LEGISLATIVE RESEARCH COMMISSION

Managed Care Issues

REPORT TO THE

2000 SESSION OF THE

1999 GENERAL ASSEMBLY

OF NORTH CAROLINA

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TABLE OF CONTENTS

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

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RALEIGH, NC 27601

May 4, 2000

TO THE MEMBERS OF THE 1999 GENERAL ASSEMBLY (REGULAR SESSION 2000):

The Legislative Research Commission herewith submits to you for your consideration its 2000 report on managed care. The report was prepared by the Legislative Research Commission's Committee on Managed Care Issues pursuant to G.S. 120-30.17(1).

Respectfully submitted,

James B. Black
Speaker of the House

Marc Basnight
President Pro Tempore

Cochairs
Legislative Research Commission

1999 - 2000

LEGISLATIVE RESEARCH COMMISSION

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PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is cochaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission, prompted by actions during the 1998 Session and 1999 Sessions, has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The Cochairs of the Legislative Research Commission, under the authority of G.S. 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Cochairs, one from each house of the General Assembly, were designated for each committee.

The study of managed care was authorized by Section 2.1 of Chapter 395 of the 1999 Session Laws (Regular Session, 1999). Part II of Chapter 395 allows for studies authorized by that Part for the Legislative Research Commission to consider

Senate Bill 1089 and H.J.R 1461 in determining the nature, scope and aspects of the study. Section 1 of Senate Bill 1089 reads in part:

:"Section 1. The Legislative Research Commission may study the following issues relating to managed care:

(1) Quality of care.

(2) Cost of care and cost-containment measures of managed care plans.

(3) Provider selection and retention, including whether any provider willing to meet the terms, conditions, and standards, including the terms of reimbursement, of a managed care plan should be allowed to participate in the plan (SB 1090).

(4) The establishment of a consumer's insurance advocate to appear on behalf of consumers in actions and proceedings involving insurance products and services, to publish consumer-oriented insurance information, to respond to consumer complaints, to advocate on behalf of State employees with respect to insurance products and services provided to those employees, and to report on its activities (SB 1108).

(5) Requiring the Commissioner of Insurance to submit reports on the status of managed care to the General Assembly and Governor, including information on outcome data, utilization review, provider access, and related matters (SB 1089).

(6) Providing funds to pay for prescription drugs for certain persons ineligible for Medicaid but whose income no more than two hundred percent (200%) above poverty level, and who has a life-threatening disease or condition for which the drugs have been prescribed (SB 1109).

(7) Liability of providers and managed care plans.

(8) Any other issues concerning the delivery of managed care."

The relevant portions of Chapter 395 are included in Appendix A.

The Legislative Research Commission authorized this study under authority of G.S. 120-30.17(1) and grouped this study in its Insurance and Managed Care Issues area under the direction of Representative Verla Insko. The Committee was chaired by Senator Allen Wellons and Representative Edd Nye The full membership of the Committee is listed in Appendix B of this report. A committee notebook containing the committee minutes and all information presented to the committee will be filed in the Legislative Library by the end of the 1999-2000 biennium.

COMMITTEE PROCEEDINGS

The Legislative Research Commission's Managed Care Issues Committee met five times prior to the 2000 Session of the 1999 General Assembly. The Committee was charged with studying managed care issues.

At its first meeting, the Committee heard a presentation from Ms. Barbara Morales Burke, Senior Deputy Commissioner with the Department of Insurance. Ms. Burke presented information concerning regulation and market performance in managed care in North Carolina. She stated that there are fewer managed care companies in the State now than in the past. Several companies have pulled out of the State. The State had ten (10) HMOs in 1992, and the number peaked in 1997 with 24 full service HMOs. Currently, 20 HMOs exist in the State and that number may go down by one or two due to mergers. Only three HMOs have been consistently profitable; the remainder lose money on a regular basis. In response to that, premiums increased in 1999 and 2000 for the first time in several years. A recent survey conducted by William Mercer, Inc., a large benefits consulting company, found that North Carolina is experiencing the largest increase in premiums of any state in the country. North Carolina's average increase was 9.9% compared to 7.5% nationally. Ms. Morales Burke stated that the higher increase in North Carolina could be due to HMOs keeping their rates on the low side for the past several years. Now, the HMOs facing financial losses and increased medical costs, and must increase rates.

Mr. Bill Stevens, Deputy Commissioner, Consumer Services Division within the Department of Insurance, spoke to the committee regarding the division and consumer HMO complaints. His division handles approximately a hundred thousand phone calls a year, regarding all types of complaints. Complaints raised by consumers include:

- Denial of claims.
- Delay of settlements.
- Medical necessity determination issues.
- Access to care issues.
- Concerns about premiums.

Ms. Nancy O'Dowd, Deputy Commissioner, Managed Care and Health Benefits Division within the Department of Insurance, spoke to the Committee on the activities of the Department in relation to the regulation of the managed cared industry in North Carolina. Ms. O'Dowd stated that with the passage of Senate Bill 594 during this past session of the General Assembly, HMOs are subject to G.S. 58-3-100(c) effective January 1, 2000. Under G.S. 58-3-100(c), HMOs are required to acknowledge claims in 30 days. This provision gives the Department enforcement authority to take action when it is determined that a carrier's claims payment practices are improper and unfair.

At its second meeting, Ms. Barbara Morales Burke summarized for the Committee information concerning the Federal Patient's Rights Legislation. Two bills both addressing the issue, Senate Bill 1344 and House Bill 2990, are currently in Congressional conference committee. She indicated that states, not Congress, have been the innovators and parties to act in the area of patient's rights in managed care issues.

Mr. Adam Searing, Project Director for the North Carolina Health Access Coalition, spoke to the Committee about accountability in health plan decision making. He stated that the Harvard School of Public Health and the Kaiser Family Foundation surveyed doctors and nurses nationally and asked them how often care is denied to their patients and does that denial impact the care the patients are receiving. Nine out of ten doctors said their patients are experiencing health plan denial for coverage of services and one-half of all nurses surveyed said that a health

plan denial of care resulted in a decline in their patients health. Mr. Searing stated that three states have passed laws allowing a patient to recover damages if a health plan makes a negligent decision. Thirty-seven other states have expressed an interest in looking at this issue.

Mr. Jim Kerr, an attorney with Smith Anderson Law Firm representing the North Carolina Medical Society, also addressed the Committee on the issue of health plan accountability. He said that the ERISA legislation was designed to prevent abuses in the administration of pension plans. The debate in the courts is whether Congress ever intended to provide a shield for negligent actions of health plans when ERISA was first adopted more than twenty years ago.

Ms. Peg O'Connell, Director of External Relations, Medical Review of North Carolina, Inc., made a presentation concerning the Medicare Independent Appeals and Grievance Review and the role of the Peer Review Organization. The Medical Review of North Carolina, Inc. works to assure health care services provided to the State's Medicare beneficiaries are medically necessary, are furnished in the appropriate setting, and meet professionally recognized standards of health care with respect to quality.

At its third meeting, Dr. Pam Silberman, Vice-President of the Institute of Medicine and a member of the Committee, spoke about the *Consumer Guide to Health Plan Selection*, a web-based guide that provides information to assist consumers and businesses in the selection of health care plans. This consumer guide project, started a year ago, provides information on:

- Understanding managed care.
- Consumer protection.
- Member responsibility.
- Questions to ask your health plan.

The guide provides a mechanism by which a consumer may compare the 13 primary HMOs in North Carolina, and also provides "hot links" to other managed care resources.

Mr. Henry Landsberger, with the American Association of Retired Persons (AARP), presented the results of a statewide survey sponsored by AARP. The survey, *What North Carolina's Citizens Think of Managed Care, and What They Want*, found support for both an ombudsman program and for a third stage independent appeals entity.

Mr. Paul Mahoney, Executive Director of the NC Association of Health Plans addressed the Committee on the issue of the uninsured. As a result of state and federal mandates, companies are providing greater benefits today than they did 10 years ago. However, with increased benefits come increasing costs pressures. This double-edged sword has resulted in companies providing more benefits to fewer people. Estimates indicate that for every one percent increase in premiums, 200,000 people drop coverage. Ten years ago, there were 37 million uninsured Americans. Today, there are 47 million uninsured persons. Mr. Mahoney also acknowledged there are significant problems in the delivery of health care. A recent report by the Institute of Medicine puts the annual death toll for medical errors between 44,000 and 100,000 a year.

Mr. Steve Keene, Director of Government Affairs, North Carolina Medical Society, spoke in support of an independent review process along with health plan liability legislation. He said the review process needs to be external and there should be a requirement that health plans follow the results of the review.

Representative Joe Hackney presented the fourth edition of HB1133, Health Insurance Liability, to the Committee. The bill provides a cause of action to individuals harmed or damaged by the decisions of a managed care entity. Representative Hackney stated HB1133 plugs a gap in the liability system with respect to health care decisions made by the HMOs. The need for such legislation is created due to the lack of substantial remedies for certain persons who are damaged by health care decisions made by the managed care entity.

Mr. Alan Hirsch, Senior Deputy Attorney General, Consumer Protection and Anti-Trust Division of the NC Department of Justice, conveyed to the Committee three issues his Department supports:

1) The rights of states to make the determination as to the medical care their citizens receive.
2) Patients Bill of Rights.
3) Enforcement mechanisms to ensure patients receive what they need.

At the fourth meeting of the Committee, Ms. Elizabeth Ouzts, Executive Director of North Carolina Public Interest Research Group (NC PIRG), an environmental and consumer advocacy organization, spoke in favor of legislation:

- Establishing liability on behalf of managed care entities.
- Establishing independent external review.
- Creating an ombudsman program.

The Department of Insurance also briefed the Committee on proposed legislation regarding several aspects of managed care. The proposed bills were:

1) HMO Insolvency
2) Prompt Payment
3) External Review
4) HMO Liability.

Also presented to the Committee by the North Carolina Association of Health Plans were lists of proposed changes to the draft bills. The Committee discussed the bills and adopted the concepts presented in the proposed legislation from the Department of Insurance. However, the Committee desired to have the Department of Insurance work with the North Carolina

Association of Health Plans to address issues raised by the North Carolina Association of Health Plans. The Committee requested that revised drafts be presented at the next meeting.

