

SENATE BILL NO. 2400

Introduced by

Senators Kilzer, DeMers

Representatives Berg, Rose

1 A BILL for an Act to create and enact four new subsections to section 26.1-04-03, four new
2 subsections to section 26.1-26.4-02, and four new sections to chapter 26.1-36 of the North
3 Dakota Century Code, relating to fairness in health insurance practices, disclosure of health
4 plan information, confidentiality of medical information maintained by health carriers, contract
5 limitations, and health care grievance procedures; and to amend and reenact subsection 14 of
6 section 26.1-04-03, subsections 4 and 5 of section 26.1-26.4-02, sections 26.1-26.4-03,
7 26.1-26.4-04, 26.1-26.4-04.1, 26.1-47-02, and subsection 2 of section 26.1-47-03 of the North
8 Dakota Century Code, relating to prohibited health insurance practices, health care utilization
9 review procedures, and preferred provider arrangements.

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

11 **SECTION 1. AMENDMENT.** Subsection 14 of section 26.1-04-03 of the 1997
12 Supplement to the North Dakota Century Code is amended and reenacted as follows:

13 14. As used in subsections 15 ~~and~~, 16, and section 2 of this Act, unless the context
14 otherwise requires:

15 a. "Entity" includes a third-party administrator ~~or other person with responsibility~~
16 ~~for contracts with health care providers under a health plan~~, an insurance
17 company as defined in section 26.1-02-01, or any other entity providing a plan
18 of health insurance or health benefits subject to state insurance regulation.

19 b. "Health care provider" means a person that delivers, administers, or
20 supervises health care products or services, for profit or otherwise, in the
21 ordinary course of business or professional practice.

22 c. "Health plan" means any public or private plan or arrangement that provides
23 or pays the cost of health benefits, including any organization of health care

- 1 providers that furnishes health services under a contract or agreement with
2 this type of plan.
- 3 d. "Medical communication" means any communication, other than a knowing
4 and willful misrepresentation, made by a health care provider to a patient
5 regarding the health care needs or treatment options of the patient and the
6 applicability of the health plan to the patient's needs or treatment. The term
7 includes communications concerning:
- 8 (1) Tests, consultations, and treatment options;
9 (2) Risks or benefits associated with tests, consultations, and options;
10 (3) Variation in experience, quality, or outcome among any health care
11 providers or health care facilities providing any medical service;
12 (4) The process, basis, or standard used by an entity to determine whether
13 to authorize or deny health care services or benefits; and
14 (5) Financial incentives or disincentives based on service utilization
15 provided by an entity to a health care provider.
- 16 e. "Medically necessary care" means health care services, supplies, or
17 treatments that a reasonably prudent physician or other health care provider
18 would provide to a patient for the prevention, diagnosis, or treatment of
19 illness, injury, or disease or their symptoms in a manner that is in accordance
20 with generally accepted standards of medical practice, clinically appropriate in
21 terms of type, frequency, extent, site, and duration, and not primarily for the
22 convenience of the patient, physician, or other health care provider.
- 23 f. "Patient" includes a former, current, or prospective patient or the guardian or
24 legal representative of any former, current, or prospective patient.

25 **SECTION 2.** Four new subsections to section 26.1-04-03 of the 1997 Supplement to
26 the North Dakota Century Code are created and enacted as follows:

27 Incentives to withhold medically necessary care. An entity may not offer a health
28 care provider, and a contract with a health care provider under a health plan may
29 not contain, an incentive plan that includes a specific payment made to, or withheld
30 from, the provider as an inducement to deny, reduce, limit, or delay medically
31 necessary care covered by the health plan and provided with respect to a patient.

1 This subsection does not prohibit incentive plans, including capitation payments or
2 shared-risk arrangements, that are not tied to specific medical decisions with
3 respect to a patient. In addition to the proceedings and penalties provided in this
4 chapter, a contract provision violating this subsection is void.

5 Retaliation for patient advocacy. An entity may not take any of the following
6 actions against a health care provider solely because the provider, in good faith,
7 reports to state or federal authorities an act or practice by the entity that
8 jeopardizes patient health or welfare, advocates on behalf of a patient in a
9 utilization review program or grievance procedure, or protests a decision, policy, or
10 practice on behalf of a patient that the provider reasonably believes interferes with
11 the provider's ability to provide medically necessary care:

- 12 a. Refusal to contract with the health care provider;
13 b. Termination of or refusal to renew a contract with the health care provider;
14 c. Refusal to refer patients to or allow others to refer patients to the health care
15 provider; or
16 d. Refusal to compensate the health care provider for covered services that are
17 medically necessary.

