post discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an individual has entered the second trimester of pregnancy on or before the date of the notice required under subdivision (b)(1) of this section or the

date of enrollment in a new plan described in subsection (c) of this section, and the provider was treating the pregnancy before the date of the notice or the date of enrollment in the plan, then the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) **Transitional Period: Terminal Illness.** – If an individual was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section or at the time of enrollment in the plan under subsection (c) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the plan, then the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) **Permissible Terms and Conditions.** – An insurer may condition coverage of continued treatment by a provider under subsection (b) or subsection (c) of this section upon the following terms and conditions:

- (1) When care is provided pursuant to subsection (b) of this section, the provider agrees to accept reimbursement from the insurer and, with respect to cost-sharing, from the insured involved at the rates applicable before the start of the transitional period as payment in full.
- (2) When care is provided pursuant to subsection (c) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area or the PPO or other rate agreed to by the provider and insurer, if applicable, plus the applicable copayment from the newly covered insured, as reimbursement in full from the insurer and the insured for all covered services.
- (3) The provider agrees to comply with the quality assurance programs of the insurer responsible for payment under this subsection and to provide to the insurer necessary medical information related to the care provided. The insurer's quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the insured.
- (4) The provider agrees to adhere to the insurer's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan approved by the insurer, and member hold harmless provisions.
- (5) The receipt of notification from the insured within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subsection (c) of this section that the insured elects to continue receiving treatment by the provider.
- (6) The provider agrees to discontinue providing services at the end of the transition period and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.

(i) **Construction.** – Nothing in this section shall be construed to do any of the following:

- (1) Require the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, require the coverage of benefits not provided under the policy in which the newly covered insured is enrolled.

- (2) Require an insurer to offer a transitional period when the insurer terminates a provider's contract for reasons relating to quality of care or fraud. Refusal by an insurer to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.
- (3) Prohibit an insurer from extending any transitional period beyond that specified in this section.
- (4) Prohibit an insurer from terminating the continuing services of a provider when the insurer has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. A termination for these reasons shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each insurer shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description. (2021-151, s. 1.)

§ 58-50-57. Offsets against provider reimbursement for workers' compensation payments forbidden.

(a) An insurer that provides a health benefit plan as defined in G.S. 58-3-167 shall not offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.

(b) No contract between an insurer that provides a health benefit plan as defined in G.S. 58-3-167 and a medical provider shall contain a provision that authorizes the insurer to offset or reverse a health plan payment against a provider reimbursement for other medical charges unless the health plan payment was for a specific medical charge for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article. (2001-216, s. 5; 2001-487, s. 102(b).)

§ 58-50-58. Reserved for future codification purposes.

§ 58-50-59. Reserved for future codification purposes.

§ 58-50-60: Repealed by Session Laws 1997-519, s. 4.4.

§ 58-50-61. Utilization review.

(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

- (1) "Certificate of coverage" includes a policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.

- (1a) "Clinical peer" means a health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.
- (2) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.
- (3) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.
- (4) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
 - a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
 - b. Serious impairment to bodily functions.
 - c. Serious dysfunction of any bodily organ or part.
- (5) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.
- (6) "Grievance" means a written complaint submitted by a covered person about any of the following:
 - a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.
 - b. Claims payment or handling; or reimbursement for services.
 - c. The contractual relationship between a covered person and an insurer.
 - d. The outcome of an appeal of a noncertification under this section.
- (7) "Health benefit plan" means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
 - a. Accident.
 - b. Credit.
 - c. Disability income.

- d. Long-term or nursing home care.
- e. Medicare supplement.
- f. Specified disease.
- g. Dental or vision.
- h. Coverage issued as a supplement to liability insurance.
- i. Workers' compensation.
- j. Medical payments under automobile or homeowners.
- k. Hospital income or indemnity.
- l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or a pharmacy.

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

(10) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.

(11) "Managed care plan" means a health benefit plan in which an insurer either (i) requires a covered person to use or (ii) creates incentives, including financial incentives, for a covered person to use providers that are under contract with or managed, owned, or employed by the insurer.

(12) "Medically necessary services or supplies" means those covered services or supplies that are:

- a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
- b. Except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- c. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- d. Within generally accepted standards of medical care in the community.
- e. Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(13) "Noncertification" means a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical

necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "noncertification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "noncertification" includes any situation in which an insurer or its designated agent makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

(14) "Participating provider" means a provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide health care services to covered persons in return for direct or indirect payment from the insurer, other than coinsurance, copayments, or deductibles.

(15) "Provider" means a health care provider.

(16) "Stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.

(17) "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, providers, or facilities. These techniques may include:

- a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.
- b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
- c. Certification. – A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
- d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.
- e. Discharge planning. – The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.
- f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.

- g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.
- h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

(18) "Utilization review organization" or "URO" means an entity that conducts utilization review under a managed care plan, but does not mean an insurer performing utilization review for its own health benefit plan.

(b) Insurer Oversight. – Every insurer shall monitor all utilization review carried out by or on behalf of the insurer and ensure compliance with this section. An insurer shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program. If an insurer contracts to have a URO perform its utilization review, the insurer shall monitor the URO to ensure compliance with this section, which shall include:

- (1) A written description of the URO's activities and responsibilities, including reporting requirements.
- (2) Evidence of formal approval of the utilization review organization program by the insurer.
- (3) A process by which the insurer evaluates the performance of the URO.

(c) Scope and Content of Program. – Every insurer shall prepare and maintain a utilization review program document that describes all delegated and nondelegated review functions for covered services including:

- (1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.
- (2) Data sources and clinical review criteria used in decision making.
- (3) The process for conducting appeals of noncertifications.
- (4) Mechanisms to ensure consistent application of review criteria and compatible decisions.
- (5) Data collection processes and analytical methods used in assessing utilization of health care services.
- (6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.
- (7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.
- (8) The staff position functionally responsible for day-to-day program management.
- (9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

(e) Insurer Responsibilities. – Every insurer shall:

- (1) Routinely assess the effectiveness and efficiency of its utilization review program.
- (2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.
- (3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.
- (4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.
- (5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.
- (6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

(f) Prospective and Concurrent Reviews. – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary

information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.

(g) **Retrospective Reviews.** – As used in this subsection, "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer shall make the determination within 30 days after receiving all necessary information. For a certification, the insurer may give written notification to the covered person's provider. For a noncertification, the insurer shall give written notification to the covered person and the covered person's provider within five business days after making the noncertification.

(h) **Notice of Noncertification.** – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

(i) **Requests for Informal Reconsideration.** – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with subsection (h) of this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, the insurer shall issue a new notice in accordance with subsection (h) of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, it shall treat the request for informal reconsideration as a request for an appeal; provided that the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

(j) **Appeals of Noncertifications.** – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

(k) **Nonexpedited Appeals.** – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the

decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:

- (1) The professional qualifications and licensure of the person or persons reviewing the appeal.
- (2) A statement of the reviewers' understanding of the reason for the covered person's appeal.
- (3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
- (4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
- (5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.
- (6) Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

(l) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications.

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(n) Maintenance of Records. – Every insurer and URO shall maintain records of each review performed and each appeal received or reviewed, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. These records shall be retained by the insurer and URO for a period of five years or, for

domestic companies, until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(o) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70. (1997-443, s. 11A.122; 1997-519, s. 4.1; 1999-116, s. 1; 1999-391, ss. 1-4; 2001-417, ss. 2-7; 2001-416, ss. 4.4, 5; 2003-105, s. 1; 2005-223, s. 8; 2008-124, s. 5.1; 2013-199, ss. 13, 14, 15; 2020-69, s. 3(c).)

§ 58-50-62. Insurer grievance procedures.

(a) Purpose and Intent. – The purpose of this section is to provide standards for the establishment and maintenance of procedures by insurers to assure that covered persons have the opportunity for appropriate resolutions of their grievances.

(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. A decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question is not subject to the insurer's grievance procedures, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of grievances. Appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

(b1) Informal Consideration of Grievances. – If the insurer provides procedures for informal consideration of grievances, the procedures shall be in writing, and the following requirements apply:

- (1) If the grievance concerns a clinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e) (1) of this section apply on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner;
- (2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in subsection (c) of this section; or
- (3) If the insurer is unable to render an informal consideration decision within 10 business days after receipt of the grievance, the insurer shall treat the request as a request for a first-level grievance review, except that the requirements of subdivision (e) (1) of this section apply beginning on the day the insurer determines an informal consideration decision cannot be made before the tenth business day after receipt of the grievance.

