GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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HOUSE BILL 1537*
Committee Substitute Favorable 6/21/00

Short Title: Prompt Pay/Patient Protection. (Public)

Sponsors:

Referred to:

May 16, 2000

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

PART I. PROMPT PAY.

Section 1. Article 3 of Chapter 58 of the General Statutes is amended by adding new sections 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. Long-term or nursing home care.
g. Medical payments under motor vehicle or homeowners' insurance policies.
h. Medicare supplement.
i. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
j. Workers' compensation.

(2) 'Claimant' includes a health care provider or facility that is responsible under contract with the insurer or by valid assignment of benefits 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 Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(4) '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.

(5) Notice that coordination of benefits information is needed in order to pay the claim.

(6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail and an electronic claim on the day the claim is electronically transmitted.

(c) If the claim is denied, the notice shall include the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith 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 all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain that utilization management or medical necessity standard. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. 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, if the form is other than a UB or HCFA 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 reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

(e) In order to facilitate submission of complete claims by providers, insurers shall provide to providers treatment codes and payments applicable to each treatment code used by the insurer to process claims.

(f) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the rate of one and one half (1.5%) percent per month, compounded daily, beginning on the date on which the claim should have been paid. If additional information was requested by the insurer under subsection (b) of this section, interest on health benefit claim payments shall begin to accrue on the 31st day after the insurer received the additional information. 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.

(g) Insurers may require that claims be submitted not less than 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, not less than 180 days after the date of the patient's discharge from the facility. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant 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.

(h) 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. Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under subsection (c) of this section. 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.

(i) To the extent permitted by the contract between the insurer and the health care provider or health care facility, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Recoveries by the insurer must be accompanied by the specific reason and adequate information to identify the specific claim. To the extent permitted by the contract between the insurer and the health care provider or health care facility, the health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds.

Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may be specified in the contract between the insurer and health care provider or health care facility.

(j) Every insurer shall maintain records of its activities under this section, including records of when each claim was received, 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.

(k) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law.

(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 part 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. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(m) This section does not apply to claims processed by an insurer on claims adjudication software that was implemented prior to January 1, 1982, provided that the insurer:

(1) Verifies with the Commissioner that its claims adjudication software complies with this subsection; and

(2) Is implementing a new claims adjudication software system and is proceeding in good faith to move all claims to the new system as soon as possible and in any event no later than December 31, 2002.

This subsection expires January 1, 2003.

(n) The Commissioner shall adopt rules to implement this section.

"**§ 58-3-226. Reports on prompt processing.**

(a) As used in this section, the terms ‘insurer' and ‘claimant' have the meaning applied in G.S. 58-3-225.

(b) An insurer shall file with the Commissioner quarterly reports that contain all of the following:

(1) The number and percentage of total claims received by the insurer during the prior quarter.

(2) The number and percentage of claims processed in which the claimant was required to submit additional information to facilitate processing.

(3) The number and percentage of claims in which the claimant was notified that proof of loss was inadequate or incomplete, or notified that the claim was not submitted on the required form.

(4) The value and percentage of total claims paid within 30 calendar days of receipt of the claim.

(5) The value and percentage of total claims in which the undisputed portion was paid within 30 days of receipt of the claim.

(6) The number and percentage of total claims that were denied because the insurer did not receive additional information within 90 days after the request for additional information was made.

(7) The number and percentage of total claims paid within 30 calendar days of receipt of additional information from the claimant.

(8) The total dollar amount of penalties and interest paid by the insurer pursuant to G.S. 58-3-225.

(c) An insurer shall file the reports required by this section on or before the first day of each quarter. The Commissioner shall make the reports available for public inspection immediately upon receipt of the report."

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."

PART II. EXTERNAL REVIEW/MANAGED CARE.

Section 4. The title of Article 50 of Chapter 58 of the General Statutes reads as rewritten:

"ARTICLE 50.
GENERAL ACCIDENT AND HEALTH INSURANCE REGULATIONS."

Section 5. Article 50 of Chapter 58 of the General Statutes is amended as follows:

(1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the heading "Miscellaneous Provisions."

(2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the heading "PPOs, Utilization Review and Grievances."

(3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the heading "Scope and Sanctions."

(4) By designating G.S. 58-50-75 through G.S. 58-50-95 as Part 4 with the heading "Health Benefit Plan External Review."

(5) By designating G.S. 58-50-100 through G.S. 58-50-156 as Part 5 with the heading "Small Employer Group Health Insurance Reform."

Section 6. G.S. 58-50-151 is recodified as G.S. 58-51-116.

Section 7. 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 8. 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 a noncertification decision, 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's health care provider or the individual who is the subject of the protected health information or the individual's legal guardian, including the custodial parent(s) of a minor child.