18 Unfair reimbursement. An entity may not require that a health care provider
19 receive under a health plan, pursuant to policies of the entity or a contract with the
20 health care provider, the lowest payment for services and items that the health
21 care provider charges or receives from any other entity. In addition to the
22 proceedings and penalties provided in this chapter, a contract provision violating
23 this subsection is void.

24 Unfair participation requirements. An entity that offers multiple health plans or
25 products may not require a health care provider, as a condition of participation in a
26 health plan or product of the entity, to participate in any of the entity's other health
27 plans or products. In addition to the proceedings and penalties provided in this
28 chapter, a contract provision violating this subsection is void.

29 **SECTION 3.** Four new subsections to section 26.1-26.4-02 of the North Dakota
30 Century Code are created and enacted as follows:

1 "Emergency medical condition" means a medical condition of recent onset and
2 severity, including severe pain, that would lead a prudent layperson acting
3 reasonably and possessing an average knowledge of health and medicine to
4 believe that the absence of immediate medical attention could reasonably be
5 expected to result in serious impairment to bodily function, serious dysfunction of
6 any bodily organ or part, or would place the person's health, or with respect to a
7 pregnant woman the health of the woman or her unborn child, in serious jeopardy.

8 "Emergency services" means health care services, supplies, or treatments
9 furnished or required to screen, evaluate, and treat an emergency medical
10 condition.

11 "Health insurance carrier" includes an insurance company as defined in section
12 26.1-02-01 or any other entity providing a plan of health insurance or health
13 benefits subject to state insurance regulation.

14 "Medical review criteria" means the written screening procedures, decision
15 abstracts, clinical protocols, and practice guidelines used by a utilization review
16 agent to determine whether health care services are medically necessary.

17 **SECTION 4. AMENDMENT.** Subsections 4 and 5 of section 26.1-26.4-02 of the North
18 Dakota Century Code are amended and reenacted as follows:

19 4. "Utilization review" means a system for prospective ~~and~~, concurrent, or
20 retrospective review of the medical necessity ~~and appropriateness in the allocation~~
21 of health care ~~resources and~~ services given or proposed to be given to an
22 individual within this state. Utilization review does not include elective requests for
23 clarification of coverage.

24 5. "Utilization review agent" means a health insurance carrier performing utilization
25 review or any other person or entity performing utilization review, except:
26 a. An agency of the federal government; or
27 b. An agent acting on behalf of the federal government or the department of
28 human services, but only to the extent that the agent is providing services to
29 the federal government or the department of human services.

1 **SECTION 5. AMENDMENT.** Section 26.1-26.4-03 of the North Dakota Century Code
2 is amended and reenacted as follows:

3 **26.1-26.4-03. Certification - Medical review criteria.**

4 1. A utilization review agent may not conduct utilization review in this state unless the
5 utilization review agent has certified to the commissioner in writing that the agent is
6 in compliance with section 26.1-26.4-04. Certification must be made annually on
7 or before March first of each calendar year. In addition, a utilization review agent
8 must file the following information:

9 4- a. The name, address, telephone number, and normal business hours of the
10 utilization review agent.

11 2- b. The name and telephone number of a person for the commissioner to contact.

12 3- c. A description of the appeal procedures for utilization review determinations
13 and any other written utilization review program descriptions and procedures
14 required by section 26.1-26.4-04.

15 4- d. A list of the third-party payers for whom the ~~private~~ utilization review agent is
16 performing utilization review in the state.

17 2. A utilization review agent shall, prior to implementing new medical review criteria or
18 substantially or materially altering existing medical review criteria, obtain input from
19 physicians actively practicing in this state and practicing in the relevant specialty
20 areas. The input must include input from physicians who are not employees of or
21 consultants to the utilization review agent. The input must be documented in a
22 manner permitting verification by the insurance commissioner. A ~~provider may~~
23 ~~request that a~~ utilization review agent shall furnish ~~the~~ a provider, upon request,
24 with the medical review criteria ~~to be~~ used in evaluating proposed or delivered
25 health care services.