(c) Grievance Procedures. – Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

(d) Maintenance of Records. – Every insurer shall maintain records of each grievance received and the insurer's review of each grievance, as well as documentation sufficient to demonstrate compliance with this section. The maintenance of these records, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner that apply to insurers. The insurer shall retain these records for five years or, for domestic companies, until the Commissioner has adopted a final report of a general examination that contains a review of these records for that calendar year, whichever is later.

(e) First-Level Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

(1) The insurer does not have to allow a covered person to attend the first-level grievance review. A covered person may submit written material. Except as provided in subdivision (3) of this subsection, within three business days after receiving a grievance, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material.

(2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:

- a. The professional qualifications and licensure of the person or persons reviewing the grievance.
- b. A statement of the reviewers' understanding of the grievance.
- c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
- d. A reference to the evidence or documentation used as the basis for the decision.
- e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.
- f. Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

(3) For grievances concerning the quality of clinical care delivered by the covered person's provider, the insurer shall acknowledge the grievance within 10 business days. The acknowledgement shall advise the covered person that (i) the insurer will refer the grievance to its quality assurance committee for review and consideration or any appropriate action against the provider and (ii) State law does not allow for a second-level grievance review for grievances concerning quality of care.

(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review

decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.

- (1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:
 - a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.
 - b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.
 - c. The availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.
- (2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

(g) Second-Level Grievance Review Procedures. – An insurer's procedures for conducting a second-level grievance review shall include:

- (1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.
- (2) The covered person shall be notified in writing at least 15 days before the review meeting date.
- (3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

(h) Second-Level Grievance Review Decisions. – An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:

- (1) The professional qualifications and licensure of the members of the review panel.
- (2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

- (3) The review panel's recommendation to the insurer and the rationale behind that recommendation.
- (4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
- (5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
- (6) The rationale for the insurer's decision if it differs from the review panel's recommendation.
- (7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
- (8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.
- (9) Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

- (i) **Expedited Second-Level Procedures.** – An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.
- (j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.
- (k) **Violation.** – A violation of this section subjects an insurer to G.S. 58-2-70. (1997-519, s. 4.2; 2001-417, ss. 8-11; 2001-446, s. 4.6; 2003-105, s. 2(a)-(d); 2008-124, s. 5.2; 2013-199, ss. 16, 17.)

§ 58-50-63: Expired pursuant to Session Laws 2005-453, s. 3, effective July 1, 2005.

§ 58-50-64. Reserved for future codification purposes.

Part 3. Scope and Sanctions.

§ 58-50-65. Certain policies of insurance not affected.

(a) Nothing in Articles 50 through 55 of this Chapter applies to or affects any policy of liability or workers' compensation insurance, except that the provisions of G.S. 58-50-56(g) and (h) apply to policies of workers' compensation insurance and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care provisions of this Chapter and managed care provisions of Chapter 97 of the General Statutes with respect to workers' compensation insurance, the provisions of Chapter 97 govern.

(b) Nothing in Articles 50 through 55 of this Chapter shall apply to or in any way affect contracts supplemental to contracts of life or endowment insurance where such supplemental

contracts contain no provisions except such as operate to safeguard such insurance against lapse or to provide special benefits therefor in the event that the insured shall be totally, or totally and permanently disabled by reason of accidental bodily injury or by sickness, nor to contracts issued as supplements to life insurance contracts or contracts of endowment insurance, and intended to increase the amount insured by such life or endowment contracts in the event that the death or disability of the insured shall result from accidental bodily injuries: Provided, that no such supplemental contracts shall be issued or delivered to any person in this State unless and until a copy of the form thereof has been submitted to and approved by the Commissioner under such reasonable rules and regulations as he shall make concerning the provisions in such contracts, and their submission to and approval by him.

(c) Nothing in Articles 50 through 55 of this Chapter shall apply to or in any way affect fraternal benefit societies.

(d) The provisions of G.S. 58-51-5(5) and G.S. 58-51-15(a)(1), (4), and (10) may be omitted from railroad ticket policies sold only at railroad stations or at railroad ticket offices by railroad employees. (1911, c. 209, s. 5; 1913, c. 91, s. 12; C.S., s. 6489; 1921, c. 136, s. 5; 1945, c. 385; 1947, c. 721; 1991, c. 636, s. 3; c. 720, ss. 4, 42; 1993 (Reg. Sess., 1994), c. 679, s. 10.4; 1995, c. 193, s. 42; 1999-219, s. 4.1.)

§ 58-50-70. Punishment for violation.

Any company, association, society, or other insurer or any officer or agent thereof, which or who issues or delivers to any person in this State any policy in willful violation of Articles 50 through 55 of this Chapter, shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be punished only by a fine of not more than five thousand dollars (\$5,000) for each offense; and the Commissioner may revoke the license of any company, corporation, association, society, or other insurer of another state or country, or of the agent thereof, which or who willfully violates any provision of Articles 50 through 55 of this Chapter. (1911, c. 209, s. 6; 1913, c. 91, s. 13; C.S., s. 6490; 1985, c. 666, s. 28; 1991, c. 720, ss. 4, 42; 1993, c. 539, s. 467; 1994, Ex. Sess., c. 24, s. 14(c).)

Part 4. Health Benefit Plan External Review.

§ 58-50-75. Purpose, scope, and definitions.

(a) The purpose of this Part is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an appeal decision upholding a noncertification or a second-level grievance review decision upholding a noncertification, as defined in this Part.

(b) This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to G.S. 58-50-61, the State Health Plan for Teachers and State Employees, and any optional plans or programs operating under Part 2 of Article 3A of Chapter 135 of the General Statutes. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

- (1) "Covered benefits" or "benefits" means those benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under the terms of a health benefit plan.
- (2) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes another

person, including the covered person's health care provider, acting on behalf of the covered person. Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.

(3) "Independent review organization" or "organization" means an entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions. (2001-446, s. 4.5; 2007-298, s. 8.5; 2007-323, s. 28.22A(o); 2007-345, s. 12; 2009-382, s. 24; 2014-115, s. 4.1.)

§ 58-50-76: Reserved for future codification purposes.

§ 58-50-77. Notice of right to external review.

(a) An insurer shall notify the covered person in writing of the covered person's right to request an external review and include the appropriate statements and information set forth in this section at the time the insurer sends written notice of:

- (1) A noncertification decision under G.S. 58-50-61;
- (2) An appeal decision under G.S. 58-50-61 upholding a noncertification; and
- (3) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a noncertification decision under G.S. 58-50-61, a statement informing the covered person that if the covered person has a medical condition where the time frame for completion of an expedited review of an appeal decision involving a noncertification decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, then the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of an appeal involving a noncertification decision under G.S. 58-50-61, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(c) The insurer shall include in the notice required under subsection (a) of this section for a notice related to an appeal decision under G.S. 58-50-61, a statement informing the covered person that:

- (1) If the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited review of a grievance involving an appeal decision under G.S. 58-50-62, but that the Commissioner will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.
- (2) If the covered person has not received a written decision from the insurer within 60 days after the date the covered person files the second-level grievance with the insurer pursuant to G.S. 58-50-62 and the covered person has not requested or agreed to a delay, the covered person may file a request for external review

under G.S. 58-50-80 and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(d) The insurer shall include in the notice required under subsection (a) of this section for a notice related to a final second-level grievance review decision under G.S. 58-50-62, a statement informing the covered person that:

- (1) If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; or
- (2) If the second-level grievance review decision 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, the covered person may request an expedited external review under G.S. 58-50-82.

(e) In addition to the information to be provided under this section, the insurer shall include a copy of the description of both the standard and expedited external review procedures the insurer is required to provide under G.S. 58-50-93, including the provisions in the external review procedures that give the covered person the opportunity to submit additional information. (2001-446, s. 4.5.)

§ 58-50-78: Reserved for future codification purposes.

§ 58-50-79. Exhaustion of internal grievance process.

(a) Except as provided in G.S. 58-50-82, a request for an external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62.

(b) A covered person shall be considered to have exhausted the insurer's internal grievance process for purposes of this section, if the covered person:

- (1) Has filed a second-level grievance involving a noncertification appeal decision under G.S. 58-50-61 and G.S. 58-50-62, and
- (2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 60 days since the date the covered person can demonstrate that a grievance was filed with the insurer.

(c) Notwithstanding subsection (b) of this section, a covered person may not make a request for an external review of a noncertification involving a retrospective review determination made under G.S. 58-50-61 until the covered person has exhausted the insurer's internal grievance process.

(d) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance and appeal procedures under G.S. 58-50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion requirement. If the requirement to exhaust the insurer's internal grievance procedures is waived, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82. In addition, the

insurer may choose to eliminate the second-level grievance review under G.S. 58-50-62. In such case, the covered person may file a request in writing for a standard external review under G.S. 58-50-80 or may make a request for an expedited external review as set forth in G.S. 58-50-82 within 60 days after receiving notice of an appeal decision upholding a noncertification. (2001-446, s. 4.5; 2009-382, s. 25.)