At its fifth meeting, the Committee heard presentations from Dr. Melvin T. Pinn, Jr. and Sharon Martin, RN, both speaking on Medicaid Managed Care topics. Dr. Pinn, medical director with the Wellness Plan of NC, briefed the Committee on his organization and its function. Ms. Martin, Medicaid case manager, spoke regarding the delivery of services to the clients and the necessity of community resource coordination.

The Committee was also presented with a draft copy of the report, including each proposed bill. The Committee discussed the draft bills as presented. Linda Attarian, Staff Counsel, presented one additional bill, entitled "Internal Review Panelists," to the Committee. Discussion on the proposed bill focused on the questionable need for clinical peers at the first level grievance review. Committee member's views on this were mixed, and all agreed that further study was warranted.

At its sixth meeting, the Committee discussed and approved an amended final report.

FINDINGS AND RECOMMENDATIONS

Upon discussion and debate, the Joint Legislative Research Commission's Committee on Managed Care Issues makes the following findings and recommendations:

1. HEALTH CARE LIABILITY.

A. Findings

Based upon the presentations and briefings, the Committee finds that current law in North Carolina fails to adequately provide concise remedies to consumers with respect to health care decisions made by managed care entities. In support of this finding, the Committee states the following:

- Substantial remedies for certain persons damaged by health care decisions made by a managed care entity do not exist currently in North Carolina.
- Trends in the industry indicate that, increasingly, health care treatment decisions are being made by individuals or entities that are not the treating physician.
- A wide variety of entities are integrating the functions of determining the treatment provided, providing the decided upon treatment, and paying for the treatment. This integration of functions is resulting in a breakdown of traditional distinctions of entities and in consumers being left unprotected by the legal system.
- Historically, the General Assembly has acted to protect consumers from egregious harms due to the improper actions of other individuals and entities.

B. Recommendations

Therefore, the Committee recommends the attached bill entitled "HMO Liability." In summary, the bill does as follows:

- Provides a legal remedy to consumers damaged by the health care treatment decisions made by a managed care entity.
- Establishes a standard of care for managed care entities.
- Establishes defenses that may be asserted by the managed care entity.
- Makes void indemnification and hold-harmless clauses in the contracts between the managed care entity and the health care provider.

2. PROMPT PAYMENT OF CLAIMS.

A. Findings

Based upon the presentations and briefings, the Committee finds that insurers are not consistently and cooperatively paying health care providers within a reasonable time frame for the services rendered to the insured. In support of this finding, the Committee states the following:

- It appears that the health care providers are often requested to submit claims numerous times.

- It appears that when inquiries are made of the insurer regarding specific claims, the health care provider or insured are told that the claim was lost or not submitted.
- Current law does not allow for interest to accrue on unpaid claims for approved health care services, and such a provision would provide incentive for the insurer to pay claims in a timely manner.

B. Recommendations

Therefore, the Committee recommends the attached bill entitled "Prompt Pay." In summary, the bill does as follows:

- Within 30 days of a claim being submitted by a health care provider or facility, an insured or the insured's legal representative, the insurer must do one of the following:
    1. pay the claim.
    2. send notice of denial.
    3. send notice of that the proof of loss is either inadequate or incomplete.
    4. send notice that the claim was not submitted on the proper form(s).
- Claims not processed in accordance with the proposed legislation will accrue interest of 18 percent per annum.

3. HMO INSOLVENCY.

A. Findings

Based upon the presentations and briefings, the Committee finds that current law in North Carolina needs to be adjusted to reflect the possibility of a healthcare maintenance organization becoming insolvent, and to provide for that entity's clients to be protected in the event of insolvency. In support of this finding, the Committee states the following:

- Under current law, other types of insurers are required to participate in a guaranty association in an effort to protect the consumer/customers of the entity in the event the entity is declared insolvent. Private pension plans are also encouraged to participate in such guaranty associations.
- Under current law, North Carolina does not require that HMOs participate in such a guaranty association, and as a result, consumers are left unprotected in the event of the insolvency of their HMO insurer.
- Historically, the General Assembly has acted to protect consumers from harm caused by such events.

B. Recommendations

Therefore, the Committee recommends the attached bill entitled "HMO Solvency." In summary, the bill does as follows:

- Allows the Commissioner of Insurance to make an assessment of no more than 2% of the HMO's average premiums received in NC during the 3 calendar years preceding the year in which an HMO was declared insolvent. The money collected is be used for: payment of claims, the continuation of coverage, and administrative purposes.

- Protects the insured from losing continuance coverage if the HMO is declared insolvent by providing $300,000 expenditures on behalf of the insured and continued coverage of the lesser or one year or the remaining term of the insured's contract with the HMO.
- Establishes priority of claims.

4. EXTERNAL REVIEW.

A. Findings

Based upon presentations, the Committee finds that current law in North Carolina does not provide an orderly, mandated process whereby individuals not affiliated with the insurer and/or provider review insurance claims. In support of this finding, the Committee states the following:

- It would be beneficial to the consumer, the health care provider, and the insurer to establish a process to review, outside of the insurer's control and domain, contested claims.
- The Department of Insurance, the insurance industry, and the health care industry agree that an independent external review process is needed.
- It is desirable to establish a framework for review of claims that has a clinical peer review with an individual knowledgeable of the area to which the claim refers.

B. Recommendations

Therefore, the Committee recommends the attached bill entitled "External Review." In summary, the bill does as follows:

- Establishes an independent, external review process to be utilized after the exhaustion of the internal review process.
- Establishes time frames in which the review must be completed.
- Establishes qualifications for the individuals sitting in review capacity.

5. OMBUDSMAN PROGRAM.

Based upon presentations, the Committee agrees that such a program would be beneficial to the citizens of North Carolina. However, the Committee believes that the development of such a program should be discussed in further detail. Therefore, it is the intent of the Committee to make a report to the 2001 General Assembly regarding the establishment of an Ombudsman Program for Managed Care.

6. CLINICAL PEERS ON INTERNAL REVIEW.

A. Findings

Based upon presentations, the Committee finds that current law in North Carolina does not provide a clinical peer review during the internal grievance and review process. In support of this finding, the Committee states the following:

- It would be beneficial to the consumer, the health care provider, and the insurer to establish a process for the review of contested claims by clinical peers during the internal review process.
- The Department of Insurance, the insurance industry, and the health care industry agree that a clinical peer review process is needed.
- It is desirable to establish a framework for review of claims that has a peer review with an individual knowledgeable of the area to which the claim refers.

B. Recommendations

Therefore, the Committee recommends, by mixed vote, the attached bill entitled "Internal Review Panelists" for further discussion and consideration. In summary, the bill does as follows:

- Establishes a clinical peer review to be utilized in the internal grievance and review process.
- Establishes qualifications for the individuals sitting in review capacity.
- Requires that the clinical peer be licensed in North Carolina in the same capacity as the health care provider making the health care treatment decision at issue in the review.

APPENDIX A

CHAPTER 395
1999 Session Laws (1999 Session)

AN ACT TO AUTHORIZE STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, TO CREATE VARIOUS STUDY COMMISSIONS, TO DIRECT STATE AGENCIES AND LEGISLATIVE OVERSIGHT COMMITTEES AND COMMISSIONS TO STUDY SPECIFIED ISSUES, AND TO AMEND OTHER LAWS.

The General Assembly of North Carolina enacts:

PART I.-----TITLE

Section 1. This act shall be known as "The Studies Act of 1999".

PART II.-----LEGISLATIVE RESEARCH COMMISSION

Section 2.1. The Legislative Research Commission may study the topics listed below. When applicable, the bill or resolution that originally proposed the issue or study and the name of the sponsor is listed. Unless otherwise specified, the listed bill or resolution refers to the measure introduced in the 1999 Regular Session of the 1999 General Assembly. The Commission may consider the original bill or resolution in determining the nature, scope, and aspects of the study. The following groupings are for reference only:

. . .

(2) Insurance and Managed Care Issues:

a. Managed care issues, including any willing provider, patients' rights, managed care entity liability, office of consumer advocacy for insurance, prompt payment of health claims, and related issues (S.B. 1089 - Harris, H.J.R. 1461 - Mosley).

b. Mental health and chemical dependency parity (H.B. 713 - Alexander; S.B. 836 - Martin of Pitt).

c. Health reform recommendations of the Health Care Planning Commission and its advisory committees (established by Section 1.2 of Chapter 529 of the 1993 Session Laws) that have not been implemented but are still needed and other health reform issues (Insko).

d. Pharmacy choice/competition (H.B. 1277 - Cole; S.B. 137 - Rand).

. . .

Section 21B.4. The Commission may make an interim report to the 1999 General Assembly, Regular Session 2000, upon its convening, and shall make its final report to the 2001 General Assembly upon its convening, and to the Governor. Upon submitting its final report, the Commission shall expire.

Section 21B.5. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign appropriate professional staff from the Legislative Services Office of the General Assembly to assist with the study. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, upon the direction of the Legislative Services Commission. The

Commission may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission.

Section 21B.6. The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall each designate a cochair of the Commission. The Commission shall meet upon the call of the cochairs. A quorum of the Commission is 10 members. While in the discharge of its official duties, the Commission has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1. Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate.

Section 21B.7. From funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Study Commission on Children With Special Needs.

APPENDIX B

COMMITTEE MEMBERSHIP

Sen. Allen Wellons, Co-Chair

Sen. Charlie Dannelly

Dr. James Elliot, Jr.

Mr. Hank Estep

Sen. Oscar Harris

Dr. Pam Silberman

Dr. Steven Michael Willen

Rep. Edd Nye, Co-Chair

Rep. W. Pete Cunningham

Rep. Zeno Edwards

Rep. Larry T. Justus

Rep. Martin L. Nesbitt

Ms. Elizabeth O'Keefe

Mr. Thomas L. West

APPENDIX C

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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D

DRAFT

HMO LIABILITY

THIS IS A DRAFT 25-APR-00 16:16:12

Short Title: Managed Care Entities Liable for Damages. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT A MANAGED CARE ENTITY PROVIDING A HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS INSUREDS OR ENROLLEES CAUSED BY THE MANAGED CARE ENTITY'S FAILURE TO EXERCISE ORDINARY CARE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 1G.