26 3. Any material changes in the information filed in accordance with this section must
27 be filed with the commissioner within thirty days of the change.

28 **SECTION 6. AMENDMENT.** Section 26.1-26.4-04 of the North Dakota Century Code
29 is amended and reenacted as follows:

30 **26.1-26.4-04. Minimum standards of utilization review agents.** All utilization review
31 agents must meet the following minimum standards:

- 1 1. Utilization review program. The utilization review agent shall maintain and
2 implement a written utilization review program that describes all review activities,
3 both delegated and nondelegated, for covered services provided. The program
4 document must describe the following:
 - 5 a. Procedures to evaluate the medical necessity of health care services;
 - 6 b. Data sources and medical review criteria used in decisionmaking;
 - 7 c. The appeal procedures for utilization review decisions, including procedures
8 for notifying enrollees and providers of record of its decisions;
 - 9 d. Mechanisms to ensure consistent application of medical review criteria;
 - 10 e. Data collection processes and analytical methods used in assessing utilization
11 of health care services;
 - 12 f. Data systems used to support utilization review and enable the utilization
13 review agent to monitor health care services effectively;
 - 14 g. Provisions for assuring confidentiality of clinical and proprietary information;
 - 15 h. The organizational structure or committee that periodically assesses utilization
16 review activities and reports to the health insurance carrier's governing body;
17 and
 - 18 i. The staff position functionally responsible for daily program management.
- 19 2. Administration. A utilization review program must be administered by a physician
20 or other health care professional.
- 21 3. Medical review criteria. A utilization review program must use documented
22 medical review criteria that are based on sound clinical evidence and are evaluated
23 periodically to assure ongoing efficacy and consistent application.
- 24 4. Prior authorization or approval determinations. For a determination involving a
25 review conducted prior to an admission or a course of treatment, a utilization
26 review agent shall make the determination and provide notice by telephone of the
27 determination to the provider of record or the enrollee as soon as possible in
28 accordance with the medical exigencies of the case and no later than three
29 business days after receiving all necessary information. The utilization review
30 agent shall provide written confirmation of the telephone notification within two
31 business days of making the telephone notification.

- 1 5. Initial determination. Notification of a an initial determination by the utilization
2 review agent to certify or not to certify an admission or a course of treatment not
3 included in subsection 4, must be ~~mailed or otherwise~~ communicated by telephone
4 to the provider of record or the enrollee or other appropriate individual within two
5 business days of the receipt of the request for determination and the receipt of all
6 information necessary to complete the review.
- 7 2. The utilization review agent shall provide written confirmation of the telephone
8 notification within two business days of making the telephone notification. Any
9 adverse determination by a utilization review agent as to the necessity ~~or~~
10 ~~appropriateness~~ of an admission, service, or procedure must be reviewed by a
11 physician or, if appropriate, a licensed psychologist, or determined in accordance
12 with standards or guidelines approved by a physician or licensed psychologist.
- 13 3. 6. Specification of reasons and notice. Any notification of a determination under this
14 section not to certify an admission or ~~service or procedure~~ course of treatment
15 must include the principal reason for the determination and the procedures to
16 initiate an appeal of the determination.
- 17 7. Concurrent review. For a concurrent review determination with respect to a
18 patient's hospital stay or course of treatment, a utilization review agent shall make
19 the determination within one business day of obtaining all necessary information
20 and shall notify by telephone the provider of record or the enrollee within one
21 business day of making the determination of the decision to certify or deny an
22 extended stay or additional services. The utilization review agent shall provide
23 written confirmation of the telephone notification within one business day of making
24 the telephone notification.
- 25 8. Retrospective review. For retrospective review determinations involving reviews of
26 medical necessity conducted after services have been provided to a patient, a
27 utilization review agent shall make the determination regarding the services and
28 provide written notice of the determination to the provider of record or the enrollee
29 within thirty days of receiving all necessary information.
- 30 9. Appeals process. A utilization review agent shall provide, at a minimum, an
31 appeals process for an enrollee or provider of record to appeal any adverse

1 determination which meets the standards for first appeals and expedited appeals
2 pursuant to subsection 10 and for final appeals pursuant to subsection 15. Nothing
3 in this section otherwise prohibits an agent from providing an appeals process that
4 allows for more than two levels of appeals, except for an expedited appeals
5 process.