§ 58-50-80. Standard external review.

(a) Within 120 days after the date of receipt of a notice under G.S. 58-50-77, a covered person may file a request for an external review with the Commissioner.

(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

- (1) Notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The notice shall include a request for any information that the Commissioner requires to conduct the preliminary review under subdivision (2) of this subsection and require that the insurer deliver the requested information to the Commissioner within three business days of receipt of the notice.
- (2) Conduct 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 noncertification appeal decision or the second-level grievance review decision upholding a noncertification reasonably appears to be a covered service under the covered person's health benefit plan.
 - c. The covered person has exhausted the insurer's internal appeal and grievance processes under G.S. 58-50-61 and G.S. 58-50-62, unless the covered person is considered to have exhausted the insurer's internal appeal or grievance process under G.S. 58-50-79, or unless the insurer has waived its right to conduct an expedited review of the appeal decision.
 - d. The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review.
- (3) Notify in writing the covered person and the covered person's provider who performed or requested the service whether the request is complete and whether the request has been accepted for external review. If the request is complete and accepted for external review, the notice shall include a copy of the information that the insurer provided to the Commissioner pursuant to subdivision (b)(1) of this section, and inform the covered person that the covered person may submit to the assigned independent review organization in writing, within seven days after the receipt of the notice, additional information and supporting documentation relevant to the initial denial for the organization to consider when conducting the external review. If the covered person chooses to send additional information to the assigned independent review organization, then the covered person shall at the same time and by the same means, send a copy of

that information to the insurer. The Commissioner shall also notify the covered person in writing of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of Health Insurance Smart NC.

- (4) Notify the insurer in writing whether the request for external review has been accepted. If the request has been accepted, the notice shall direct the insurer or its designee utilization review organization to provide to the assigned organization and to the covered person or authorized representative who made the request for external review on behalf of the covered person, within seven days of receipt of the notice, the documents and any information considered in making the noncertification appeal decision or the second-level grievance review decision.
- (5) Assign the review to an independent review organization approved under G.S. 58-50-85. The assignment shall be made using an alphabetical list of the independent review organizations, systematically assigning reviews on a rotating basis to the next independent review organization on that list capable of performing the review to conduct the external review. After the last organization on the list has been assigned a review, the Commissioner shall return to the top of the list to continue assigning reviews.
- (6) Forward to the review organization that was assigned by the Commissioner any documents that were received relating to the request for external review.

(c) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not complete, the Commissioner shall request from the covered person the information or materials needed to make the request complete. The covered person shall furnish the Commissioner with the requested information or materials within 150 days after the date of the insurer's decision for which external review is requested.

(d) If the finding of the preliminary review under subdivision (b)(2) of this section is that the request is not accepted for external review, the Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer in writing of the reasons for its nonacceptance.

(e) Failure by the insurer or its designee utilization review organization to provide the documents and information within the time specified in this subsection shall not delay the conduct of the external review. However, if the insurer or its utilization review organization fails to provide the documents and information within the time specified in subdivision (b)(4) of this section, the assigned organization may terminate the external review and make a decision to reverse the noncertification appeal decision or the second-level grievance review decision. Within one business day of making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(f) If the covered person submits additional information to the Commissioner pursuant to subdivision (b)(3) of this section, the Commissioner shall forward the information to the assigned review organization within two business days of receiving it and shall forward a copy of the information to the insurer.

(g) Upon receipt of the information required to be forwarded under subsection (f) of this section, the insurer may reconsider its noncertification appeal decision or second-level grievance review decision that is the subject of the external review. Reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision under this subsection

shall not delay or terminate the external review. The external review shall be terminated if the insurer decides, upon completion of its reconsideration, to reverse its noncertification appeal decision or second-level grievance review decision and provide coverage or payment for the requested health care service that is the subject of the noncertification appeal decision or second-level grievance review decision.

(h) Upon making the decision to reverse its noncertification appeal decision or second-level grievance review decision under subsection (g) of this section, the insurer shall notify the covered person, the organization, and the Commissioner in writing of its decision. The organization shall terminate the external review upon receipt of the notice from the insurer sent under this subsection.

(i) The assigned organization shall review all of the information and documents received under subsections (b) and (f) of this section that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review organization, to the extent the documents or information are available, shall consider the following in reaching a decision:

- (1) The covered person's medical records.
- (2) The attending health care provider's recommendation.
- (3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
- (4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
- (5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.
- (6) Medical necessity, as defined in G.S. 58-3-200(b).
- (7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan with the insurer.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(j) Within 45 days after the date of receipt by the Commissioner of the request for external review, the assigned organization shall provide written notice of its decision to uphold or reverse the noncertification appeal decision or second-level grievance review decision to the covered person, the insurer, the covered person's provider who performed or requested the service, and the Commissioner. In reaching a decision, the assigned review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(k) The organization shall include in the notice sent under subsection (j) of this section:

- (1) A general description of the reason for the request for external review.
- (2) The date the organization received the assignment from the Commissioner to conduct the external review.
- (3) The date the organization received information and documents submitted by the covered person and by the insurer.
- (4) The date the external review was conducted.
- (5) The date of its decision.

- (6) The principal reason or reasons for its decision.
- (7) The clinical rationale for its decision.
- (8) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.
- (9) The professional qualifications and licensure of the clinical peer reviewers.
- (10) Notice to the covered person that he or she is not liable for the cost of the external review.

(l) Upon receipt of a notice of a decision under subsection (k) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer shall within three business days reverse the noncertification appeal decision or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification appeal decision or second-level grievance review decision. In the event the covered person is no longer enrolled in the health benefit plan when the insurer receives notice of a decision under subsection (k) of this section reversing the noncertification appeal decision or second-level grievance review decision, the insurer that made the noncertification appeal decision or second-level grievance review decision shall be responsible under this section only for the costs of those services or supplies the covered person received or would have received prior to disenrollment if the service had not been denied when first requested.

(m) For the purposes of this section, a person is presumed to have received a written notice two days after the notice has been placed, first-class postage prepaid, in the United States mail addressed to the person. The presumption may be rebutted by sufficient evidence that the notice was received on another day or not received at all. (2001-446, s. 4.5; 2002-187, ss. 3.1, 3.2; 2003-105, s. 3; 2005-223, s. 10(a); 2009-382, ss. 26, 27; 2013-199, s. 18.)

§ 58-50-81: Reserved for future codification purposes.

§ 58-50-82. Expedited external review.

(a) Except as provided in subsection (g) of this section, a covered person may file a request for an expedited external review with the Commissioner at the time the covered person receives any of the following:

- (1) A noncertification decision under G.S. 58-50-61(f) if all of the following conditions apply:
 - a. The covered person has a medical condition where the time frame for completion of an expedited review of an appeal involving a noncertification set forth in G.S. 58-50-61(l) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.
 - b. The covered person has filed a request for an expedited appeal under G.S. 58-50-61(l).
- (2) An appeal decision under G.S. 58-50-61(k) or G.S. 58-58-61(l) upholding a noncertification if all of the following conditions apply:
 - a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in

G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function.

b. The covered person has filed a request for an expedited second-level grievance review of a noncertification as set forth in G.S. 58-50-62(i).

(3) A second-level grievance review decision under G.S. 58-50-62(h) or G.S. 58-50-62(i) upholding a noncertification if all of the following conditions apply:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function.

b. If the second-level grievance concerns a noncertification of 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.

(b) Within two days after receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the noncertification, noncertification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external review.

(3) If the request is eligible for external review and the covered person's treating provider requesting the service that is the subject of the external review has certified the request on a form prescribed by the Commissioner, then one of the following shall apply:

a. For a request made pursuant to subdivision (a)(1) of this section, the request shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be notified.

- b. For a request made pursuant to subdivision (a)(2) of this section, the request shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be notified.
- c. For a request made pursuant to sub-subdivision (a)(3)a. of this section, the request shall be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.
- d. For a request made pursuant to sub-subdivision (a)(3)b. of this section, the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.

(c) As soon as possible, but within the same day after receiving notice under subdivision (b)(2) of this section that the request has been assigned to a review organization, the insurer or its designee utilization review organization shall provide or transmit all documents and information considered in making the noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method. A copy of the same information shall be sent by the same means or other expeditious means to the covered person or the covered person's representative who made the request for expedited external review.

(d) In addition to the documents and information provided or transmitted under subsection (c) of this section, the assigned organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

- (1) The covered person's pertinent medical records.
- (2) The attending health care provider's recommendation.