"Health Care Liability.

"§ 90-21.50. Legislative findings and intent.

(a) The General Assembly finds that a wide variety of entities are integrating the functions of paying for health care, determining what health care is paid for, and providing the care. This integration of functions is breaking down traditional distinctions. Increasingly, payor determinations are governing health care and controlling decisions that in the past were the exclusive domain of health care providers and patients. The General Assembly further finds that this integration of functions

makes it imperative that managed care entities be held fully responsible for the consequences of their decisions, much as health care professionals have been held responsible for the consequences of their decisions.

(b) The state's interest in regulating the business of insurance as provided in this Article is to protect insurance purchasers and their beneficiaries, including employees, their dependents and families, and any other patients covered by private employer-sponsored benefit plans, from the harm that may occur when managed care entities, act improperly. To this end, health care providers rather than managed care entities are in charge of patient care.

(c) It is the intent of the General Assembly in enacting this Article to ensure that adequate State law remedies exist for all persons who are subject to the wrongful acts of those entities that contract to provide insurance for the health of North Carolina citizens. The existence of these remedies and the deterrent effects of these remedies are necessary to protect the health and safety of the residents of this State.

"§ 90-21.51. Definitions.

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' 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.
m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) 'Health care provider' means:

a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

'Health care provider' includes:

1. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services;
2. The officers and directors of a health care facility; and
3. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(3) 'Health care service' means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) 'Health care treatment decision' means a determination that:

a. Is made by a managed care entity;

b. Governs the extent to which health care services are provided for, arranged for, paid for, or reimbursed under a health benefit plan; and

c. Affects the quality of the diagnosis, care, or treatment provided under the health benefit plan to an enrollee or insured of the health benefit plan.

(5) 'Insured or enrollee' means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) 'Insurer' means any entity that is or should be licensed under Articles 6, 7, 16, 49, 65, or 67 of this Chapter.

(7) 'Managed care entity' means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

'Managed care entity' does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) 'Ordinary care' means:

a. For a carrier or managed care entity, that degree of care that a carrier or managed care entity of ordinary prudence would use under the same or similar circumstances.

b. For a person that is an agent of employee of a carrier or managed care entity, that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the person would use in the same or similar circumstances.

(9) 'Physician' means:

a. An individual licensed as a medical doctor under Article 1 of this Chapter to practice medicine in this State;

b. A professional association or corporation comprising medical doctors and organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by medical doctors.

"§ 90-21.52. Duty to exercise ordinary care; liability for damages for harm.

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by:

(1) Its agents, ostensible agents, or employees; or

(2) Representatives that are acting on its behalf and over whom it has the right to exercise influence or control which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) Neither the managed care entity nor an agent or employee or representative for whom the managed care entity is liable under subsection (b) of this section controlled, influenced, or participated in the health care treatment decision; and

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any laws that prohibit the practice of medicine by a corporate entity or by a health maintenance organization.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service that is not covered under its health benefit plan.

(h) A managed care entity may not enter into a contract with a health care provider, or with an employer or employer group purchasing organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction.

(i) A managed care entity shall not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

"§ 90-21.53. No liability under this Article on the part of an employer or employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider.

(a) This Article does not create any liability on the part of an employer or employer group purchasing organization that purchases a health benefit plan or assumes risk on behalf of its employees.

(b) This Article does not create any liability on the part of an employer of an enrollee or insured or that employer's employees, unless the employer is the enrollee's or insured's managed care entity and makes coverage determinations under a managed care plan. This Article does not create any liability on the part of an employee organization, a voluntary employee beneficiary organization, or a similar organization, unless such organization is the enrollee's or insured's managed care entity and makes coverage determinations under a managed care plan.

(c) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes from a physician or health care provider.

"90-21.54. Separate trial required.

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider.

§ 90-21.55. Punitive damages.

An action brought under this Article is subject to the provisions and limitations of Chapter 1D of the General Statutes for recovery of punitive damages.

90-21.55. Exhaustion of administrative remedies and appeals.

(a) Except as provided in this section, no action shall be commenced under this Article until the plaintiff has exhausted all internal and external administrative remedies established under Parts 2 and 4 of Article 50 of Chapter 58 of the General Statutes.

(b) The plaintiff may file a claim without exhausting all internal and external administrative remedies established under Parts 2 and 4 of Article 50 of Chapter 58 of the General Statutes if the plaintiff proves the following to the court:

(1) Harm to the plaintiff has already occurred because of the conduct of the managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the managed care entity for whose conduct the managed care entity is liable.

(2) The administrative review would not be beneficial to the plaintiff.

(c) This Article does not prohibit a plaintiff from pursuing other appropriate remedies for relief.

Section 2. G.S. 1A-1, Rule 42, reads as rewritten:

"Rule 42. Consolidation; separate trials.

(a) Consolidation. -- ~~When~~ Except as provided in subdivision (b)(2) of this section, when actions involving a common question of law or fact are pending in one division of the court, the judge may order a joint hearing or trial of any or all the matters in issue in the actions; he may order all the actions consolidated; and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay. When actions involving a common question of law or fact are pending in both the superior and the district court of the same county, a judge of the superior court in which the action is pending may order all the actions consolidated, and he may make such orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

(b) Separate trials. --

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, ~~crossclaim,~~ cross-claim, counterclaim, or third-party claim, or of any separate issue or

of any number of claims, ~~crossclaims,~~ cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider."

Section 3. This act becomes effective July 1, 2001, and applies to causes of action arising on and after that date.

Bill Summary
HEALTH CARE LIABILITY

BILL ANALYSIS

Committee: LRC Committee/Managed Care
Date: April 27, 2000
Version: **FINAL DRAFT**

Introduced by:
Summary by: Linda Attarian
Committee Counsel

SUMMARY: ***The Act would amend Chapter 90 of the North Carolina General Statutes, by adding a new article to establish a standard of care for managed care entities which administer, deliver, arrange for, provide for, or reimburse for health care services or assume the risk for the delivery of health care services and to provide for recovery for violations of that standard. The act prohibits the shifting or delegation of liability for the acts or conduct of managed care entities and ensures that certain other liability is not created. The act would become effective July 1, 2001.***

CURRENT LAW:

Medical Malpractice: Article 1B of Chapter 90 establishes a standard of health care and a cause of action for individuals who have been harmed as a result of receiving or failing to receive health care services meeting that standard from a health care provider. The statute defines 'medical malpractice action' to mean " a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider". The standard of health care is defined as the performance of health care practice "in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.

Corporate Practice of Medicine: The current law specifically states that health maintenance organizations and provider sponsored organizations are not health care providers and are not subject to the above medical malpractice standards. However, individual providers employed by or under contract with an HMO or PSO are subject to the medical malpractice standards.

BILL ANALYSIS:

1. Applicability:

The proposed legislation applies to *health care treatment decisions* made by *managed care entities*. A managed care entity is defined as an *insurer* that delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services, or assumes the risk for the delivery of health care services. An insurer is an entity that writes a health benefit plan and is or should be licensed under the provisions of Chapter 58, either as an insurance company, a service corporation, health maintenance organization, or a multiple employer welfare arrangement.

Managed care entities are defined in the act to specifically exclude: (1) employers who purchase coverage for or on behalf of their employees and (2) *health care providers*.

A "*health care provider*" is defined to include (1) individuals who are licensed health care providers under Chapter 90 of the General Statutes and (2) health care facilities licensed under Chapters 131E (hospitals) and 122C (mental health facilities and hospitals) and their agents and employees, including any officers and directors of health care facilities.

The act defines a *health care treatment decision* as a decision that determines which and to what extent health care services will be provided and reimbursed under the plan. The decision must actually affect the quality of the diagnosis, care, or treatment provided under the plan to the enrollee or the insured.

The act applies to *health benefit plans* provided by entities that are or should be regulated under Chapter 58. The act does not apply to self-funded health plans regulated under ERISA.

2. Standard of Care/Liability:

Definition of ordinary care: The act places a duty upon the managed care entity to exercise ordinary care when making health care decisions. 'Ordinary care' is defined to mean that degree of care that a managed care entity of ordinary prudence would use under the same or similar circumstances. For a person who is an agent or employee of a managed care entity, the standard of care is that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the person would use in the same or similar circumstances.

Scope of duty: The act imposes liability upon a managed care entity for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care in making health care treatment decisions. In addition the managed care entity is also liable for damages proximately caused by the failure of its agents, employees, and representatives (over whom it has the *right* to exercise influence and control), to exercise ordinary care in making health care treatment decisions.

Liability of employer: An employer or other plan sponsor, or an employee of the employer or sponsor, will only be liable under the act for damages proximately caused by the failure to exercise ordinary care in making a health care treatment decision when the action is based on the employer, sponsor, or employee's exercise of authority to make a health care treatment decision.

Liability of health care provider or "physicians": The act does not place any liability on a physician or health care provider in addition to medical malpractice liability under current law. The act defines "physician" to include: (1) a licensed (NC) medical doctor; (2) a professional association or corporation comprising medical doctors; or 3) a person or entity wholly owned by medical doctors.

3. Defenses to Liability:

The managed care entity has a defense to an action brought under this act if (1) neither its employee, agent, or representative participated or had any influence or control over the health care treatment decision and (2) the managed care entity did not deny or delay payment for a recommended or prescribed treatment or health care service.

A managed care entity may not use as a defense in a action brought under this act any laws that prohibit the practice of medicine by a corporate entity or by an HMO.

4. Indemnification and hold-harmless clauses:

The act would make void and unenforceable any indemnification or hold-harmless clauses for the acts or conduct of the managed care entity.

5. Exhaustion of administrative remedies and appeals:

A person would not be allowed to bring an action under the act unless they first sought an external review of the health care treatment decision as allowed under Part 4 of Article 50 of Chapter 58 of the General Statutes (See proposed recommendation entitled "Independent External Review."). This requirement would not apply upon a good faith showing that harm to the insured or enrollee has already occurred because of the conduct of the managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the managed care entity for whose conduct it is liable; or the review would not be beneficial to the insured or enrollee

6. Punitive Damages:

Actions brought under the act would be subject to the limitations and restrictions placed on punitive damage awards under Chapter 1D of the General Statutes. For example, the award for punitive damages may not exceed three times the compensatory damages or $250,000, whichever is greater.