6 4. 10. First appeal. Utilization review agents shall maintain and make available a written
7 description of ~~the appeal~~ procedure by which enrollees or the provider of record
8 may seek ~~review~~ a first appeal of adverse determinations by the utilization review
9 agent. The first appeal procedure must provide for the following:

10 a. ~~On appeal, all determinations not to certify an admission, service, or~~
11 ~~procedure as being necessary or appropriate~~ Appeals must be made
12 evaluated by a physician who has not been involved in the initial adverse
13 determination or, if appropriate, a licensed psychologist who has not been
14 involved in the initial adverse determination.

15 b. Utilization review agents shall complete the adjudication of appeals of
16 adverse determinations ~~not to certify admissions, services, and procedures~~
17 and notify in writing the provider of record or the enrollee as soon as possible
18 in accordance with the medical exigencies of the case but no later than thirty
19 twenty days from the date the appeal is filed and the receipt of all information
20 necessary to complete the appeal. If the appeal upholds the adverse
21 determination, the written decision must contain:

22 (1) Any qualifying credentials, including specialties, of the physician or
23 psychologist evaluating the appeal;

24 (2) A statement of the utilization review agent's understanding of the
25 reason for the request for an appeal by the enrollee or provider of
26 record;

27 (3) A description of the agent's decision in clear terms and the medical
28 rationale in sufficient detail for the enrollee or provider of record to
29 respond further to the decision;

30 (4) A reference to the evidence or documentation used as the basis for the
31 decision, including the medical review criteria used to make the

- 1 determination, and instructions for requesting the medical review
2 criteria; and
3 (5) A description of the process for a subsequent appeal or a final appeal
4 pursuant to subsection 15.
- 5 c. Expedited appeal. Utilization review agents shall ~~provide for~~ maintain and
6 make available a written description of an expedited appeals process for
7 emergency or life-threatening by which an enrollee or the provider of record
8 may seek review of adverse determinations by the utilization review agent in
9 situations involving an emergency medical condition, including determinations
10 concerning an admission, availability of care, continued stay, or health care
11 service for an enrollee who has received emergency services but has not
12 been discharged. The appeal process must provide for the following:
- 13 (1) An expedited appeal must be evaluated by a physician trained in the
14 same or similar specialty as typically manages the medical condition,
15 procedure, or treatment under review who has not been involved in the
16 initial adverse determination.
- 17 (2) Utilization review agents shall complete the adjudication of expedited
18 appeals and notify by telephone the provider of record or the enrollee,
19 as expeditiously as the enrollee's medical condition requires, but within
20 forty-eight hours of the date the appeal is filed and the receipt of all
21 information necessary to complete the appeal. The utilization review
22 agent shall provide written confirmation of the telephone notification
23 within two business days of making the telephone notification.
- 24 (3) If the appeal upholds the adverse determination, the written decision
25 must contain the provisions specified in subdivision b of subsection 10
26 and the enrollee or provider of record may appeal the adverse
27 determination as a final appeal pursuant to subsection 15.
- 28 (4) A description of the process for a final appeal pursuant to subsection
29 15.
- 30 ~~5-~~ 11. Telephone system. Utilization review agents shall make staff available by toll-free
31 telephone at least forty hours per week during normal business hours.

- 1 ~~40.~~ 15. Final appeal. When an initial appeal, any subsequent appeal, or any expedited
2 appeal to reverse a an adverse determination is unsuccessful, ~~a subsequent~~
3 ~~determination regarding hospital, medical, or other health care services provided or~~
4 ~~to be provided to a patient which may result in a denial of third party~~
5 ~~reimbursement or a denial of precertification for that service~~ the enrollee or
6 provider of record may initiate a final appeal of the adverse determination pursuant
7 to the utilization review agent's appeals process. A final appeal must include the
8 following:
- 9 a. The appointment of a review panel comprised of physicians or other health
10 care professionals who have appropriate expertise and who were not
11 previously involved in the adverse determination. However, a final decision to
12 uphold the adverse determination must include the evaluation, findings, and
13 concurrence of a physician licensed to practice medicine in this state and
14 trained in the relevant same or similar specialty as typically manages the
15 medical condition, procedure, or treatment under review to make a final
16 determination that care provided or to be provided was, is, or may be
17 medically inappropriate necessary. The physician may not have been
18 previously involved in the adverse determination.
- 19 b. The holding of a meeting of the review panel within forty-five days of receiving
20 the request from an enrollee or provider of record for a final appeal. However,
21 if the request is from an adverse determination upheld on an expedited
22 appeal, the utilization review agent shall hold the review panel meeting as
23 expeditiously as the enrollee's medical condition requires.
- 24 c. The review panel meeting must provide the opportunity for the enrollee or
25 provider of record or their representative to appear in person before the
26 authorized representatives of the utilization review agent to present the
27 enrollee's case, submit supporting material, and ask questions of the
28 representatives of the utilization review agent. If the enrollee or provider of
29 record requests to appear, the review panel meeting must be held at a time
30 and location in this state reasonably accessible to the enrollee or the provider
31 of record. The enrollee or provider of record must be notified in writing at