(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 directly 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 directly identify an individual.

(6) 'Valid authorization' means an authorization obtained from an individual or the individual's legal guardian, including a custodial parent of a minor child in writing, electronic, or other form that indicates the individual's consent to the disclosure of protected health information for the purposes set out in G.S. 58-50-77(e).

"§ 58-50-76: **Reserved for future codification.**

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

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

(1) A noncertification decision;

(2) An appeal decision under G.S. 58-50-61 upholding a noncertification; and

(3) A second-level grievance review decision under G.S. 58-50-62 upholding the original noncertification.

(b) The insurer shall include in the notice required under subsection (a) of this section:

(1) For a notice related to a noncertification decision, a statement informing the covered person that if the covered person has a medical condition where the time frame for completion of an expedited appeal decision under G.S. 58-50-61(l) would reasonably appear to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited appeal under G.S. 58-50-61(l), but that the organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited appeal before conducting the expedited external review;

(2) For a notice related to an appeal decision upholding a noncertification under G.S. 58-50-61, a statement informing the covered person that if the covered person has a medical condition where the time frame for completion of an expedited second-level grievance review under G.S. 58-50-62(i) would reasonably appear to seriously jeopardize the life or

health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82 at the same time the covered person files a request for an expedited second-level grievance review under G.S. 58-50-62(i), but that the organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited second-level grievance review before conducting the expedited external review;

(3) 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 if the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably appear to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review under G.S. 58-50-82; and

(4) For a noncertification that 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, a statement informing the covered person that the covered person may request an expedited external review under G.S. 58-50-82.

(c) The covered person may file a grievance under the insurer's internal grievance process under G.S. 58-50-61 and G.S. 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.

(d) In addition to the information to be provided under subsections (a) and (b) 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, agent, or contractor 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, securing payment, assuring the delivery of health care, 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 those described in this subsection.

(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.

"§ 58-50-78: **Reserved for future codification.**

"**§ 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. 58-50-62; and

(2) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the insurer within 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 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 time frame for completion of an expedited appeal involving a noncertification set forth in G.S. 58-50-61(l) would reasonably appear to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function. An insurer may waive its right to conduct an expedited 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 appeal set forth in G.S. 58-50-61(l) 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(l), 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 G.S. 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.

"§ 58-50-81: **Reserved for future codification.**

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

(a) Except as provided in subsection (h) 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) A noncertification decision where:

a. The covered person has a medical condition for which the time frame for completion of an expedited appeal under G.S. 58-50-61(l) would reasonably appear to seriously jeopardize the life or health of the covered person or 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) An appeal decision upholding a noncertification where:

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

b. The covered person has filed a request for an expedited second-level grievance review under G.S. 58-50-62(i); or

(3) A second-level grievance review decision upholding a noncertification under G.S. 58-50-62(h) or (i) where the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably appear to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function; or

(4) A noncertification decision that involves 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 decision, the appeal decision involving a noncertification, or the 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 time frame 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 time frame.

(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 G.S. 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.

"§ 58-50-83: **Reserved for future codification.**

"**§ 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 reapproving organizations to conduct external reviews.

(b) Any organization wishing to be approved to conduct external reviews under this Part shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the organization satisfies the minimum qualifications established under G.S. 58-50-87.

(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 reapproval.

(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.

"§ 58-50-86: **Reserved for future codification.**

"**§ 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) Agreement to maintain and provide to the Commissioner the information set out in G.S. 58-50-90.

(4) A program for credentialing clinical peer reviewers.

(5) Agreement 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 nonrestricted 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 nonrestricted North Carolina license, registration, or certification in the same allied health occupation as the covered person's treating provider.

(5) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national,

State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this section, to be approved under G.S. 58-50-85 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review.

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(3) Any officer, director, or management employee of the insurer that is the subject of the external review.

(4) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(5) The facility at which the recommended health care service or treatment would be provided.

(6) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (d) of this section, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

"§ 58-50-88: **Reserved for future codification.**

"**§ 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.

"§ 58-50-91: **Reserved for future codification.**

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

The insurer against which a request for a standard external review or an expedited external review is filed shall reimburse the Department of Insurance for the fees charged by the organization in conducting the external review.

"**§ 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 of Chapter 58 of the General Statutes, health care providers, and insureds. In selecting the review organizations, in addition to considering cost, quality, and adherence to the requirements of the request for proposals, the Commissioner shall consider the desirability and feasibility of contracting with multiple review organizations 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."

Section 9. 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 10. 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 11. 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 12. G.S. 58-50-62 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.

(2) If the grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the covered person, the insurer shall issue a written decision that includes the information set forth in 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 13. 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 14. 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 15. 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 grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance."