7. Separate Trial:

In an action involving a managed care entity brought pursuant to this act, on motion of any party the court must order a separate trial of any claim, cross claim, counterclaim, or third party claim against any physician (includes physician -owned entities) or other health care provider.

8. Effective Date: The act becomes effective July 1, 2001.

APPENDIX D

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

D

RM-017
THIS IS A DRAFT 25-APR-00 08:57:21

Short Title: Prompt Pay. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE PROMPT PAYMENT OF CLAIMS UNDER HEALTH BENEFIT PLANS AND TO MAKE CONFORMING AMENDMENTS TO RELATED CLAIM PAYMENT LAWS.

The General Assembly of North Carolina enacts:

Section. 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-3-225. Prompt claim payments under health benefit plans.

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any plan

implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Credit.
b. Disability income.
c. Coverage issued as a supplement to liability insurance.
d. Hospital income or indemnity.
e. 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.
f. Medical payments under motor vehicle or homeowners' insurance policies.
g. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
h. Workers' compensation.

(2) 'Claimant' includes a health care provider or facility that is responsible for directly making the claim with an insurer, an insured, or an insured's legal representative.

(3) 'Health care facility' means a facility that is licensed under Chapter 131E or 122C of the General Statutes in which health care services are provided to patients.

(4) 'Health care provider' means an individual who is licensed, certified, or otherwise authorized under Chapter 90 of the General Statutes to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(5) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement

subject to Article 49 of this Chapter, that writes a health benefit plan.

(b) An insurer shall, within 30 days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) payment of the claim,

(2) notice of denial of the claim,

(3) notice that the proof of loss is inadequate or incomplete, or

(4) notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.

(c) If the claim is denied, the notice shall include the specific reason or reasons for the denial. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, the notice shall contain the specific reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

(d) If an insurer requests additional information under subsection (c) of this section and the insurer does not receive the additional information within 90 days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be re-opened if

the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the rate of 18 percent (18%) per year, beginning on the date on which the claim should have been paid. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. Failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the insured or the insured's legal representative to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

(g) If a claim for which the claimant is a health care provider or health care facility has not been paid within 60 days after receipt of the initial claim, the insurer shall send a claim status report to the insured. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured every 30 days after the previous report was sent.

(h) Any retroactive reductions of payments or demands for refund of previous overpayments that are because retroactive review-of-coverage decisions or payment levels shall be reconciled for specific claims unless the insurer and health care

provider or health care facility agree to other reconciliation methods and terms. Any retroactive demands by health care providers or health care facilities for payment because of underpayments or nonpayments for covered services shall be reconciled for specific claims unless the insurer and health care provider or health care facility agree to other reconciliation methods and terms. The period for which retroactive adjustments may be made may be specified in the contract between the insurer and health care provider or health care facility.

(i) As used in this subsection, 'copayment or deductible' means the portion of a charge for services covered by a health benefit plan that, under the plan's terms, it is the obligation of the insured to pay. No health care provider or health care facility shall directly or indirectly seek payment or collection of the claim, other than a copayment or deductible, from an insured or an insured's legal representative while the claim is being resolved under this section. No health care provider or health care facility shall report an insured or an insured's legal representative to any credit reporting agency while the claim is being resolved under this section. A violation of this subsection by a health care provider or health care facility is a violation of Article 2 of Chapter 75 of the General Statutes.

(j) Every insurer shall maintain records of its activities under this section, including records of when each claim was , paid, denied, or pended, and the insurer's review and handling of each claim under this section, as well as documentation sufficient to demonstrate compliance with this section. The information to be included in these records and the maintenance of these records by the insurer, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner.

(k) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70."

(l) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material party by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages.

Section 2. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer. This subsection does not apply to insurers subject to G.S. 58-3-225."

Section 3. G.S. 58-51-15(a)(7) reads as rewritten:

"(7) A provision in the substance of the following language: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ~~90~~ 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within ~~90~~ 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal ~~capacity,~~ capacity of the insured, later than one year from the time proof is otherwise required."

Section. 4. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section. 5. This act becomes effective July 1, 2001, and applies to claims or services rendered on or after July 1, 2001.

Bill Summary
PROMPT PAYMENT

BILL ANALYSIS

Committee: LRC/Managed Care
Date: April 27, 2000
Version: **FINAL DRAFT**

Introduced by:
Summary by: Linda Attarian
Committee Counsel

SUMMARY: ***Section 1 of the act adds a new section to Article 3 to require a licensed insurer to pay an complete and uncontested claim submitted by a claimant within 30 days. If the claim is not paid within 30 days, interest at 18 percent will be added to the claim. The act requires the insurer to notify the claimant by email or in writing within the same 30 days if the claim is contested or denied. If a claim is denied or contested in part, the insurer must pay the undisputed portion of the claim within the same 30 days. The denial or contest notice is required to include the specific reasons supporting the denial or contest and an itemized list of any additional information required for the insurer to complete the processing for the claim. The insurer must pay the claim within 30 days after receiving the additional information. A violation of the act would subject the insurer to civil penalties, restitution or license suspension or revocation by the Commissioner of Insurance pursuant to G.S. 58-2-70.***

Sections 2 and 3 make conforming changes to existing law. Section 4 is a severability clause. The bill would become effective on July 1, 2001.

CURRENT LAW: G.S. 58-3-100 authorizes the Commissioner of Insurance to impose a civil penalty if an insurer fails to acknowledge a claim within 30 days after receiving notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgment of the claim shall be made to the claimant or his legal representative by advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of a settlement; or shall be a written denial of the claim.

Uniform claim forms: G.S. 58-3-171 and rules adopted by the Commissioner require all claims submitted by institutional health care providers to health benefit plans to be submitted on the HCFA 1450 (UB 92), or a substantively similar claim form, and all claims submitted by noninstitutional health care providers to be submitted on the HCFA 1500, or a substantively similar claim form. Payors and health care providers that receive or generate claims or send payments by electronic means must accept or generate the appropriate ASC X12 Standard Format for their health care claims submission and remittance transactions. Additional information beyond that contained on the uniform form or format may be collected, but must meet certain requirements set by the Commissioner.

Current Remedies for claim settlement practices in violation of Chapter 58: G.S. 58-63-15(11) defines certain claim settlement practices which, if committed with sufficient frequency to indicate a general business practice, will constitute an unfair and deceptive act or practice in the practice of insurance. Allegations of such practice patterns are subject to investigation by the Commissioner, who may file charges and issue a cease and desist order. Violations of the cease and desist order will subject the insurer to a penalty (in addition to any other applicable penalties) of not less than $1,000, but not more than $5,000 for each violation. No private right of action is created under the Article. However, unfair and

$5,000 for each violation. No private right of action is created under the Article. However, unfair and deceptive acts in the insurance area are not regulated exclusively by Article 63, but are also actionable under § 75-1.1, which provides for a private right of action.

G.S. 58-2-70 authorizes the Commissioner of Insurance to seek appropriate remedies from any person who violates any provision of Chapter 58. The Commissioner has the authority to impose fines, petition the court to order appropriate restitution and suspend or revoke the violator's license.

BILL ANALYSIS: Section 1 of the bill amends Article 63 of Chapter 58 pertaining to the regulation of unfair trade practices in the business of insurance. The act adds a new section to Article 63 to require a licensed insurer to pay a clean claim submitted by a claimant for covered services within 30 days. A claimant includes a health care provider or facility, an insured or an insured's legal representative. Within 30 days of receipt of the claim, the insurer must send the claimant, by paper mail or electronic mail one of the following:

1. Payment of the claim.
2. A notice of denial.
3. A notice that the proof of loss is either inadequate or incomplete.
4. A notice that the claim was not submitted on the form required by the health plan or the contract between the provider or facility and the insurer.

Notice requirements: The notice of denial must include the reasons for the denial. The notice that the proof of loss is either inadequate or incomplete or that the claimed benefit or benefits are not covered under the plan must include the reasons why the claim has not been paid along with an itemization or description of the information needed to process the claim. If the claim is not on the form required by the health benefit plan or the contract between the health care provider or facility, the notice shall include the required forms and complete instructions as to the format to be used. If the claim is denied in part, the insurer must pay the undisputed portion and send notice of the denial or contest within 30 days of receiving the claim.

Time frame for payment after receiving the requested information: The insurer has 30 days in which to pay the claim after it receives the requested information. If the requested information is not received within 90 days of making the request, the insurer shall deny the claim, and must send the claimant notice of the denial. If the insurer receives the requested information within one year after the date of the notice of denial, the insurer must reopen the claim.

Interest accrual: Claims that are not processed according to the time frames discussed above will bear interest at 18 percent per year. The interest will begin on the date the claim should have been paid.

Timeframe within which to submit a claim: The act allows insurers to require claimants to submit claims within 180 calendar days of the last date the insured's health care provider provides health care services to the insured or from the date the insured is discharged from a health care facility. Failure to submit a claim within 180 days due to a reasonable impossibility does not invalidate or reduce any claim, provided that the claim is submitted as soon as reasonably possible. In all cases where the claimant has legal capacity, the claim must be submitted within 365 days of the time submittal would have otherwise been required.

Informing the insured on the status of a disputed claim: In cases where the claim is submitted by the insured's health care provider or facility, the insurer must send a claim status report to the insured if the

Reconciling retroactive demands for overpayments and underpayments: Demands by an insurer for refunds for overpayments or demands by providers for additional payment because of underpayments or nonpayments for covered services must be reconciled for specific claims unless the parties agree on a different way to handle the movement of the money. This means that the party owed money must identify the specific service(s) and claim payment(s) that were involved in the error. Both parties would have to reflect the adjustment in the account/claims experience of the insured in question. In cases where a plan contracts with a provider, the parties could agree on a different way to handle the allocation of the refund or additional payment. Regardless of how the parities reconcile the transaction, the insurer must ensure that the patient's claims experience is adjusted to reflect the ultimate adjustment.