1 least fifteen days in advance of the review date. Upon request of an enrollee
2 or provider of record, the utilization review agent shall provide the enrollee or
3 the provider of record with all relevant information that is not confidential or
4 privileged.

5 d. If the appeal upholds the adverse determination, the written decision must
6 contain the provisions specified in subdivision b of subsection 10. The
7 decision must contain the telephone number and address of the insurance
8 commissioner's office.

9 16. ~~However, the~~ The insurance commissioner may find that the standards in this
10 ~~section chapter~~ have been met if the utilization review agent has received approval
11 or accreditation by a utilization review accreditation organization that imposes
12 standards that meet or exceed the standards imposed by this chapter, as
13 determined by the commissioner.

14 **SECTION 7. AMENDMENT.** Section 26.1-26.4-04.1 of the North Dakota Century Code
15 is amended and reenacted as follows:

16 **26.1-26.4-04.1. Utilization review in this state - Conditions of employment - Scope**
17 **of chapter.**

18 1. A utilization review agent is deemed to be conducting utilization review in this state
19 if the agent conducts utilization review involving services rendered or to be
20 rendered in the state regardless of where the agent actually performs the utilization
21 review. No person may be employed or compensated as a private review agent
22 under any agreement or contract where compensation of the review agent is
23 contingent upon a denial ~~or~~ reduction, limitation, or delay in the payment for
24 hospital, medical, or other health care services.

25 2. This chapter applies to a health insurance carrier that provides or performs
26 utilization review services. The requirements of this chapter also apply to any
27 designee of the health insurance carrier that performs utilization review functions
28 on the carrier's behalf. A health insurance carrier shall monitor all utilization review
29 activities carried out by or on behalf of the carrier and ensure that the requirements
30 of this chapter and any related rules of the insurance commissioner are met. If a
31 health insurance carrier contracts to have utilization review performed by another

1 entity, the commissioner shall hold the health insurance carrier responsible for
2 ensuring that the requirements of this chapter and any related rules of the
3 commissioner are met.

4 **SECTION 8.** A new section to chapter 26.1-36 of the North Dakota Century Code is
5 created and enacted as follows:

6 **Information disclosure.** An insurance company, as defined in section 26.1-02-01, a
7 health maintenance organization, or any other entity providing a plan of health insurance or
8 health benefits subject to state insurance regulation may not deliver, issue, execute, or renew a
9 health insurance policy or health service contract unless that insurer provides the insured with a
10 plan description that discloses in writing the terms and conditions of the policy or contract. The
11 plan description must use the plain and ordinary meaning of words so as to reasonably ensure
12 comprehension by a layperson and must be made available to each insured prior to the
13 delivery, issuance, execution, or renewal of the policy or contract.

- 14 1. The information required to be disclosed by the insurer must include, in addition to
15 any other disclosures required by law:
- 16 a. A general description of benefits and covered services, including benefit limits
17 and coverage exclusions and the definition of medical necessity used by the
18 insurer in determining whether benefits will be covered;
 - 19 b. A general description of the insured's financial responsibility for payment of
20 premiums, deductibles, coinsurance, and copayment amounts, including any
21 maximum limitations on out-of-pocket expenses, any maximum limits on
22 payments for health care services, and the maximum out-of-pocket costs for
23 services that are provided by nonparticipating health care professionals;
 - 24 c. A general explanation of the extent to which benefits and services may be
25 obtained from nonparticipating providers, including any out-of-network
26 coverage or options;
 - 27 d. A general explanation of the extent to which a person covered under the
28 policy or contract may select from among participating providers and any
29 limitations imposed on the selection of participating health care providers;
 - 30 e. A general description of the insurer's use of any prescription drug formulary or
31 any other general limits on the availability of prescription drugs;