- (3) Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
- (4) The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
- (5) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.
- (6) Medical necessity, as defined in G.S. 58-3-200(b).
- (7) Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The assigned organization shall review the terms of coverage under the covered person's health benefit plan to ensure that the organization's decision shall not be contrary to the terms of coverage under the covered person's health benefit plan.

The assigned organization's determination shall be based on the covered person's medical condition at the time of the initial noncertification decision.

(e) As expeditiously as the covered person's medical condition or circumstances require, but not more than three days after the date of receipt of the request for an expedited external review, the assigned organization shall make a decision to uphold or reverse the noncertification, noncertification appeal decision, or second-level grievance review decision and notify the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner of the decision. In reaching a decision, the assigned organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

(f) If the notice provided under subsection (e) of this section was not in writing, within two days after the date of providing that notice, the assigned organization shall provide written confirmation of the decision to the covered person, the covered person's provider who performed or requested the service, the insurer, and the Commissioner and include the information set forth in G.S. 58-50-80(k).

Upon receipt of the notice of a decision under subsection (e) of this section that reverses the noncertification, noncertification appeal decision, or second-level grievance review decision, the insurer shall within one day reverse the noncertification, noncertification appeal decision, or second-level grievance review decision that was the subject of the review and shall provide coverage or payment for the requested health care service or supply that was the subject of the noncertification, noncertification appeal decision, or second-level grievance review decision.

(g) An expedited external review shall not be provided for retrospective noncertifications. (2001-446, s. 4.5; 2005-223, ss. 10(b), 11, 12; 2007-298, ss. 3.1, 3.2; 2009-382, ss. 28-30; 2013-199, s. 10; 2015-281, s. 9; 2019-179, s. 6(a), (b).)

§ 58-50-83: Reserved for future codification purposes.

§ 58-50-84. Binding nature of external review decision.

- (a) An external review decision is binding on the insurer.
- (b) 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.

(c) A covered person may not file a subsequent request for external review involving the same noncertification appeal decision or second-level grievance review decision for which the covered person has already received an external review decision under this Part. (2001-446, s. 4.5.)

§ 58-50-85. Approval of independent review organizations.

(a) The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Part to ensure that an organization satisfies the minimum qualifications established under G.S. 58-50-87. The Commissioner shall develop an application form for initially approving and for reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87. Applicants must submit pricing information sufficient to demonstrate that if selected, the applicant's total fee per review will not exceed commercially reasonable fees charged for similar services in the industry. The Commissioner shall not approve any independent review organization that either fails to provide sufficient pricing information or has fees that do not meet the guidelines established under this subsection.

(c) In order to be eligible for approval by the Commissioner, an independent review organization 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 established under G.S. 58-50-87. 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.

(d) An approval is effective for two years, unless the Commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum qualifications established under G.S. 58-50-87.

(e) Whenever the Commissioner determines that an independent review organization no longer satisfies the minimum requirements established under G.S. 58-50-87, the Commissioner shall terminate the approval of the independent review organization. (2001-446, s. 4.5; 2009-382, s. 31.)

§ 58-50-86: Reserved for future codification purposes.

§ 58-50-87. Minimum qualifications for independent review organizations.

(a) As a condition of approval under G.S. 58-50-85 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 G.S. 58-50-80 and G.S. 58-50-82 that include, at a minimum:

- (1) A quality assurance mechanism in place that ensures:
 - a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner.
 - b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

- c. The confidentiality of medical and treatment records and clinical review criteria.
- d. That any person employed by or under contract with the independent review organization adheres to the requirements of this Part.
- e. The independence and impartiality of the independent review organization and the external review process and limits the ability of any person to improperly influence the external review decision.

(2) A toll-free telephone service to receive information on a 24-hour-day, seven-day-a-week basis related to external reviews that is capable of accepting or recording inquiries or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) An agreement to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) An agreement to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(6) That the independent review organization consult with a medical doctor licensed to practice in North Carolina to advise the independent review organization on issues related to the standard of practice, technology, and training of North Carolina physicians with respect to the organization's North Carolina business.

(b) All clinical peer reviewers assigned by an independent review organization to conduct external reviews shall be medical doctors or other appropriate health care providers who meet the following minimum qualifications:

- (1) Be an expert in the treatment of the covered person's injury, illness, or medical condition that is the subject of the external review.
- (2) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar injury, illness, or medical condition of the covered person.
- (3) If the covered person's treating provider is a medical doctor, hold a nonrestricted license and, if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.
- (4) If the covered person's treating provider is not a medical doctor, hold a nonrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider.
- (5) 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 peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, 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.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer 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 insurer 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 insurer 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.
- (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.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer 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 subsection (d) of this section, 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 peer reviewer from conducting the external review. (2001-446, s. 4.5.)

§ 58-50-88: Reserved for future codification purposes.

§ 58-50-89. Hold harmless for Commissioner and independent review organizations.

The Commissioner, an independent review organization, or a clinical peer reviewer working on behalf of an independent review organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence. (2001-446, s. 4.5; 2002-187, s. 3.3; 2019-179, s. 6(c).)

§ 58-50-90. External review reporting requirements.

(a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct an external review shall maintain written records in the aggregate and by insurer on all requests for external review for which it conducted an external review during a calendar year and submit a report to the Commissioner, as required under subsection (b) of this section.

(b) Each organization required to maintain written records on all requests for external review under subsection (a) of this section for which it was assigned to conduct an external review

shall submit to the Commissioner, upon the Commissioner's request, a report in the format specified by the Commissioner.

- (c) The report shall include in the aggregate and for each insurer:
 - (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 noncertification appeal decision or second-level grievance review decision and the number resolved reversing the noncertification appeal decision or second-level grievance review decision.
 - (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 under G.S. 58-50-80 that were terminated as the result of a reconsideration by the insurer of its noncertification appeal decision or second-level grievance review decision after the receipt of additional information from the covered person.
 - (6) Any other information the Commissioner may request or require.
- (d) The organization shall retain the written records required under this section for at least three years.
- (e) Each insurer shall maintain written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review of which the insurer receives notice from the Commissioner under this Part. The insurer shall retain the written records required under this section for at least three years. (2001-446, s. 4.5; 2009-382, s. 32.)

§ 58-50-91: Reserved for future codification purposes.

§ 58-50-92. Funding of external review.

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review, including work actually performed by the organization for a case that was terminated due to the insurer's decision to reconsider a request and reverse its noncertification decision, prior to the insurer notifying the organization of the reversal pursuant to G.S. 58-50-80(j), or when a review is terminated pursuant to G.S. 58-50-80(h) because the insurer failed to provide information to the review organization. (2001-446, s. 4.5.)

§ 58-50-93. Disclosure requirements.

(a) Each insurer 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 description required under subsection (a) of this section 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 a noncertification, noncertification appeal decision or a second-level grievance review decision upholding a noncertification with the Commissioner. The statement shall include the telephone number and address of the Commissioner.

(c) In addition to subsection (b) of this section, 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. (2001-446, s. 4.5.)

§ 58-50-94. Selection of independent review organizations.

(a) At least every two years, or more frequently if the Commissioner determines is needed to secure adequate selection of independent review organizations, the Commissioner shall prepare and publish requests for proposals from independent review organizations that want to be approved under G.S. 58-50-85. All proposals shall be sealed. The Commissioner shall open all proposals in public.

(b) After the public opening, the Commissioner shall review the proposals, examining the quality of the services offered by the independent review organizations, the reputation and capabilities of the independent review organizations submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The Commissioner shall determine which proposal or proposals would satisfy the provisions of this Part. The Commissioner shall make his determination in consultation with an evaluation committee whose membership includes representatives of insurers subject to Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations and shall ensure that, for any given type of case involving highly specialized services and treatments, at least one review organization is available and capable of reviewing the case.

(c) An independent review organization may seek to modify or withdraw a proposal only after the public opening and only on the basis that the proposal contains an unintentional clerical error as opposed to an error in judgment. An independent review organization seeking to modify or withdraw a proposal shall submit to the Commissioner a written request, with facts and evidence in support of its position, before the determination made by the Commissioner under subsection (b) of this section, but not later than two days after the public opening of the proposals. The Commissioner shall promptly review the request, examine the nature of the error, and determine whether to permit or deny the request.

(d) The provisions of Article 3C of Chapter 143 of the General Statutes do not apply to this Part. (2001-446, s. 4.5; 2009-382, s. 33.)

§ 58-50-95: Repealed by Session Laws 2015-92, s. 5, effective June 19, 2015.

Part 5. Small Employer Group Health Insurance Reform.