Payment/collection and credit protection: No provider or facility may report an insured or their legal representative to a credit reporting agency while a claim is in dispute. Further, no provider or facility may seek payment (other than copayment or deductible) from the insured while the claim in dispute. A violation will subject the provider or facility to the application of Article 2, Chapter 75 (Prohibited Acts by Debt Collectors). This act provides a private right of action, and authorizes the court to impose civil penalties up to $2,000 for each violation.

Record keeping: Insurers must maintain records and other documentation to demonstrate compliance with the act according to adopted by the Commissioner. Such records include documentation of how the insurer reviewed and handled each claim, including the date it was paid, denied, or pended.

Violations of the act: A single violation of the act would subject the insurer to the sanctions provided for under G.S. 58-2-70.

Sections 2 and 3 make conforming changes to existing law.

Section 4 is a severability clause.

The act becomes effective on July 1, 2001, and applies to services rendered on or after that date.

APPENDIX E

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

D

RM-016
THIS IS A DRAFT 25-APR-00 09:05:44

DRAFT

Short Title: HMO Insolvency. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROTECT PERSONS ENROLLED IN AN HMO FROM THE CONSEQUENCES OF THE INSOLVENCY OF THAT HMO BY AUTHORIZING ASSESSMENTS OF REMAINING HMOs IN THE STATE TO PAY FOR UNCOVERED EXPENDITURES OF AND CONTINUATION OF COVERAGE FOR THE ENROLLEES.

The General Assembly of North Carolina enacts:

Section. 1. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-67-126. Insolvency protection; assessment.

(a) When an HMO in this State is declared insolvent by a court of competent jurisdiction, the Commissioner may levy an assessment on solvent HMOs doing business in this State to pay claims for uncovered expenditures for enrollees who are residents of this State and to provide continuation of coverage for enrollees not covered under G.S. 58-67-120, G.S. 58-67-125, or G.S. 58-67-130. Assessments against an HMO may not exceed two percent (2%) of that HMO's average annual premiums received in North Carolina on policies and contracts during the three calendar years immediately preceding the year in which the insolvent HMO was declared insolvent.

(b) To provide the funds necessary to carry out the powers and duties of the Commissioner under this section, the Commissioner shall assess and notify in writing the HMOs at such time and for such amounts, as the Commissioner finds necessary. Assessments not paid within 30 days of the written notice shall accrue interest at the rate of one percent (1%) per month, or any part thereof. Assessments shall not be made until necessary to implement the purposes of this section. Computation of assessments under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(c) The Commissioner may use funds obtained under subsection (a) of this section to pay claims for uncovered expenditures for enrollees of an insolvent HMO who are residents of this State, provide for continuation of coverage for enrollees who are residents of this State and are not covered under G.S. 58-67-120, G.S. 58-67-125, or G.S. 58-67-130, and administrative costs. The Commissioner may by rule prescribe the time, manner, and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver. A receiver or liquidator of an insolvent HMO shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(d) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the extent of the benefits received. The Commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The Commissioner is subrogated to these rights against the assets of an insolvent HMO held by a receiver or liquidator of another jurisdiction.

(e) The assignment of subrogation rights of the Commissioner and allowed claim under this section have the same priority against the assets of the insolvent HMO as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

(f) When assessed funds are unused following the completion of the liquidation of a HMO, the Commissioner will distribute on a pro rata basis any unused amounts received under subsection (a) of this section to the HMOs that have been assessed under this section.

(g) The aggregate coverage of uncovered expenditures under this section shall not exceed $300,000 with respect to one individual. Continuation of coverage for an enrollee shall continue for the duration of the contract period for which premiums have been paid and continuation of coverage for an enrollee who is confined in an inpatient facility shall continue until his or her discharge or expiration of benefits. The Commissioner may provide continuation of coverage on any reasonable basis; including, continuation of the HMO contract or substitution of indemnity coverage in a form determined by the Commissioner.

(h) The Commissioner may abate or defer, in whole or in part, the assessment of an HMO if, in the Commissioner's opinion, payment of the assessment would endanger the HMO's ability to fulfill its contractual obligations. If an assessment against an HMO 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 HMOs in a manner consistent with the basis for assessments set forth in this section. An HMO that fails to pay an assessment within 30 days after notice is subject to a civil penalty of not more than $1,000 per day, or suspension or revocation of its license, or both.

(i) It is proper for any HMO, in determining its premium rates and policy owner dividends, to consider the amount reasonably necessary to meet its assessment obligations under this section."

Section 2. G.S. 58-30-220(2) reads as rewritten:

"(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims of HMO enrollees and HMO enrollees' beneficiaries; beneficiaries, including situations where an enrollee or beneficiary is liable to a health care provider for services provided under the HMO plan; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds,

annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

Section. 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act becomes effective January 1, 2001.

Bill Summary
HMO INSOLVENCY

BILL ANALYSIS

Committee:	LRC/Managed Care Issues	**Introduced by:**	
Date:	April 27, 2000	**Summary by:**	Linda Attarian
Version:	**FINAL DRAFT**		Committee Counsel

SUMMARY: ***The act would amend Article 67 of Chapter 58 pertaining to the regulation of health maintenance organizations (HMOs) to provide a mechanism with which the Commissioner of Insurance may ensure that uncovered claims against an insolvent HMO are covered and health care coverage for enrollees is continued.***

CURRENT LAW:

Warning of financial instability: § 58-67-105 authorizes the Commissioner of Insurance to order an HMO that is experiencing financial instability to take reasonable actions to rectify the situation. The Commissioner is authorized to adopt rules to set uniform standards and criteria for the early warning that the continued operation of any HMO might be hazardous to its enrollees, creditors, or the general public.

Net worth: § 58-67-110 requires each full service HMO to maintain a minimum net worth of not less than one million dollars ($1,000,000). This amount is increased annually, depending on the amount of the HMO's contingency reserves. The statute further requires every full service HMO to have and maintain at all times an adequate plan, acceptable to the Commissioner, for protection against insolvency.

Insolvency protection: § 58-67-115 provides that unless the HMO maintains a special deposit or has adequate insurance or a guaranty arrangement, each contract between every HMO and a participating provider must include a hold harmless clause to ensure that in the event the HMO fails to pay for health care services, the subscriber or enrollee will not be liable to the provider for any amount the HMO is unable to pay the provider. The special deposit must be in cash or cash equivalent and is calculated according to specific circumstances. In all cases, the deposit is controlled by and administered by the Commissioner. If the HMO has a guaranty arrangement, it must be approved in writing by the Commissioner.

Continuation of benefits: § 58-67-120 provides that each HMO must have a plan for handling insolvency and for the continuation of benefits. The HMO must ensure that its enrollees continue to receive benefits for the duration of the contract period for which premiums have been paid, or if the enrollee is confined in an inpatient facility until the discharge or expiration of benefits. The Commissioner may require the HMO

- to acquire insurance to cover the expenses to be paid for benefits after an insolvency, or
- to contribute to an insolvency reserve, or
- to submit letters of credit.

Assignment of coverage: § 58-67-125 authorizes the Commissioner, in the event of an insolvency of an HMO, to order all other carriers that participated in the enrollment process with the insolvent HMO to offer enrollees of the insolvent HMO a 30-day enrollment period from the date of insolvency. The coverage and rates must be the same that the carrier had offered to the enrollees of the group at its last

regular enrollment period. If no other HMOs participated in the enrollment process with the insolvent HMO or if the Commissioner determines that the other health benefit plan or plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent HMO, then the Commissioner must allocate the insolvent HMO's group and nongroup enrollees among all other HMOs that operate within a portion of the insolvent HMO's service area.

Replacement coverage safeguards: § 58-67-130 provides that any insurer that has contracted with an HMO to provide replacement coverage within a period of 60 days from the date of discontinuance of the HMO contract or policy must immediately cover all enrollees who were validly covered under the previous HMO, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy. Further, the contract for replacement coverage must provide for full benefits for conditions that proceeded the effective date of the succeeding insurer's contract.

Guaranty Associations: HMOs are not required to belong to guaranty associations. Guaranty associations cover claims against insolvent insurance companies by assessing the member companies an amount necessary to cover the claims. These associations can be found in Articles 48 (property and casualty) and 62 (life and health) of GS Chapter 58 and in Article 3 of GS Chapter 97.

BILL ANALYSIS: Section 1 of the act does not establish an HMO guaranty association, but instead authorizes the Commissioner to assess, as necessary, other HMOs for the unpaid obligations of the insolvent HMO. The Commissioner may waive or abate the assessment if the Commissioner determines the assessment would endanger the HMO's ability to continue coverage. The total of all assessments against a solvent HMO in one calendar year may not exceed two percent (2%) of the solvent HMO's average annual premiums during the three (3) calendar years preceding the year the insolvent HMO was declared insolvent. If an HMO fails to pay the assessment within 30 days of notice, it may be fined up to $1,000 per day and have its license suspended or revoked. In addition, assessments will accrue interest at the rate of one percent (1%) per month. Assessments must be reasonably accurate and necessary to protect persons enrolled in an HMO from the consequences of insolvency.

The act authorizes the Commissioner to arrange for continuation of coverage of enrollees of an insolvent HMO. The Commissioner would be authorized to require other HMOs or other indemnity insurers to provide continuation coverage. The continuation coverage could not exceed $300,000 for any one individual and would continue for the duration of the contract period for which premiums have been paid. Coverage of enrollees confined to inpatient facilities would continue until discharge.

Section 2 of the act clarifies the priority under Article 30 of Chapter 58 of claims for benefits and for losses incurred as a result of HMO insolvency. Medical care claims owed by HMO enrollees, including situations where an enrollee is liable to health care providers for services provided under a HMO plan would be paid like other claims under insurance and HMO contracts.

Section 3 provides a severability clause.

Section 4 provides that the act will become effective January 1, 2001.

APPENDIX F

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

D

RM-020
THIS IS A DRAFT 27-APR-00 16:38:08

Short Title: External Review/Managed Care. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE STANDARDS FOR THE ESTABLISHMENT AND MAINTENANCE OF EXTERNAL REVIEW PROCEDURES IN HEALTH INSURANCE AND MANAGED CARE TO ASSURE THAT COVERED PERSONS HAVE THE OPPORTUNITY FOR AN INDEPENDENT REVIEW OF A HEALTH BENEFIT PLAN COVERAGE DECISION MADE BY THE INSURER OR MANAGED CARE PLAN; AND TO MAKE CONFORMING AMENDMENTS TO EXISTING LAWS ON UTILAZTION REVIEW AND GRIEVANCES.