- 1 f. A general description of the procedures and any conditions for persons
2 covered under the policy or contract to change participating primary and
3 specialty providers;
- 4 g. A general description of the procedures and any conditions for obtaining
5 referrals;
- 6 h. A general description of the procedure for providing emergency services,
7 including an explanation of what constitutes an emergency situation and
8 notice that emergency services are not subject to prior authorization, the
9 procedure for obtaining emergency services and any cost-sharing applicable
10 to emergency services, including out-of-network services, and any limitation
11 on access to emergency services;
- 12 i. A general description of any utilization review policies and procedures,
13 including a description of any required prior authorizations or other
14 requirements for health care services and appeal procedures;
- 15 j. A general description of all complaint or grievance rights and procedures used
16 to resolve disputes between the insurer and persons covered under the policy
17 or contract or a health care provider, including the method for filing grievances
18 and the timeframes and circumstances for acting on grievances and appeals;
- 19 k. A general description of any methods used by the insurer for providing
20 financial payment incentives or other payment arrangements to reimburse
21 health care providers. This subdivision may not be construed as requiring
22 public disclosure of individual contracts or the specific details of financial
23 arrangements between a health care provider and an insurer;
- 24 l. Notice of appropriate mailing addresses and telephone numbers to be used
25 by persons covered under the policy or contract in seeking information or
26 authorization for treatment;
- 27 m. If applicable, notice of the provisions required by section 26.1-47-03 that
28 ensure access to health care services in preferred provider arrangements;
29 and
- 30 n. Notice that the information described in subsection 2 is available upon
31 request.

- 1 2. An insurer shall provide the following written information if requested by a person
2 covered under a policy or contract:
- 3 a. A description of any process for credentialing participating health care
4 providers;
- 5 b. A description of the policies and procedures established to ensure
6 confidentiality of patient information;
- 7 c. A description of the procedures followed by the insurer to make decisions
8 about the experimental nature of individual drugs, medical devices, or
9 treatments;
- 10 d. With regard to any preferred provider arrangement or other network health
11 plan, a list by specialty of the name and location of participating health care
12 providers and the number, types, and geographic distribution of providers
13 participating in the health plan; and
- 14 e. Whether a specifically identified drug is included or excluded from coverage.
- 15 3. Nothing in this section may be construed as preventing an insurer from making the
16 information under subsections 1 and 2 available to a person covered under the
17 policy or contract through a handbook or similar publication.

18 **SECTION 9.** A new section to chapter 26.1-36 of the North Dakota Century Code is
19 created and enacted as follows:

20 **Confidentiality of medical information.**

- 21 1. An insurance company, as defined in section 26.1-02-01, health maintenance
22 organization, or any other entity providing a plan of health insurance or health
23 benefits subject to state insurance regulation may not deliver, issue, execute, or
24 renew a health insurance policy or health service contract unless confidentiality of
25 medical information is assured pursuant to this section. An insurer shall adopt and
26 maintain procedures to ensure that all identifiable information maintained by the
27 insurer regarding the health, diagnosis, and treatment of persons covered under a
28 policy or contract is adequately protected and remains confidential in compliance
29 with all federal and state laws and regulations and professional ethical standards.
30 Unless otherwise provided by law, any data or information pertaining to the health,
31 diagnosis, or treatment of a person covered under a policy or contract, or a