§ 58-50-100. Title and reference.

This section and G.S. 58-50-105 through G.S. 58-50-156 are known and may be cited as the North Carolina Small Employer Group Health Coverage Reform Act, referred to in those sections as "this Act". (1991, c. 630, s. 1; 2006-105, s. 1.9.)

§ 58-50-105. Purpose and intent.

The purpose and intent of this Act is to promote the availability of accident and health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group accident and health insurance marketplace. (1991, c. 630, s. 1.)

§ 58-50-110. Definitions.

As used in this Act:

- (1) Repealed by Session Laws 2001-334, s. 12.1, effective August 3, 2001.
- (1a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of G.S. 58-50-130, and to the extent applicable, the provisions of Article 68 of this Chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.
- (1b) "Adjusted community rating" means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for the following demographic factors: age, gender, family composition, and geographic areas, as determined pursuant to G.S. 58-50-130(b).
- (2) Repealed by Session Laws 1993, c. 529, s. 3.3.
- (3) "Basic health care plan" means a health care plan for small employers that is lower in cost than a standard health care plan and is required to be offered by all small employer carriers pursuant to G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125.
- (4) "Board" means the board of directors of the Pool.
- (5) "Carrier" means any person that provides one or more health benefit plans in this State, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization (HMO), and a multiple employer welfare arrangement.
- (5a) "Case characteristics" means the demographic factors age, gender, family size, geographic location, and industry.
- (6), (7) Repealed by Session Laws 1993, c. 529, s. 3.3.
- (8) "Committee" means the Small Employer Carrier Committee as created by G.S. 58-50-120.
- (9) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee.
- (10) "Eligible employee" means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis.
- (10a) "Grandfathered health plan" means a health benefit plan providing coverage considered grandfathered health coverage described in 45 C.F.R. § 147.140(a).
- (11) "Health benefit plan" means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; HMO subscriber contract; plan provided by a MEWA or plan provided by another benefit

arrangement, to the extent permitted by ERISA, subject to G.S. 58-50-115. Health benefit plan does not include benefits described in G.S. 58-68-25(b).

(12) "Impaired insurer" has the same meaning as prescribed in G.S. 58-62-20(6) or G.S. 58-62-16(8).

(12a) "Industry" means a demographic factor used to reflect the financial risk associated with a specific industry.

(13) Repealed by Session Laws 1993, c. 529, s. 3.3.

(14) "Late enrollee" has the same meaning as defined in G.S. 58-68-30(b)(2); provided that the initial enrollment period shall be a period of at least 30 consecutive calendar days. In addition to the special enrollment provisions in G.S. 58-68-30(f), an eligible employee or dependent shall not be considered a late enrollee under a small employer health benefit plan if:

- a. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.
 - 1, 2. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.
 - 3, 4. Repealed by Session Laws 1993, c. 529, s. 3.3.
- b. The individual elects a different health benefit plan offered by the small employer during an open enrollment period;
- c. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.
- d. A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment for a spouse is made within 30 days after issuance of the court order. A minor child shall be enrolled in accordance with the requirements of G.S. 58-51-120; or
- e. Repealed by Session Laws 1998-211, s. 9, effective November 1, 1998.

(15) Repealed by Session Laws 1993, c. 529, s. 3.3.

(16) "Pool" means the North Carolina Small Employer Health Reinsurance Pool created in G.S. 58-50-150.

(17) "Preexisting-conditions provision" means a preexisting-condition provision as defined in G.S. 58-68-30.

(18) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

(19) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(20) "Risk-assuming carrier" means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-140.

(21) "Reinsuring carrier" means a small employer carrier electing to comply with the requirements set forth in G.S. 58-50-145.

(21a) "Self-employed individual" means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

(22) "Small employer" means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within this State, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this State, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of this Act that apply to a small employer shall continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. For purposes of this subdivision, the term small employer includes self-employed individuals. Effective January 1, 2014, this definition shall apply only to grandfathered group health plans subject to this Act.

(22a) Repealed by Session Laws 2013-357, s. 4(a), effective January 1, 2016.

(22b) "Small employer" means, in connection with a nongrandfathered nontransitional group health plan with respect to a calendar year and a plan year, an employer who meets the definition of small employer under 42 U.S.C. § 18024(b). The number of employees shall be determined using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.

(23) "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers.

(24) "Standard health care plan" means a health care plan for small employers required to be offered by all small employer carriers under G.S. 58-50-125 and approved by the Commissioner in accordance with G.S. 58-50-125. (1991, c. 630, s. 1; 1993, c. 408, ss. 1, 2; c. 529, s. 3.3; 1993 (Reg. Sess., 1994), c. 569, s. 6; 1997-259, s. 2; 1998-211, s. 9; 2001-334, ss. 12.1, 12.2; 2006-154, ss. 5, 6; 2013-357, ss. 2(b), 4(a), (b); 2015-281, s. 12.)

§ 58-50-112. Affiliated companies; HMOs.

For the purposes of this Act, companies that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier except that any insurance company, hospital service plan, or medical service plan that is an affiliate of an HMO located in North Carolina or any HMO located in North Carolina that is an affiliate of an insurance company, a health service corporation, or a medical service corporation may treat the HMO as a separate carrier and each HMO that operates only one HMO in a service area of North Carolina may be considered a separate carrier. (1991, c. 630, s. 1.)

§ 58-50-113: Repealed by Session Laws 1993, c. 529, s. 3.4.

§ 58-50-115. Health benefit plans subject to Act.

(a) A health benefit plan is subject to this Act if it provides health benefits for small employers and if any of the following conditions are met:

- (1) Any part of the premiums or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage or adjustments or otherwise, by a small employer for any portion of the premium;
- (2) The health benefit plan is treated by the employer as part of a plan or program for the purpose of sections 106, 125, or 162 of the United States Internal Revenue Code; or
- (3) The small employer has permitted payroll deductions for the eligible enrollees for the health benefit plans.

(b) Repealed by Session Laws 1993, c. 529, s. 3.5, effective January 1, 1995.

(c) Repealed by Session Laws 2024-57, s. 3G.1(a), effective January 1, 2025, and applicable to licenses issued under Article 50A of Chapter 58 of the General Statutes on or after that date. (1991, c. 630, s. 1; 1993, c. 529, s. 3.5; 2013-357, s. 2(c); 2019-202, s. 4(b); 2020-69, s. 3(d); 2024-57, s. 3G.1(a).)

§ 58-50-120: Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

§ 58-50-125. Health care plans; formation; approval; offerings.

- (a), (a1) Repealed by Session Laws 2013-357, s. 2(e), effective January 1, 2015.
- (b) Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.
- (c) Except as provided under Article 68 of this Chapter, the plans developed under this section are not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider.
- (d) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4b). A small employer carrier shall not modify any health benefit plan with respect to a small employer, any eligible employee, or dependent through riders, endorsements, or otherwise, in order to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. In the case of an eligible employee or dependent of an eligible employee who, before the effective date of the plan, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or dependent of an eligible employee to enroll in the health benefit plan currently held by the small employer.
- (e) Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.
- (f) To the extent it is required under this section and G.S. 58-68-40, every small employer carrier shall fairly market all of its small group health benefit plans it offers on a guaranteed issue basis to all small employers in the geographic areas in which the carrier makes coverage available or provides benefits.
- (g) Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.
- (h) The provisions of subsection (d) of this section apply to every health benefit plan delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as determined by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of

the issuance of the health benefit plan. (1991, c. 630, s. 1; c. 761, s. 10; 1993, c. 529, s. 3.6; 1997-259, ss. 3, 4; 2006-154, ss. 1, 2, 9, 10, 14; 2013-357, ss. 2(d), (e).)

§§ 58-50-126, 58-50-127: Repealed by Session Laws 2013-357, s. 2(a), effective January 1, 2014.

§ 58-50-130. Required health care plan provisions.

- (a) Health benefit plans covering small employers are subject to the following provisions:
 - (1) to (4) Repealed by Session Laws 1997-259, s. 5, effective July 14, 1997.
 - (4a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage; however, participation and contribution requirements may vary among small employers only by the size of the small employer group and shall not differ because of the health benefit plan involved. In applying minimum participation requirements to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether an applicable participation level is met. "Qualifying existing coverage" means benefits or coverage provided under: (i) Medicare, Medicaid, and other government funded programs; or (ii) an employer-based health insurance or health benefit arrangement, including a self-insured plan, that provides benefits similar to or in excess of benefits provided under the basic health care plan.
- (4b) Late enrollees may only be excluded from coverage for the greater of 18 months or an 18-month preexisting-condition exclusion; however, if both a period of exclusion from coverage and a preexisting-condition exclusion are applicable to a late enrollee, the combined period shall not exceed 18 months. If a period of exclusion from coverage is applied, a late enrollee shall be enrolled at the end of that period in the health benefit plan held at the time by the small employer.
- (5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than 12 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:
 - a. Provides direct coverage of health expenses payable to an individual.
 - b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars (\$20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.
 - c. Has an annual aggregate attachment point lower than the greater of one of the following:
 - 1. One hundred twenty percent (120%) of expected claims.