The General Assembly of North Carolina enacts:

Section 1. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 50.

General <u>Accident and Health Insurance</u> Regulations."

Section 2. Article 50 of Chapter 58 of the General Statutes is divided into five Parts as follows:

Part 1. Miscellaneous Provisions Comprising G.S. 58-50-1 through G.S. 58-50-45

Part 2. PPOs, Utilization Review, and Grievances Comprising G.S. 58-50-50 through G.S. 58-50-64

Part 3. Scope and Sanctions Comprising G.S. 58-50-65 and G.S. 58-50-70

Part 4. Health Benefit Plan External Review Comprising G.S. 58-50-75 through G.S. 58-50-95, as enacted in Section @ of this act.

Part 5. Small Employer Group Health Insurance Reform Act Comprising G.S. 58-50-100 through G.S. 58-50-156.

Section 3. G.S. 58-50-151 is recodified as G.S. 58-51-116.

Section 4. The prefatory language of G.S. 58-50-61(a) reads as rewritten:

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

Section 5. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"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 persons that provide or perform utilization review. 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) 'Disclose' means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(3) 'Health information' means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to: the past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family; the provision of health care services to an individual; or payment for the provision of health care services to an individual.

(4) 'Independent review organization' or 'organization' means an entity that conducts independent external reviews of appeals of noncertifications and second level grievance review decisions.

(5) 'Protected health information' means health information that identifies an individual who is the subject of the information; or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"§ 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 a decision on a second-level grievance review in which the insurer upheld its original noncertification as set forth in G.S. 58-50-62.

(b) 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 timeframe for completion of an expedited review of a grievance involving an appeal decision under G.S. 58-50-61 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person 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. 58-50-61 and 58-50-62, but that the organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance before conducting the expedited external review.

(2) The covered person may file a grievance under the insurer's internal grievance process under G.S. 58-50-61 and 58-50-62, but if the insurer has not issued a written decision to the covered person within 45 days after the date the covered person files the grievance with the insurer 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 of this section and shall be considered to have exhausted the insurer's internal grievance process for purposes of G.S. 58-50-79.

(c) 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 timeframe for completion of a standard external review under G.S. 58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person 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.

(d) In addition to the information to be provided under subsections (b) and (c) of 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.

(e) An insurer that has collected protected health information under a valid authorization under this Part may use and disclose the protected health information to a person acting on behalf of or at the direction of the insurer for the performance of the insurer's insurance functions: claims administration, claims adjustment and management, fraud investigation, underwriting, loss control, rate-making functions, reinsurance, risk management, case management, disease management, quality assessment, quality improvement, provider credentialing verification, utilization review, peer review activities, grievance procedures, policyholder service functions, and internal administration of compliance, managerial, and information systems. Additional insurance functions may be allowed for the purpose of this subsection with the prior approval of the Commissioner. The protected health information shall not be used or disclosed for any purpose other than in the performance of the insurer's insurance functions.

(f) Except for a request for an expedited external review under G.S. 58-50-82, all requests for external review shall be made in writing to the Commissioner.

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

(a) Except as provided in subsections (d) through (g) of this section, 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 grievance process 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 58-50-62.

(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

45 days since the date the covered person filed the grievance 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) At the same time a covered person files a request for an expedited review of an appeal involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file a request for an expedited external review of the noncertification under G.S. 58-50-82 if the covered person has a medical condition where the timeframe for completion of an expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(j) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited review of an appeal and allow the covered person to proceed with an expedited external review of the noncertification.

(e) Upon receipt of a request for an expedited external review under subsection (d) of this section, the organization conducting the external review in accordance with the provisions of G.S. 58-50-82 shall immediately determine whether the covered person shall be required to complete the expedited review process set forth in G.S. 58-50-61(j) before it conducts the expedited external review, unless the insurer has waived its right to conduct an expedited review of the appeal decision.

(f) Upon a determination made under subsection (e) of this section that the covered person must first complete the expedited appeal process under G.S. 58-50-61(j), the organization immediately shall notify the covered person and the insurer of this determination and that it will not proceed with the expedited external review under G.S. 58-50-82 until completion of the expedited appeal process and the covered person's grievance at the completion of the expedited appeal process remains unresolved.

(g) A request for an external review of a noncertification may be made before the covered person has exhausted the insurer's internal grievance procedures under G.S. 58-50-61 and G.S. 58-50-

62 whenever the insurer agrees to waive the exhaustion requirement.

(h) If the requirement to exhaust the insurer's internal grievance procedures is waived under subsection (g) of this section, the covered person may file a request in writing for a standard external review as set forth in G.S. 58-50-80.

"§ 58-50-80. Standard external review.

(a) Within 60 days after the date of receipt of a notice of a noncertification appeal decision or a second level grievance review decision 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 immediately shall notify and send a copy of the request to the insurer that made the decision which is the subject of the request. The insurer shall immediately submit to the Commissioner the information required for the preliminary review under subsection (c) of this section.

(c) Within five business days after the date of receipt of a request for an external review, the Commissioner shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time the health care service 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.

(2) 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.

(3) The covered person has exhausted the insurer's internal grievance process under G.S.58-50-62(i) unless the covered person is not required to exhaust the insurer's internal grievance process under G.S. 58-50-79.

(4) The covered person has provided all the information and forms required by the Commissioner that are

necessary to process an external review, including the authorization form provided under G.S. 58-50-77(e).

(d) Upon completion of the preliminary review under subsection (c) of this section, the Commissioner immediately shall notify the covered person in writing whether the request is complete and whether the request has been accepted for external review.

(e) If the request is accepted for external review, the Commissioner shall:

(1) Include in the notice provided under subsection (d) of this section a statement that the covered person may submit to the Commissioner in writing within seven days after the date of the notice additional information and supporting documentation that the organization shall consider when conducting the external review.

(2) Immediately notify the insurer in writing of the acceptance of the request for external review.

(3) Provide the covered person and the covered person's provider with a list of organizations approved under G.S. 58-50-85.

(4) Inform the covered person that the covered person has the right to select the organization of his or her choice and notify the Commissioner within five days after receipt of the notice, and that if the covered person does not select an organization and inform the Commissioner of the selection within five days after receipt of the notice, the Commissioner will assign an organization to conduct the external review.

(f) If 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 90 days after the date of the insurer's decision for which external review is requested. If the request is not accepted for external review, the Commissioner shall inform the covered person and the insurer in writing of the reasons for its nonacceptance.

(g) If the insured does not select an organization of his or her choice and notify the Commissioner of the selection within five days after receipt of the Commissioner's notice under subsection (e) of this section, the Commissioner shall systematically assign an appropriate independent review organization that has been approved under G.S. 58-50-85 to conduct the external review. In reaching a decision, the assigned 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 58-50-62.

(h) Within seven days after the date of receipt of the notice provided under subsection (e) of this section, the insurer or its designee utilization review organization shall provide to the assigned organization, the documents and any information considered in making the noncertification appeal decision or the second level grievance review decision. Except as provided in subsection (i) of this section, 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.

(i) If the insurer or its utilization review organization fails to provide the documents and information within the time specified in subsection (h) 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. Immediately upon making the decision under this subsection, the organization shall notify the covered person, the insurer, and the Commissioner.

(j) The assigned organization shall review all of the information and documents received under subsections (h) and (i) of this section and any other information submitted in writing by the covered person under subsection (e) of this section that has been forwarded to the organization by the Commissioner. Upon receipt of any information submitted by the covered person under subsection (e) of this section, at the same time the Commissioner forwards the information to the organization, the Commissioner shall forward the information to the insurer.

(k) Upon receipt of the information required to be forwarded under subsection (j) 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.

(l) Immediately upon making the decision to reverse its noncertification appeal decision or second level grievance review decision under subsection (k) 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.

(m) In addition to the documents and information provided under subsections (h) and (i) of this section, the assigned organization, to the extent the documents or information are available and the organization considers them appropriate, 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 terms of coverage under the covered person's health benefit plan with the insurer 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.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government, national or professional medical

societies, boards and associations. Local practice guidelines may be used when appropriate.

(6) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.

(7) Medical necessity, as defined in G.S. 58-3-200(b).

(n) 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, and the Commissioner.

(o) The organization shall include in the notice sent under subsection (n) 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.

(p) Upon receipt of a notice of a decision under subsection (n) of this section reversing the noncertification appeal decision or second level grievance review decision, the insurer immediately shall approve the coverage that was the subject of the noncertification appeal decision or second level grievance review decision.

"§ 58-50-82. Expedited external review.

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

(1) An appeal decision upholding a noncertification if:

a. The noncertification appeal decision involves a medical condition of the covered person for which the timeframe for completion of an expedited second level grievance review of a noncertification set forth in G.S. 58-50-62(l) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

b. The covered person has filed a request for an expedited appeal of a noncertification as set forth in G.S. 58-50-61(l); or

(2) A second level grievance review decision upholding a noncertification under G.S. 58-50-62(h) or (i):

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

b. 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) At the time the Commissioner receives a request for an expedited external review, the Commissioner immediately shall:

(1) Notify and provide a copy of the request to the insurer that made the noncertification appeal decision or second level grievance review decision which is the subject of the request.

(2) For a request that the Commissioner has determined meets the reviewability requirements set forth in

G.S. 58-50-80(c), assign an organization that has been approved under G.S. 58-50-87. The organization shall immediately determine whether the request should be reviewed on an expedited basis because the timeframe for completion of a standard external review under G.S. 58-50-80 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The organization shall then inform the covered person, insurer, and Commissioner of its determination and conduct a review and make a decision on the review within the appropriate timeframe.

(c) 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 58-50-62.

(d) At the time the insurer receives the notice under subsection (b) of this section, the insurer or its designee utilization review organization shall immediately provide or transmit all necessary documents and information considered in making the final noncertification decision to the assigned organization electronically or by telephone or facsimile or any other available expeditious method.