- 1 prospective insured, obtained by an insurer from that person or from a health care
2 provider, regardless of whether the information is in the form of paper, is preserved
3 on microfilm, or is stored in computer-retrievable form, is confidential and may not
4 be disclosed to any person except:
- 5 a. If the data or information identifies the covered person or prospective insured
6 upon a written, dated, and signed approval by the covered person or
7 prospective insured, or by a person authorized to provide consent pursuant to
8 section 23-12-13 for a minor or an incapacitated person;
- 9 b. If the data or information identifies the health care provider upon a written,
10 dated, and signed approval by the provider. However, this subdivision may
11 not be construed to prohibit an insurer from disclosing data or information
12 pursuant to chapter 23-01.1 or from disclosing, as part of a contract or
13 agreement in which the health care provider is a party, data or information
14 that identifies a provider as part of mutually agreed upon terms and conditions
15 of the contract or agreement;
- 16 c. If the data or information does not identify either the covered person or
17 prospective insured or the health care provider, the data or information may
18 be disclosed upon request for use for statistical purposes only;
- 19 d. Pursuant to statute or court order for the production or discovery of evidence;
20 or
- 21 e. In the event of a claim or litigation between the covered person or prospective
22 insured and the insurer in which the data or information is pertinent.
- 23 2. An insurer may claim any statutory privileges against disclosure that the health
24 care provider who furnished the information to the insurer is entitled to claim.
- 25 3. This section may not be construed to prevent disclosure necessary for an insurer
26 to conduct utilization review consistent with the standards imposed by chapter
27 26.1-26.4 to facilitate payment of a claim or to reconcile or verify claims under a
28 shared risk or capitation arrangement. Nor may this section be construed to limit
29 the insurance commissioner's access to records of the insurer for purposes of
30 enforcement or other activities related to compliance with state or federal laws;
31 however, medical records acquired by the commissioner as part of an examination

1 of an insurer's business practices under section 26.1-03-19.2 or any other
2 regulatory action or proceeding commenced by the commissioner are confidential.

3 **SECTION 10.** A new section to chapter 26.1-36 of the North Dakota Century Code is
4 created and enacted as follows:

5 **Contract limitations.**

6 1. An insurance company as defined by section 26.1-02-01 issuing a health and
7 accident policy, a health maintenance organization, or any other entity providing a
8 plan of health insurance or health benefits subject to state insurance regulation
9 may not terminate a physician's participating contract, designate a physician as
10 nonpayable, or otherwise impose sanctions on any physician unless the
11 requirements of this section are met. If a physician engages in a practice pattern
12 that indicates provision of care that is not medically necessary, the entity shall
13 inform the physician, in writing, as to the manner in which the physician's practice
14 pattern indicates provision of care that is not medically necessary. The entity shall
15 consult with the physician and provide a reasonable time period of not less than six
16 months within which to modify the physician's practice pattern. If the physician's
17 practice pattern continues, the entity may impose reasonable sanctions on the
18 physician, terminate the physician's participating contract or, if the physician's
19 practice pattern thereafter continues to indicate provision of care that is not
20 medically necessary, the physician may be designated as nonpayable. If
21 considered for sanction, termination, or nonpayable status, the affected physician
22 must first be given the opportunity to be present and to be heard by a committee
23 appointed by the entity which must include a majority representation of the
24 physician's specialty. The entity may not impose sanctions on a physician,
25 terminate a physician, or designate a physician as nonpayable in the absence of
26 the committee's recommendation to do so. All reports, practice profiles, data, and
27 proceedings of the entity relative to a physician who is sanctioned, terminated, or
28 considered for designation as nonpayable are confidential and may not be
29 disclosed or be subject to subpoena or other legal process except in a legal
30 proceeding between the physician and the entity.

- 1 2. If the entity uses a practice profile as a factor in its contract review to evaluate a
2 physician's practice pattern, the entity shall disclose in its contract with the
3 physician, and upon request of the physician provide at any time, a description of
4 the criteria, data sources, and methodologies used to compile the practice profile
5 concerning the physician and the manner in which the practice profile is used to
6 evaluate the physician. An entity may not sanction a physician, terminate a
7 physician's participating contract, or designate a physician as nonpayable on the
8 basis of a practice profile without informing the physician of the specific data
9 underlying those findings. For purposes of this section, a "practice profile" means
10 a profile, summary, economic analysis, or other analysis of data concerning the
11 cost, quality, or quantity of services rendered by an individual physician, group of
12 physicians, or preferred provider. In addition, an entity in developing practice
13 profiles or otherwise measuring physician performance shall:
- 14 a. Make severity adjustments, including allowances for the severity of illness or
15 condition of the patient mix and allowances for patients with multiple illnesses
16 or conditions;
- 17 b. Periodically evaluate, with input from specialty-specific physicians as
18 appropriate, the quality and accuracy of practice profiles, data sources, and
19 methodologies;
- 20 c. Develop and implement safeguards to protect against the unauthorized use or
21 disclosure of practice profiles; and
- 22 d. Provide the opportunity for any physician at any time to examine the
23 accuracy, completeness, or validity of any practice profile concerning the
24 physician and to prepare a written response to the profile. The entity shall
25 negotiate in good faith with the physician to correct any inaccuracies or to
26 make the profile complete. If the inaccuracies or deficiencies are not
27 corrected to the satisfaction of the physician, the entity shall submit the written
28 response prepared by the physician along with the profile at the time the
29 profile is used pursuant to subsection 1 or provided to any third party
30 consistent with section 9 of this Act.