2. Twenty thousand dollars (\$20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis.

- (6) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group except in the case of late enrollees as provided in G.S. 58-50-130(a)(4).
- (7), (8) Repealed by Session Laws 1997-259, s. 5.
- (9) The health benefit plan must meet the applicable requirements of Article 68 of this Chapter.

(b) For all small employer health benefit plans that are grandfathered health benefit plans and that are subject to this section, the premium rates are subject to all of the following provisions:

- (1) Small employer carriers shall use an adjusted-community rating methodology in which the premium for each small employer can vary only on the basis of the eligible employee's or dependent's age as determined under subdivision (6) of this subsection, the gender of the eligible employee or dependent, number of family members covered, or geographic area as determined under subdivision (7) of this subsection, or industry as determined under subdivision (9) of this subsection. Premium rates charged during a rating period to small employers with similar case characteristics for same coverage shall not vary from the adjusted community rate by more than twenty-five percent (25%) for any reason, including differences in administrative costs and claims experience.
- (2) Rating factors related to age, gender, number of family members covered, geographic location, or industry may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to the Commissioner's review.
- (3) A small employer carrier shall not modify the premium rate charged to a small employer or a small employer group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date, unless the group is composite rated and composition of the group changed by twenty percent (20%) or more or benefits are changed. The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of all of the following:
 - a. The percentage change in the adjusted community rate as measured from the first day of the prior rating period to the first day of the new rating period.

- b. Any adjustment, not to exceed fifteen percent (15%) annually, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer.
- c. Any adjustment because of change in coverage or change in case characteristics of the small employer group.

(4), (5) Repealed by Session Laws 1995, c. 238, s. 1.

(6) Unless the small employer carrier uses composite rating, the small employer carrier shall use the following age brackets:

- a. Younger than 15 years;
- b. 15 to 19 years;
- c. 20 to 24 years;
- d. 25 to 29 years;
- e. 30 to 34 years;
- f. 35 to 39 years;
- g. 40 to 44 years;
- h. 45 to 49 years;
- i. 50 to 54 years;
- j. 55 to 59 years;
- k. 60 to 64 years;
- l. 65 years.

Carriers may combine, but shall not split, complete age brackets for the purposes of determining rates under this subsection. Small employer carriers shall be permitted to develop separate rates for individuals aged 65 years and older for coverage for which Medicare is the primary payor and coverage for which Medicare is not the primary payor.

(7) A carrier shall define geographic area to mean medical care system. Medical care system factors shall reflect the relative differences in expected costs, shall produce rates that are not excessive, inadequate, or unfairly discriminatory in the medical care system areas, and shall be revenue neutral to the small employer carrier.

(8) The Department may adopt rules to administer this subsection and to assure that rating practices used by small employer carriers are consistent with the purposes of this subsection. Those rules shall include consideration of differences based on all of the following:

- a. Health benefit plans that use different provider network arrangements may be considered separate plans for the purposes of determining the rating in subdivision (1) of this subsection, provided that the different arrangements are expected to result in substantial differences in claims costs.
- b. Except as provided for in sub-subdivision a. of this subdivision, differences in rates charged for different health benefit plans shall be reasonable and reflect objective differences in plan design, but shall not permit differences in premium rates because of the case characteristics of groups assumed to select particular health benefit plans.
- c. Small employer carriers shall apply allowable rating factors consistently with respect to all small employers.

(9) In any case where the small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification divided by the lowest rate factor associated with any other industry classification shall not exceed 1.2.

(b1) For all small employer health benefit plans that are not grandfathered health benefit plans and that are subject to this section, the premium rates are subject to all of the following provisions:

(1) A small employer carrier shall use a method to develop premiums for small employer group health benefit plans that are not grandfathered health plans which spreads financial risk across a large population and allows adjustments for only the following factors:

- a. Age, except that the rate shall not vary by more than the ratio of three to one (3:1) for adults.
- b. Whether the plan or coverage covers individual or family.
- c. Geographic rating areas.
- d. Tobacco use, except that the rate shall not vary by more than the ratio of one and two-tenths to one (1.2:1) due to tobacco use.

With respect to family coverage under a health benefit plan, the rating variations for age and tobacco use shall be applied based on the portion of premium that is attributable to each family member covered under the plan.

(2) A small employer carrier shall consider the claims experience of all enrollees in all small employer group health benefit plans that are not grandfathered health plans offered by the insurer in the small employer group market in this State to be members of a single risk pool. No small employer carrier shall consider claims experience of grandfathered health plans in developing the single risk pool.

(c) Repealed by Session Laws 1993, c. 529, s. 3.7.

(d) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following and shall provide this information to the small employer upon request:

- (1) Repealed by Session Laws 1993, c. 529, s. 3.7.
- (2) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rates.
- (3) Provisions relating to renewability of policies and contracts.
- (4) Provisions affecting any preexisting conditions provision.
- (5) The benefits available and premiums charged under all health benefit plans for which the small employer is eligible.

(e) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(f) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that it is in compliance with this Act and that its rating

methods are actuarially sound. The small employer carrier shall retain a copy of the certification at its principal place of business.

(g) A small employer carrier shall make the information and documentation described in subsection (e) of this section available to the Commissioner upon request. Except in cases of violations of this Act, the information is proprietary and trade secret information and is not subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction. Nothing in this section affects the Commissioner's authority to approve rates before their use under G.S. 58-65-60(e) or G.S. 58-67-50(c).

(h) The provisions of subdivisions (a)(1), (3), and (5) and subsections (b) through (g) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1, 1992. The provisions of subdivisions (a)(2) and (4) of this section apply to health benefit plans delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after the date the plan becomes operational, as designated by the Commissioner. For purposes of this subsection, the date a health benefit plan is continued is the anniversary date of the issuance of the health benefit plan.

(i) A small employer carrier shall not modify the premium rate charged to a small group nongrandfathered health benefit plan or a small employer group member, including changes in rates related to the increasing age of a group member, for 12 months from the initial issue date or renewal date. (1991, c. 630, s. 1; 1993, c. 408, s. 6; c. 529, ss. 3.2, 3.7; 1993 (Reg. Sess., 1994), c. 569, ss. 7, 8; c. 678, ss. 24, 25; 1995, c. 238, s. 1; c. 507, s. 23A.1(b); 1995 (Reg. Sess., 1996), c. 669, s. 1; 1997-259, ss. 5, 6; 1998-211, ss. 9.1, 10; 1999-132, s. 4.1; 2001-334, ss. 3, 12.3; 2006-154, s. 7; 2013-357, ss. 2(f), (g), 3; 2019-202, s. 5(a); 2023-133, s. 14(a).)

§ 58-50-131. Premium rates for health benefit plans; approval authority; hearing.

(a) No schedule of premium rates for coverage for a health benefit plan subject to this act, or any amendment to the schedule, shall be used in conjunction with any such health benefit plan until a copy of the schedule of premium rates or premium rate amendment has been filed with and approved by the Commissioner. Any schedule of premium rates or premium rate amendment filed under this section shall be established in accordance with G.S. 58-50-130(b). The schedule of premium rates shall not be excessive, unjustified, inadequate, or unfairly discriminatory and shall exhibit a reasonable relationship to the benefits provided by the contract of insurance. Each filing shall include a certification by an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the U.S. Qualifications Standards promulgated by the American Academy of Actuaries pursuant to its Code of Professional Conduct.

(b) The Commissioner shall approve or disapprove a schedule of premium rates within 60 days of receipt of a complete filing. It shall be unlawful to use a schedule of premium rates until approved. If the Commissioner disapproves the filing, the Commissioner shall notify the filer, shall specify the reasons for disapproval, and shall provide an opportunity for resubmission.

(c) The Commissioner shall adopt rules as necessary or proper (i) to prevent the federal preemption of health insurance regulation in the State, (ii) to implement the provisions of this section, and (iii) to establish minimum standards for loss ratios of policies subject to this section in accordance with accepted actuarial principles and practices to assure that the benefits are reasonable in relation to the premium charged. The Commissioner shall adopt rules to require the submission of supporting data and any information that the Commissioner considers necessary or

proper to determine whether the filed schedule of premium rates meets the standards set forth in this section. (2011-196, s. 4; 2013-199, s. 9.)