(e) In addition to the documents and information provided or transmitted under subsection (d) of this section, the assigned organization, to the extent the information or documents are available and the organization considers them appropriate, 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 terms of coverage under the covered person's health benefit plan with the insurer 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.

(5) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations. Local practice guidelines may be used when appropriate.

(6) Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization in making noncertification decisions.

(7) Medical necessity, as defined in G.S. 58-3-200(b).

(f) As expeditiously as the covered person's medical condition or circumstances require, but not more than four 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 appeal decision or second level grievance review decision and notify the covered person, the insurer, and the Commissioner of the decision.

(g) If the notice provided under subsection (f) 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 insurer, and the Commissioner; and include the information set forth in G.S. 58-50-80(o). Upon receipt of the notice a decision under subsection (f) of this section reversing the noncertification appeal decision or second level grievance review decision, the insurer immediately shall approve the coverage that was the subject of the noncertification.

(h) An expedited external review may not be provided for retrospective noncertifications.

"**§ 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.

"§ 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 re-approving 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.

(c) The Commissioner may, in his discretion, determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established under G.S. 58-50-87 will cause an independent review organization to be deemed to have met, in whole or in part, the requirements of this section and G.S. 58-50-87. A decision by the Commissioner to recognize an accreditation program for the purpose of granting deemed status may be made only after reviewing the accreditation standards and program information submitted by the accrediting body. An independent review organization seeking deemed status due to its accreditation shall submit original documentation issued by the accrediting body to demonstrate its accreditation.

(d) The Commissioner may charge an application fee that independent review organizations shall submit to the Commissioner with an application for approval and re-approval.

(e) 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.

(f) 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 and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Part that is maintained by the Commissioner under subsection (g) of this section.

(g) The Commissioner shall maintain and periodically update a list of approved independent review organizations.

"§ 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.

(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, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

(3) Agree 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) Agree to contractual terms or written requirements established by the Commissioner regarding the procedures for handling a review.

(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 non-restricted license from the North Carolina Medical Board 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 non-restricted North Carolina license, registration, or certification in the same allied health occupation as the covered person's treating provider;and

(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.

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

No independent review organization or clinical peer reviewer working on behalf of an organization shall be liable in 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.

"§ 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, at least annually, 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(k) and (l) 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.

"§ 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 for the fees charged by the organization in conducting the external review.

"§ 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 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.

"§ 58-50-94. Competitive selection of independent review organizations.

(a) 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 costs and 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, 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 in order to allow insureds a choice of review organizations, and shall ensure that at least one review organization is available to and capable of reviewing cases involving highly specialized services and treatments of any nature. The Commissioner may reject any or all proposals.

(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.

"§ 58-50-95. Report by Commissioner.

The Commissioner shall report semiannually to the Joint Legislative Committee on Health Care Oversight regarding the nature and appropriateness of reviews conducted under this Part. The report should include the number of reviews, character of the reviews, dollar amounts in question, and any other information releant to the evaluation of the effectiveness of this Part."

Section 6. G.S. 58-50-61(a)(13) reads as rewritten:

"(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 an evaluation or review of medical information about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic and the extent to which coverage under the health benefit plan is affected by that decision."

Section 7. G.S. 58-50-61(a)(17)g. reads as rewritten:

"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."

Section 8. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Informal Reconsideration.— An insurer may establish procedures for informal reconsideration of noncertifications and if established, such procedures shall be in writing. 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. insurer, after a written notice of noncertification has been issued in accordance with subsection (h) of this section. 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 in fewer than 10 business days, it shall treat the request for informal reconsideration as a request for an appeal, except that the requirements of subsection (k) of this section shall apply on or before the 10th business day after receipt of the request for an informal reconsideration."

Section 9. G.S. 58-50-62(a) is amended by adding a new subsection to read:

"(b1) Informal Consideration of Grievances. If the insurer provides procedures for informal considerations 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 shall apply on the 10th business day after receipt of the grievance; or

(2) If the grievance concerns a non-clinical 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 G.S.58-50-62(c).

(3) If the insurer is unable to render an informal consideration decision within 10 business days of 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 shall apply on

the 10th business day after receipt of the grievance."

Section 10. G.S. 58-50-61(k)(5) reads as rewritten:

"(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.~~ G.S. 58-50-62 if the insurer's decision on the appeal is to uphold its noncertification."

Section 11. G.S. 58-50-62(e)(2)e. reads as rewritten:

"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.~~ section if the insurer's decision on the first level grievance review is not in favor of the covered person."

Section 12. G.S. 58-50-62(h)(7) reads as rewritten:

"(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 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."

Section 13. The Commissioner of Insurance shall report semiannually to the Joint Legislative Health Care Oversight Committee regarding the nature and appropriateness of reviews conducted under this Part. The report shall include the number of reviews, character of the reviews, dollar amounts in question, and any other information relevant to the evaluation of the effectiveness of the external review procedures establishes pursuant to this act.

Section 14. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section. 15. This act becomes effective July 1, 2001.

Bill Summary
INDEPENDENT EXTERNAL REVIEW

BILL ANALYSIS

Committee: LRC/Managed Care
Date: April 27, 2000
Version: **FINAL DRAFT**

Introduced by:
Summary by: Linda Attarian
Committee Counsel

SUMMARY: ***The proposed legislation would add a new Part to Article 50 Chapter 58 of the General Statutes to establish an external, independent review process for consumers to obtain an external review of disputes regarding complaints and issues relating to the consumer's health benefit plan. A request for an external review would be made to the Commissioner of Insurance after exhausting all internal appeals. External reviews would be conducted by independent review organizations that are approved by the Commissioner of Insurance. The decision of the review organization must be made within 45 days or four days if necessary to avoid jeopardizing the health or life of the covered person. The decision would be binding upon the insurer. The insurer would pay the cost of the review. The act would become effective July 1, 2001, and would not be applicable to self-funded employer health plans regulated under ERISA.***

CURRENT LAW: **<u>Internal</u> Appeal and Grievance Procedures.**

North Carolina law provides for two step internal appeal and grievance procedure that allows consumers to appeal denials of preauthorizations of covered services or other matters in dispute between the consumer and the health benefit plan. Consumers whose appeal of a preauthorization denial or whose first-level grievance review has been decided in favor of the insurer have a right to file a written grievance with the insurer and to have a panel investigate and make a determination regarding the grievance. Consumers also have a right to request the review, appeal and grievance through a person authorized to act on their behalf or through their health care provider.

Appeals of Utilization Review Decisions: Under current law, when a consumer requests authorization of a particular procedure or service or continued authorization of ongoing care, the insurer must make a determination within two business days of the request. If the insurer denies authorization (referred to as a noncertification), the consumer may informally appeal the denial. This informal appeal procedure allows the consumer to explain why the procedure should have been authorized. This appeal requires that the preauthorization denial be reviewed by at least one medical doctor, licensed in NC, who was not involved in the denial. The insurer must issue a written decision to the consumer and the health care provider within 30 days of the request for review. The insurer must provide an expedited review and issue a decision within four days when it is necessary to avoid jeopardizing the health of the patient.

First-Level Grievance Appeal: If the dispute concerns a matter of dissatisfaction other than a request for covered services, the consumer has a right to an informal review of the grievance. The current law requires that the insurer select someone with appropriate expertise, who was not involved in the matter, to evaluate the grievance. A written decision must be issued within 30 days of the request.

Second-Level Grievance Appeal: If the consumer is dissatisfied with the outcome of the informal, first level grievance appeal, or of the informal appeal of the denial of preauthorization, the consumer has a right to file a formal, second-level grievance appeal with the insurer. At this stage, the matter giving rise to the appeal must be evaluated by persons who were not previously involved in the matter, who are not

employed by the insurer and who do not have a financial interest in the outcome of the appeal. However, these persons are appointed to serve on the panel by the insurer.

When the grievance concerns a utilization review matter or clinical issue, all members of the review panel must be health care professionals with appropriate expertise, including at least one clinical peer. One member of the panel may be an employee of the insurer if the panel is made up of three or more persons and the insurer included a clinical peer in the review of an appeal or first level grievance. The review must be held within 45 days of receipt of request and a written decision must be provided to the consumer seven days after the review meeting. An expedited review (within four days) must be provided if it is necessary to avoid jeopardizing the life or health of the patient.

BILL ANALYSIS:

Sections 1 through 4 of the bill divide Article 50 of Chapter 58 of the General Statutes, concerning general regulation of insurance, into five Parts and make conforming changes to existing language in the Article. Section 5 adds a new Part 4 to Article 50 of Chapter 58 to create a mechanism for independent, external review of an appeal decision upholding an initial noncertification decision or a second level grievance review decision that upheld an initial noncertification decision. The Part will apply to all persons who provide or perform utilization review.

Sections 6 amends the definition of "noncertification" under G.S. 58-3-190 to include (1) determinations and claims concerning whether a health care service provided in an emergency setting meets the prudent layperson standard for coverage; and (2) any review concerning whether a requested treatment is experimental, investigational, or cosmetic and the extent to which coverage under the health benefit plan is affected by that decision.

Section 7 amends the definition of "retrospective review" under G.S. 58-50-61(a)(17)g to specifically include reviews of claims concerning whether a health care service provided in an emergency setting meets the prudent layperson standard for coverage.

Section 8 amends G.S. 58-60-61(j), (Appeals of Noncertifications) to require informal reconsiderations of noncertifications to be conducted only after a written notice of the noncertification, meeting the requirements of G.S. 58-60-61 (h), has been issued. G.S. 58-60-61 (h) requires the notice to include the reasons for the noncertification, instructions on how to appeal the noncertifications, and instructions on how to request a written statement of the review criteria the insurer used in to make the noncertification. If the insurer is unable to reach an informal reconsideration decision in fewer than 10 business days, the informal reconsideration is to be treated as a formal appeal.

Section 9 adds a new subsection to G.S. 58-50-62 (Insurer grievance procedures), to provide similar requirements for procedures related to informal considerations of grievances as those outlined in Section 8.

Sections 10-12 makes clarifying and conforming amendments to current law.

Section 13 requires the Commissioner of Insurance to make biannual reports to the Joint Legislative Health Care Oversight Committee concerning the number and appropriateness of external appeals requested and conducted.