1 **SECTION 11.** A new section to chapter 26.1-36 of the North Dakota Century Code is
2 created and enacted as follows:

3 **Grievance procedures.**

- 4 1. An accident and health insurance policy may not be delivered or issued for delivery
5 by an insurance company, as defined in section 26.1-02-01, or any other entity
6 providing a plan of health insurance or health benefits subject to state insurance
7 regulation to a person in this state unless the entity establishes and maintains a
8 grievance procedure for resolving complaints by covered persons and providers
9 and addressing questions and concerns regarding any aspect of the plan, including
10 access to and availability of services, quality of care, choice and accessibility of
11 providers, and network adequacy. The grievance procedure is in addition to
12 compliance with utilization review standards, if applicable, under chapter 26.1-26.4.
13 The procedure must include:
14 a. A system to record and document, over a period of at least three previous
15 years, all grievances and appeals;
16 b. A process for the timely processing and resolution of grievances, and appeals
17 of resolutions; and
18 c. Procedures for followup action, including methods to inform the covered
19 person or provider of the resolution of the grievance.
20 2. The procedure must be approved by the insurance commissioner. The
21 commissioner may examine the grievance procedures.

22 **SECTION 12. AMENDMENT.** Section 26.1-47-02 of the North Dakota Century Code is
23 amended and reenacted as follows:

24 **26.1-47-02. Preferred provider arrangements.** Notwithstanding any provision of law
25 to the contrary, any health care insurer may enter into preferred provider arrangements.

- 26 1. Preferred provider arrangements must:
27 a. Establish the amount and manner of payment to the preferred provider. The
28 amount and manner of payment may include capitation payments for
29 preferred providers.

- 1 b. Include mechanisms, subject to the minimum standards imposed by chapter
2 26.1-26.4, which are designed to ~~minimize the cost of the health benefit plan.~~
3 ~~These mechanisms may:~~
- 4 (1) ~~Provide for the review and control of~~ the utilization of health care
5 services-
- 6 (2) ~~Establish~~ and establish a procedure for determining whether health
7 care services rendered are medically necessary.
- 8 c. Include mechanisms which are designed to preserve the quality of health
9 care.
- 10 d. With regard to an arrangement in which the preferred provider is placed at risk
11 for the cost or utilization of health care services, specifically include a
12 description of the preferred provider's responsibilities with respect to the
13 health care insurer's applicable administrative policies and programs,
14 including utilization review, quality assessment and improvement programs,
15 credentialing, grievance procedures, data reporting requirements, and any
16 applicable federal or state programs. Any administrative responsibilities or
17 costs not specifically described or allocated in the contract establishing the
18 arrangement as the responsibility of the preferred provider are the
19 responsibility of the health care insurer.
- 20 2. Preferred provider arrangements may not unfairly deny, reduce, limit, or delay
21 health benefits to persons for covered medically necessary services or interfere
22 with or alter the decision of a treating physician regarding the manner or setting in
23 which particular services are delivered if the services are covered and medically
24 necessary for treatment or diagnosis.
- 25 3. Preferred provider arrangements may not restrict a health care provider from
26 entering into preferred provider arrangements or other arrangements with other
27 health care insurers.

28 **SECTION 13. AMENDMENT.** Subsection 2 of section 26.1-47-03 of the North Dakota
29 Century Code is amended and reenacted as follows:

- 30 2. If the policy or subscriber agreement provides differences in benefit levels payable
31 to preferred providers compared to other providers, the differences may not unfairly

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1 deny, reduce, limit, or delay payment for covered services and may be no greater
2 than necessary to provide a reasonable incentive for covered persons to use the
3 preferred provider.