§ 58-50-135: Repealed by Session Laws 2013-357, s. 2(a), effective January 1, 2014.

§ 58-50-140: Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

§ 58-50-145: Repealed by Session Laws 2006-154, s. 9, effective July 23, 2006.

§ 58-50-149. Limit on cessions to the Reinsurance Pool.

In addition to any individual or group previously reinsured in accordance with G.S. 58-50-150(g)(1), the Pool shall only reinsure a health benefit plan issued or delivered for original issue by a reinsuring carrier on or after October 1, 1995, if the health benefit plan provides coverage to a small employer with no more than 25 eligible employees, including self-employed individuals. Notwithstanding any other provision of law, the Pool shall cease to reinsure any individual or group on January 1, 2007. Reinsuring carriers as of that date shall continue to be governed by G.S. 58-50-135(b) and G.S. 58-50-150 until and through the termination of the Pool. (1995, c. 517, s. 29; 2006-154, s. 8.)

§ 58-50-150. North Carolina Small Employer Health Reinsurance Pool.

(a) There is created a nonprofit entity to be known as the North Carolina Small Employer Health Reinsurance Pool. All carriers issuing or providing health benefit plans in this State from January 1, 1992, until the termination of the Pool, except any small employer carrier electing to be a risk-assuming carrier, are members of the Pool.

(b) The members shall select the initial Board, subject to the Commissioner's approval. The Board shall consist of five members. There shall be no more than two members of the Board representing any one carrier. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. Voting rights shall be based on net group health benefit plan premium derived from small employer business. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and health insurance, one HMO, one nonprofit hospital or medical service plan. Four of the members of the Board shall be small employer carriers. In approving selection of the Board, the Commissioner shall assure that all members are fairly represented.

(c) If the initial Board is not elected at the organizational meeting, the Commissioner shall appoint the initial Board within 30 days of the organizational meeting.

(d) As used in this section, "plan of operation" includes articles, bylaws, and operating rules of the Pool. Within 180 days after the appointment of the initial Board, the Board shall submit to the Commissioner a plan of operation and any amendments necessary or suitable to assume the fair, reasonable, and equitable administration of the Pool. The Commissioner shall approve the plan of operation if it assures the fair, reasonable, and equitable administration of the Pool and provides for the proportionate basis in accordance with the provisions of subsections (h) through (o) of this section. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this section shall be made available. If the Board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Commissioner shall adopt and promulgate a plan of operation or amendment, as appropriate.

The Commissioner shall amend any plan of operation he adopts, as necessary, after a plan of operation is submitted by the Board and approved by the Commissioner.

(e) The plan of operation shall establish procedures for, among other things:

- (1) Handling and accounting of assets and moneys of the Pool, and for an annual financial reporting to the Commissioner.
- (2) Filling vacancies on the Board, subject to the Commissioner's approval.
- (3) Selecting an administering carrier and setting forth the powers and duties of the administering carrier.
- (4) Reinsuring risks in accordance with the provisions of this Act.
- (5) Collecting assessments from members subject to assessment to provide for claims reinsured by the Pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.
- (6) Any additional matters in the Board's discretion.

(f) The Pool has the general powers and authority granted under the laws of this State to insurance companies licensed to transact accident and health insurance except the power to issue coverage directly to enrollees, and, in addition, the specific authority to do all of the following:

- (1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the Commissioner's approval, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions.
- (2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members.
- (3) Take any legal action necessary to avoid the payment of improper, incorrect, or fraudulent claims against the Pool or the coverage reinsured by the Pool.
- (4) Issue various reinsurance policies in accordance with the requirements of this section.
- (5) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the Pool.
- (6) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the Pool's operation.
- (7) Assess members in accordance with the provisions of subsections (h) through (o) of this section; and make advance interim assessments that are reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the Pool's fiscal year.
- (8) Appoint from among members appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the Pool's authority.
- (9) Borrow money to effect the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default are legal investments for members and may be carried as admitted assets.

(g) Any member that elects to be a reinsuring carrier may cede, and the Pool shall reinsure the reinsuring carrier, subject to all of the following:

- (1) The Pool shall reinsure any basic and standard health care plan originally issued or delivered for original issue by a reinsuring carrier on or after January 1, 1992, under the requirements in G.S. 58-50-125(d). With respect to a basic or standard health care plan, the Pool shall reinsure the level of coverage provided and, with respect to other plans, the Pool shall reinsure the level of coverage provided in the basic or standard health care plan up to, but not exceeding, the level of coverage provided under either the basic or standard health care plans. Small group business of reinsuring carriers in force before January 1, 1992, may not be ceded to the Pool until January 1, 1995, and then only if and when the Board determines that sufficient funding sources are available.
- (2) The Pool shall reinsure eligible employees or their dependents or entire small employer groups according to the following:
 - a. With respect to eligible employees and their dependents who either (i) are employed by a small employer as of the date such employer's coverage by the member begins or (ii) are hired after the beginning of the employer's coverage by the member: The coverage may be reinsured within 60 days after the beginning of the eligible employees' or dependents' coverage under the plan.
 - b. With respect to eligible employees and their dependents, when the entire employer group is eligible for reinsurance: A small employer carrier may reinsure the entire employer group within 60 days after the beginning of the group's coverage under the plan.
 - c. With respect to any person reinsured, no reinsurance may be provided for a reinsured employee or dependent until five thousand dollars (\$5,000) in benefit payments have been made for services provided during a calendar year for that reinsured employee or dependent, which payments would have been reimbursed through the reinsurance in the absence of the five thousand dollar (\$5,000) deductible. The Boards shall review periodically the amount of the deductible and adjust it for inflation. In addition, the member shall retain ten percent (10%) of the next fifty thousand dollars (\$50,000) of benefit payments during a calendar year and the Pool shall reinsure the remainder; provided that the members' liability under this section shall not exceed ten thousand dollars (\$10,000) in any one calendar year with respect to any one person reinsured. The amount of the member's maximum liability shall be periodically reviewed by the Board and adjusted for inflation, as determined by the Board.
 - d. Reinsurance may be terminated for each reinsured employee or dependent on any plan anniversary.
 - e. Premium rates charged for reinsurance by the program to an HMO that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization under 42 U.S.C. § 300 et seq., shall be reduced to reflect the restrictions and requirements of 42 U.S.C. § 300 et seq.
 - f. Every carrier subject to G.S. 58-50-130 shall apply its case management and claims handling techniques, including but not limited to utilization

review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured and nonreinsured business.

g. Except as otherwise provided in this section, premium rates charged by the Pool for coverage reinsured by the Pool for that classification or group with similar case characteristics and coverage shall be established as follows:

1. One and one-half times the rate established by the Pool with respect to the eligible employees and their dependents of a small employer, all of whose coverage is reinsured with the Pool and who are reinsured in accordance with this section.
2. Five times the rate established by the Pool with respect to an eligible employee or dependent who is reinsured in accordance with this section.

(3) The Pool shall reinsure no more than the level of benefits provided in either the basic or standard health care plan established in accordance with G.S. 58-50-125.

(4) The Pool may issue different types and levels of reinsurance coverage, including stop-loss coverage; and the reinsurance premium shall be adjusted to reflect the type and level of reinsurance coverage issued.

(5) The reinsurance premium shall also be adjusted to reflect cost containment features of the plan of operation that have proven to be effective including, but not limited to: preferred provider provisions, utilization review of medical necessity of hospital and physician services, case management benefit alternatives, and other managed care provisions or methods of operation.

(h) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the Pool expenses of administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health benefit plan premiums and benefits paid by a member that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments. As used in this section, "net premiums" means health benefit plan premiums for insured plans but does not mean premiums or revenue received by a carrier for Medicare and Medicaid contracts.

(i) Any net losses for the year shall be recouped by assessments of members as follows:

(1) The Board shall determine an equitable assessment formula to recoup assessments of members that takes into consideration both overall market share of small employer carriers that are members of the Pool and the share of new business of the small employer carriers assumed during the preceding calendar year. For the first three years of operation of the Pool, if an assessment is based on an adjustment made, the assessment shall not be less than fifty percent (50%) nor more than one hundred fifty percent (150%) of the amount it would have been if the assessment were based on the proportional relationship of the small employer carrier's total premiums for small employer coverage written in the year to the total premiums of small employer coverage written by all small employer carriers in this State in the year. The Board shall also determine whether the assessment base used to determine assessments shall be made on a transitional basis or shall be permanent. In no event shall assessments exceed

four percent (4%) of the total health benefit plan premium earned in this State from health benefit plans covering small employers of members during the calendar year coinciding or ending during the fiscal year of the Pool. The Board may change the assessment formula, including an assessment adjustment formula, if applicable, from time to time as appropriate.