Section 14 is a severability clause.

Section 15 makes the bill effective July 1, 2001.

See attached chart for the key elements of Section 5, Independent External Review.

North Carolina Law Addressing External Grievance Review Procedures

1	Predominant State Regulator Involved in the External Review	Department of Insurance (DOI).
2	Entities Whose Decisions are Eligible for External Review	Health Insurer.
3	Who May Request External Review	Covered Person.
4	Decisions that are Eligible for External Review	1) A noncertification appeal decision and 2) a second level grievance review decision.
5	Dollar Threshold for External Review	None.
6	Cost Sharing Requirements	None.
7	Exhausting Internal Grievance Procedures	With some exceptions, a request for an external review shall not be made until the covered person has exhausted the insurer's internal grievance process. If the covered person has filed a grievance involving a noncertification appeal decision, but the insurer has not issued a written decision to the covered person within 45 days after the date it was filed and the covered person has not requested or agreed to a delay, the covered person is considered to have exhausted the insurer's internal grievance process.
8	Expedited Review	A covered person may make a request for an expedited external review with the Commissioner and if the Commissioner determines that the request meets the reviewability standards, an Independent Review Organization (IRO) will be assigned to complete the review on an expedited basis. If the IRO determines that the timeframe for a standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the IRO must conduct the review and make the decision within four days.

9	General Description of Process	The request for external review is filed with the Department of Insurance. DOI notifies the health carrier of the filing of the request and provides a copy. DOI conducts a preliminary review to make sure the case is eligible. If the external review request is accepted, DOI notifies the insurer and covered person. The covered person has five days to select an approved Independent Review Organization (IRO). If the covered person hasn't selected an organization within five days, the Commissioner makes an assignment. The covered person and the insurer submit documents and information considered in making the internal review decision. The IRO conducts external review. IRO reverses or upholds determination, then notifies the covered person, Commissioner, and insurer. Except for a request for an expedited external review, all requests for external review must be made in writing.
10	Funding	The insurer against which a request for a standard review or an expedited external review is filed shall pay the cost of the IRO in conducting the external review.
11	Qualifications of Reviewer	The Commissioner approves IROs eligible to be assigned to conduct external reviews. The Commissioner develops an application form for initially approving and for re-approving organizations. Any IRO wishing to be approved submits the application form and includes 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. To be approved under G.S. 58-50-87, an IRO maintains written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process 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 IRO and suitable matching of reviewers to specific cases. c. The confidentiality of medical and treatment records and clinical review criteria. AND d. That any person employed by or under contract with the IRO adheres to the requirements of this Part. 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, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

	Qualifications for reviewers, cont.	3. Agree to maintain and provide to the Commissioner the information set out in G.S. 58-50-85. 4. Agree to contractual terms or written requirements established by the Commissioner. 5. A program for credentialing clinical peer reviewers. All clinical peer reviewers assigned by an IRO shall be physicians 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. 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 physician, a license from the North Carolina Medical Board, and if a specialist medical doctor, a current certification by a recognized American medical specialty board in the area(s) appropriate. 4. If the covered person's treating provider is not a medical doctor, hold an unrestricted license, registration, or certification in the same allied health occupation as the covered person's treating provider; and 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 a 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.
12	Conflicts of Interest	Neither the IRO nor any clinical peer reviewer assigned by the IRO may have a material professional, familial, or financial conflict of interest with any of the following: 1. The insurer. 2. The covered person or the covered person's authorized representative. 3. Any officer, director, or management employee of the insurer. 4. The healthcare provider, the health care provider's medical group or independent practice association recommending the health care service or treatment. 5. The facility at which the recommended healthcare 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.

	Conflicts of Interest, cont.	The IRO 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
13	Standard of Review	The IRO reviews all of the information and documents received. In addition to documents received, the IRO considers: • the covered person's medical records, • the attending health care professional's recommendation, • consulting reports from appropriate health care professionals and other documents submitted, • the terms of coverage under the covered person's health benefit plan, • the most appropriate practice guidelines, including local practice guidelines, and any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization. • Medical necessity, as defined in G.S. 58-3-200(b). Within 45 days after the date of receipt of the request for external review, the IRO provides 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, and the Commissioner.
14	Time Frames	A covered person has 60 days after the date of receipt of a notice of a noncertification appeal decision or a second level grievance review decision to file a request with the Commissioner for an external review. Within 5 business days after the date of receipt of a request for an external review, the Commissioner has to complete a preliminary review of the request. If the request is not complete, the Commissioner will notify the covered person what information or materials are needed to review the request. The covered person has 90 days to furnish the materials. Once the request is accepted for review, the covered person has five days to select an IRO. The insurer or its designee utilization review organization has 7 days to forward documents and any information to the IRO. Within 45 days, the IRO has to provide written notice of its decision to uphold or reverse the decision to the covered person, the insurer, and the Commissioner. The decision of an expedited review must be made within four days.
15	Binding Nature of Decision	The decision is binding on the insurer. It is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law. 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.

16	Attorney's Fees	Does not address attorneys.
17	Confidentiality Requirements	For purposes of conducting an external review, the insurer provides an authorization form by which the covered person authorizes the insurer to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.
18	Liability of Reviewer	No IRO or clinical peer reviewer working on behalf of an IRO shall be liable in damages to any person for any opinions rendered during or upon completion of an external review, unless the opinion was rendered in bad faith or involved gross negligence.
19	Data Reporting	Each IRO is required to maintain for at least three years written records in the aggregate and by insurer on all requests for which it conducted an external review during a calendar year and submit a report, at least annually, to the Commissioner. Each insurer shall maintain for at least three years written records in the aggregate and for each type of health benefit plan offered by the insurer on all requests for external review that are filed with the insurer or that the insurer received notice of from the Commissioner.
20	Disclosure Requirements	Each insurer must provide each covered person a description of the plan's external review procedures, including a statement that informs the covered person of their right to file a request for external review.

APPENDIX G

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

D

00-DRM-001
(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

Short Title: Internal Review Panelists. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE UTILIZATION REVIEW AND GRIEVANCE PROCEDURES PURSUANT TO G.S. 58-50-62 TO INCLUDE ON THE REVIEW OR GRIEVANCE PANEL PROVIDERS LICENSED, CERTIFIED OR REGISTERED IN NORTH CAROLINA IN THE SAME MEDICAL OR ALLIED OCCUPATION AS THE PROVIDERS WHO ARE PARTIES TO THE REVIEW OR GRIEVANCE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

"**§ 58-50-61. 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; ensure that at least one provider holding a valid North Carolina license, registration or certification in the same medical or allied health occupation as the providers who are parties to the review, or if the provider is a medical doctor, at least one clinical peer of the party provider; and issue the decision in a timely manner pursuant to this section."

Section 2. G.S. 58-50-62 reads as rewritten:

"**§ 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. 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; except that an 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.

(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 three years or 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 grievance may be submitted by a covered person or his or her provider acting on the covered person's behalf.

(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. 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 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~~ provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the providers who are parties to the grievance, or if the provider is a medical doctor, at least one clinical peer of the party provider with appropriate expertise to evaluate the matter. 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) 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.

(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.

(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.~~ provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the providers who are parties

to the grievance, or if the provider is a medical doctor, at least one clinical peer of the party provider. ~~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~~ An insurer 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.

(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

(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.)

Section 3. This act is effective when it becomes law.

Bill Summary
INTERNAL REVIEW PANELISTS

BILL ANALYSIS

Committee:	LRC/Managed Care Issues	**Introduced by:**	
Date:	April 27, 2000	**Summary by:**	Linda Attarian
Version:	**FINAL DRAFT**		Committee Counsel

SUMMARY: ***The bill would amend G.S. 58-50-61 and 58-50-62, managed care grievance and appeals procedures, to require insurers to include on utilization review and grievance panels, providers who are licensed, certified or registered to practice in this State and who practices in the same medical or allied occupation as the providers who are parties to the review or grievance.***

CURRENT LAW

Definition of clinical peer: The term "clinical peer" means a health care professional who holds a license in a state of the United States in the same or similar specialty and routinely provides the health care services subject to the review.

Utilization review panels: North Carolina law provides that all insurers establish a utilization review program to evaluate that health care services offered by the insurer are medically necessary and appropriate. Only "qualified health care professionals" may administer the utilization review program, and they must do so under the direction of a medical doctor. The law does not define "qualified health professionals." Thus the law does not prohibit insurers from including clinical peers or providers with the same license as the party to the review in the utilization review process, but it does not require their participation.

Grievance procedures concerning utilization review: North Carolina law establishes a two-step process for appeal and grievance when a health plan denies authorization for a particular type of health service pursuant to its utilization review program. Only a medical doctor licensed in North Carolina may make this denial. A denial of authorization may be appealed under G.S. 58-50-61, and the appeal panel must include a medical doctor licensed in North Carolina, but the law does not require the inclusion of a clinical peer at this stage of the appeal. If the panel upholds the denial, the insured may proceed to a second level appeal, which is conducted according to the provisions of G.S. 58-50-62. When the subject of the second level grievance is a clinical matter, the panel must be made up of health care professionals qualified to evaluate the matter, including at least one clinical peer. If an insurer uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel, then it may use one of its employees on the second-level grievance review panel in the same matter provided the panel contains three or more persons.

BILL ANALYSIS: **Section 1** amends G.S 58-50-61(d) to require that, in issuing a utilization review decision, at least one provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the provider who is a party to the review is included in the utilization review decision making process. If one of the providers party to the review is a medical doctor, then the insurer must involve a clinical peer of that provider.

Section 2 amends G.S. 58-50-62 to require that an insurers' grievance panel includes in the first and second-level grievance review panels at least one provider holding a valid North Carolina license, registration, or certification in the same medical or allied occupation as the provider who are parties to the review. If one of the providers party to the grievance review is a medical doctor, then the insurer must

include a clinical peer of that provider on the panels. Also, since the amended section requires the inclusion of a clinical peer on the appeal of a noncertification under G.S. 58-50-61 and on a first-level grievance review panel, the bill clarifies that an insurer may include one of the insurer's employees on the second-level review panel if it has three or more persons.

The act becomes effective when it becomes law.