Section 16. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-227. Provider directories.**

(a) As used in this section, 'updated directory information' means the current participation status of a provider, information known to the insurer indicating that a provider is not currently accepting new patients, and other information included in a printed provider directory.

(b) An insurer that uses a network of contracting health care providers for its health benefit plans shall provide a copy of its current provider directory, including any specialty directory, to all insureds on or before the effective date of initial coverage and shall make these directories available to current and prospective insureds upon request. Updated directory information reflecting the most current information available to the

insurer shall be available to insureds by telephone and may also be made available by other media.

(c) Each directory shall include, in addition to the name, address, telephone number, and area of specialty for each health care provider and facility in its provider network:

(1) An indication of whether the provider may be selected as a primary care provider.

(2) An indication of whether the provider is or is not currently accepting new patients.

(3) An indication of whether the provider has any other restrictions that would limit an insured's access to coverage from that provider.

(4) A brief explanation, including costs to the insured, of how an insured may access providers outside of the network.

(5) An explanation of the insured's right to transition coverage.

(6) The consumer complaint telephone number at the Department of Insurance.

The directory shall also include the date of its publication and instructions on how a current or prospective insured can obtain information about changes in the provider network or a provider's ability to accept new patients that may have occurred since the most recent printing of the directory.

(d) The directory shall include all of the types of licensed or certified health care providers with which the insurer contracts directly or with whom the insurer has access through a contract with an intermediary organization. If a contracting provider requests, the names of any allied health care providers who practice and deliver primary care services under the supervision of the contracting provider and whose services are covered by virtue of the carrier's contract with the supervising provider shall be listed as part of the directory listing for the contracting provider.

(e) An insurer may maintain separate directories for specialty services, such as mental health, substance abuse, or centers of excellence, but shall make each of its directories available to current and prospective insureds in accordance with this section."

Section 17. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-229. Patient access to quality managed health care.**

(a) Access Ensured by Plan Fairness and Due Process. – Every health benefit plan shall:

(1) Ensure that the health plan does not require hospital privileges of providers unless such privileges are necessary for the provider's provision of the full scope of services to the insured.

(2) Ensure that the plan does not discriminate with respect to participation, reimbursement, or indemnification as to any provider acting within the scope of the provider's license or certification solely on the basis of the providers' licenses or classifications.

(3) Establish relevant objective written criteria for contracting with and credentialing providers.

(4) Establish reasonable time frames for provider enrollment, which may be continuous, or, at a minimum, at least twice a year.

(5) Complete the credentialing process for contracting providers within 60 days of receipt of all information necessary to review the provider's request for participation in the plan.

(6) Make criteria for provider participation in the plan available to all providers.

(7) Allow every contracting provider to provide covered health care services to covered persons within the full scope of the contracting provider's licensure in accordance with North Carolina State law.

(b) Insurer Responsibility for Intermediaries. – For purposes of this section G.S. 58-3-100, 58-3-191, 58-3-200, 58-3-225, 58-3-230, 58-3-235, 58-67-88, 58-50-62, and 58-67-50, the duties placed on an insurer include a duty to ensure that any intermediary the insurer contracts with to provide health care under the insurer's health benefit plan complies with the requirements of this section to ensure patient access to quality managed health care. As used in this subsection, the term 'intermediary' means an entity that employs or contracts with health care providers for the provision of health care services, and that also contracts with an insurer covering the health care services under a health benefit plan."

Section 18. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-230. Health plan disclosure requirements.**

At the time of application for delivery of a health benefit plan, the insurer shall deliver to the applicant and insured a clear and concise description of the coverage provided by the plan. The description shall be printed on a form prescribed by the Commissioner. The description shall include:

(1) Definitions of terms used in the health benefit plan.

(2) A brief description of the principal benefits or coverage provided, including any coverage exclusions or limitations.

(3) A brief description of how coverage determinations are made, including whether factors other than medical necessity and coverage exclusions and limitations are considered.

(4) A brief explanation of insurer and insured payment responsibilities, including how plan allowances, such as 'usual and customary charges', are developed.

(5) A brief explanation of provider network limitations and requirements, including requirements for the use of subnetworks, when prior authorization or precertification is required, and how tertiary and quaternary care are arranged.

(6) Tax and health plan accreditation status of the insurer.

(7) A statement that the outline is a summary of the health benefit plan and that the health benefit plan should be examined to determine health benefit plan provisions.

(8) A brief explanation, including costs to the insured of how an insured may access providers outside of the network.

(9) An explanation of the insured's right to transition coverage."

Section 19. 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 established pursuant to this act.

Section 20. 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 21. This act becomes effective July 1, 2001, and Part 1 of this act applies to claims received on or after July 1, 2001.