(2) Health benefit plan premiums and benefits paid by a member that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments. For the purposes of this section, health benefit plan premiums earned by MEWAs and other benefit arrangements, to the extent permitted by ERISA, shall be established by adding paid health losses and administrative expenses.

(j) If the assessment level is inadequate, the Board may adjust reinsurance thresholds, retention levels, or consider other forms of reinsurance. After the first three full years of operations the Board shall report to the Commissioner on its experience, the effect on reinsurance and small group rates of individual ceding, and recommendations on additional funding sources, if needed. If legislative or other broader funding alternatives are not found, the Board may enter into negotiations with representatives of health care providers to resolve any deficit through reductions in future years' payment levels for reinsured plans. Any such recommendations shall take into account the findings of the actuarial study provided for in this subsection. An actuarial study shall be undertaken within the first three years of the Pool's operation to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this Act. The study shall be developed by three actuaries appointed by the Commissioner, with one representing risk assuming carriers, one representing reinsuring carriers, and one from within the Department.

(k) Subject to the approval of the Commissioner, the Board may make an adjustment to the assessment formula for any reinsuring carrier that is an HMO approved as a federally qualified HMO by the Secretary of Health and Human Services under 42 U.S.C. § 300 for restrictions placed on them other than those for which an adjustment has already been made in subsection (b)(2) or (b)(5) of this section that are not imposed on other small group carriers.

(l) If assessments exceed actual losses and administrative expenses of the Pool, the excess shall be held at interest and used by the Board to offset future losses or to reduce Pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(m) The Board shall determine annually each member's proportion of participation in the Pool based on financial statements and other reports that the Board considers to be necessary and requires that the member files with the Board. All carriers shall report, to the Board, claims payments made and administrative expenses incurred in this State on an annual basis and on a form prescribed by the Commissioner.

(n) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(o) The Board may abate or defer, in whole or in part, the assessment of a member if, in the Board's opinion, payment of the assessment would endanger the member's ability to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this section. The member receiving the abatement or deferment shall remain liable to the Pool for the deficiency.

(p) Neither the participation in the Pool as members, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its members.

(q) Any person or member made a party to any action, suit, or proceeding because the person or member serves or served on the Board or on a committee or is or was an officer or employee of the Pool shall be held harmless and be indemnified by the Pool against all liability and costs, including the amounts of judgments, settlements, fines, or penalties, and expenses and reasonable attorneys' fees incurred in connection with the action, suit, or proceeding. However, the indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of service or office. Costs and expenses of the indemnification shall be prorated among and paid for by all members.

(r) The Pool is exempt from the taxes imposed by Article 8B of Chapter 105 of the General Statutes. (1991, c. 630, s. 1; 1993, c. 408, s. 7; 2005-223, s. 5; 2006-154, s. 12.)

§ 58-50-151. (Recodified as § 58-51-116 effective July 1, 2002) ERISA plans may not require Medicaid to pay first.

An employee benefit plan as defined in ERISA shall not include any provision which, because an individual is provided or is eligible for benefits or service pursuant to a State plan under Title XIX of the Social Security Act (Medicaid), has the effect of limiting or excluding coverage or payment for any health care for that individual under the terms of the employee benefit plan, provided that the individual is one who would otherwise be covered or entitled to benefits or services under the employee benefit plan. (1993, c. 321, s. 238.1.)

§§ 58-50-155, 58-50-156: Repealed by Session Laws 2013-357, s. 2(a), effective January 1, 2014.

Part 6. North Carolina Health Insurance Risk Pool.

§§ 58-50-175 through 58-50-215: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-220: Reserved for future codification purposes.

§ 58-50-225: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-230: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-235: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-240: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-245: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-250: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-255: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-260: Repealed by Session Laws 2013-410, s. 28.5(d), effective January 1, 2017.

§ 58-50-261: Reserved for future codification purposes.

§ 58-50-262: Reserved for future codification purposes.

§ 58-50-263: Reserved for future codification purposes.

§ 58-50-264: Reserved for future codification purposes.

§ 58-50-265: Reserved for future codification purposes.

Part 7. Contracts Between Health Benefit Plans and Health Care Providers.

§ 58-50-270. Definitions.

Unless the context clearly requires otherwise, the following definitions apply in this Part.

- (1) "Amendment" – Any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an amendment.
- (2) "Contract" – An agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis.
- (3) "Health benefit plan" – A policy, certificate, contract, or plan as defined in G.S. 58-3-167.
- (3a) "Health care provider" – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.
- (4) "Insurer" – An entity as defined in G.S. 58-3-227(a)(4). (2009-352, s. 1; 2009-487, s. 2(a).)

§ 58-50-275. Notice contact provisions.

(a) All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.

(b) Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a

communication other than an amendment if agreed to by the insurer and the provider. (2009-352, s. 1; 2009-487, s. 2(b).)

§ 58-50-280. Contract amendments.

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-275. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within 60 days.

(c) If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the initiating health benefit plan or insurer shall be entitled to terminate the contract upon 60 days written notice to the health care provider.

(d) Nothing in this Part prohibits a health care provider and insurer from negotiating contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts. (2009-352, s. 1; 2009-487, s. 2(c).)

§ 58-50-285. Policies and procedures.

(a) A health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider prior to execution of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer.

(b) The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail. (2009-352, s. 1.)

§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for noncovered services or on methods of claims payment.

(a) No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation.

(c) No agreement between an insurer or another entity contracting for the provision of dental services and a provider of dental services shall contain restrictions on methods of claim payment in which the only acceptable payment method from the insurer or entity to the provider of the dental services is a credit card payment. (2010-138, s. 1; 2019-26, s. 1.)

§ 58-50-292. Dental provider networks; confidential business information.

- (a) The following definitions apply in this section:
 - (1) Insurer. – As defined in G.S. 58-3-225(a).
 - (2) Provider network contract. – A contract between an insurer and a dental services provider specifying the rights and responsibilities of the insurer and the provider for the delivery of and payment for dental services.
 - (3) Third party. – A person or entity that enters into a contract with an insurer or with another entity to gain access to a dental provider network contract. Third party does not include an employer group or other group for which the insurer provides administrative services, including payment of claims.
- (b) An insurer may grant access to its provider network contract to a third party if:
 - (1) At the time the provider network contract is entered into and at the time the provider network contract is renewed, the insurer allows any provider who is part of the carrier's provider network to choose not to participate in third party access to the provider network contract. The third party access provision of any provider network contract shall be clearly identified in the provider network contract. An insurer shall not grant third party access to the provider network contract of any provider who does not participate in third party access.
 - (2) The insurer includes on its Web site a listing identifying all third parties who have been granted such access.
 - (3) The third party accessing the provider network contract agrees to comply with all of the provider network contract's terms.
- (c) This section shall not apply to the assignment of or access to a provider network contract to an entity operating under the same brand licensee program as the contracting entity or any affiliates of the contracting entity. (2019-26, s. 2.)

§ 58-50-295. Prohibited contract provisions related to reimbursement rates.

No contract with a health care provider shall do any of the following:

- (1) Prohibit, or grant a health insurance carrier an option to prohibit, the provider from contracting with another health insurance carrier to provide health care services at a rate that is equal to or lower than the payment specified in the contract.
- (2) Require the provider to accept a lower payment rate in the event that the provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the contract.
- (3) Require, or grant a health insurance carrier an option to require, termination or renegotiation of an existing health care contract in the event that the provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the contract.
- (4) Require, or grant a health insurance carrier an option to require, the provider to disclose, directly or indirectly, the provider's contractual rates with another health insurance carrier.
- (5) Require, or grant a health insurance carrier an option to require, the nonnegotiated adjustment by the issuer of the provider's contractual rate to

equal the lowest rate the provider has agreed to charge any other health insurance carrier.

(6) Require, or grant a health insurance carrier an option to require, the provider to charge another health insurance carrier a rate that is equal to or more than the reimbursement rate specified in the contract. (2013-46, s. 1.)

§ 58-50-300. Health benefit plans or insurers contracting for provision of vision services or materials; no limitation on fees for noncovered services or materials.

(a) No agreement between an insurer or an entity that writes vision insurance and an optometrist for the provision of vision services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone vision plan, a medical plan, or health insurance policy may require that an optometrist provide services or materials at a fee limited or set by the plan or insurer unless the services or materials are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy without regard to contractual limitations by a deductible, co-payment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation. For purposes of this section, "materials" includes lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, orthoptics, vision training, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa. (2014-43, s. 1.)