98343.0300

Fifty-sixth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT with House Amendments

ENGROSSED SENATE BILL NO. 2400

Introduced by

Senators Kilzer, DeMers

Representatives Berg, Rose

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

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

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

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

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

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

providers that furnishes health services under a contract or agreement with this type of plan.

d. "Medical communication" means any communication, other than a knowing and willful misrepresentation, made by a health care provider to a patient regarding the health care needs or treatment options of the patient and the applicability of the health plan to the patient's needs or treatment. The term includes communications concerning:

(1) Tests, consultations, and treatment options;

(2) Risks or benefits associated with tests, consultations, and options;

(3) Variation in experience, quality, or outcome among any health care providers or health care facilities providing any medical service;

(4) The process, basis, or standard used by an entity to determine whether to authorize or deny health care services or benefits; and

(5) Financial incentives or disincentives based on service utilization provided by an entity to a health care provider.

e. "Patient" includes a former, current, or prospective patient or the guardian or legal representative of any former, current, or prospective patient.

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

Incentives to withhold medically necessary care. An entity may not offer a health care provider, and a contract with a health care provider under a health plan may not contain, an incentive plan that includes a specific payment made to, or withheld from, the provider as an inducement to deny, reduce, limit, or delay medically necessary care covered by the health plan and provided with respect to a patient. This subsection does not prohibit incentive plans, including capitation payments or shared-risk arrangements, that are not tied to specific medical decisions with respect to a patient. In addition to the proceedings and penalties provided in this chapter, a contract provision violating this subsection is void. As used in this subsection, "medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury,

disease, or its symptoms which are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This definition does not preclude an entity from establishing a definition of "medically necessary care" for determining which services are covered by the health plan.

Retaliation for patient advocacy. An entity may not take any of the following actions against a health care provider solely because the provider, in good faith, reports to state or federal authorities an act or practice by the entity that jeopardizes patient health or welfare, or advocates on behalf of a patient in a utilization review program or grievance procedure:

a. Refusal to contract with the health care provider;

b. Termination of or refusal to renew a contract with the health care provider;

c. Refusal to refer patients to or allow others to refer patients to the health care provider; or

d. Refusal to compensate the health care provider for covered services that are medically necessary.

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

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

"Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of

any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

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

SECTION 4. AMENDMENT. Subsection 9 of section 26.1-26.4-04 of the North Dakota Century Code is amended and reenacted as follows:

9. ~~Utilization review agents shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for an enrollee or the enrollee's representative to notify the utilization review agent and request certification or continuing treatment for that condition.~~ When conducting utilization review or making a benefit determination for emergency services:
   a. A utilization review agent may not deny coverage for emergency services and may not require prior authorization of these services.
   b. Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

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

Information disclosure. An insurance company, as defined in section 26.1-02-01, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless that insurer makes available to persons covered under the policy or contract a plan description that discloses in writing the terms and conditions of the policy or contract. The plan description must use the plain and ordinary meaning of words so as to reasonably ensure comprehension by a layperson and must be made available to each person covered under the contract, in any manner reasonably assuring availability prior to the delivery, issuance, execution, or renewal of the policy or contract.

1. The information required to be disclosed by the insurer must include, in addition to any other disclosures required by law:

a. A general description of benefits and covered services, including benefit limits and coverage exclusions and the definition of medical necessity used by the insurer in determining whether benefits will be covered;

b. A general description of the insured's financial responsibility for payment of premiums, deductibles, coinsurance, and copayment amounts, including any maximum limitations on out-of-pocket expenses, any maximum limits on payments for health care services, and the maximum out-of-pocket costs for services that are provided by nonparticipating health care professionals;

c. A general explanation of the extent to which benefits and services may be obtained from nonparticipating providers, including any out-of-network coverage or options;

d. A general explanation of the extent to which a person covered under the policy or contract may select from among participating providers and any limitations imposed on the selection of participating health care providers;

e. A general description of the insurer's use of any prescription drug formulary or any other general limits on the availability of prescription drugs;

f. A general description of the procedures and any conditions for persons covered under the policy or contract to change participating primary and specialty providers;

g. A general description of the procedures and any conditions for obtaining referrals;

h. A general description of the procedure for providing emergency services, including an explanation of what constitutes an emergency situation and notice that emergency services are not subject to prior authorization, the procedure for obtaining emergency services and any cost-sharing applicable to emergency services, including out-of-network services, and any limitation on access to emergency services;

i. A general description of any utilization review policies and procedures, including a description of any required prior authorizations or other requirements for health care services and appeal procedures;

j. A general description of all complaint or grievance rights and procedures used to resolve disputes between the insurer and persons covered under the policy or contract or a health care provider, including the method for filing grievances and the timeframes and circumstances for acting on grievances and appeals;

k. A general description of any methods used by the insurer for providing financial payment incentives or other payment arrangements to reimburse health care providers;

l. Notice of appropriate mailing addresses and telephone numbers to be used by persons covered under the policy or contract in seeking information or authorization for treatment;

m. If applicable, notice of the provisions required by section 26.1-47-03 that ensure access to health care services in preferred provider arrangements; and

n. Notice that the information described in subsection 2 is available upon request.

2. An insurer shall provide the following written information if requested by a person covered under a policy or contract:

a. A description of any process for credentialing participating health care providers;

b. A description of the policies and procedures established to ensure confidentiality of patient information;

c. A description of the procedures followed by the insurer to make decisions about the experimental nature of individual drugs, medical devices, or treatments;

d. With regard to any preferred provider arrangement or other network health plan, a list by specialty of the name and location of participating health care providers and the number, types, and geographic distribution of providers participating in the health plan; and

e. Whether a specifically identified drug is included or excluded from coverage.

3. Nothing in this section may be construed as preventing an insurer from making the information under subsections 1 and 2 available to a person covered under the policy or contract through a handbook or similar publication.

SECTION 6. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Confidentiality of medical information.

1. An insurance company, as defined in section 26.1-02-01, health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless confidentiality of medical information is assured pursuant to this section. An insurer shall adopt and maintain procedures to ensure that all identifiable information maintained by the insurer regarding the health, diagnosis, and treatment of persons covered under a policy or contract is adequately protected and remains confidential in compliance with all federal and state laws and regulations and professional ethical standards. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a person covered under a policy or contract, or a prospective insured, obtained by an insurer from that person or from a health care provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except:
   a. If the data or information identifies the covered person or prospective insured upon a written, dated, and signed approval by the covered person or prospective insured, or by a person authorized to provide consent pursuant to section 23-12-13 for a minor or an incapacitated person;
   b. If the data or information identifies the health care provider upon a written, dated, and signed approval by the provider. However, this subdivision may not be construed to prohibit an insurer from disclosing data or information pursuant to chapter 23-01.1 or from disclosing, as part of a contract or agreement in which the health care provider is a party, data or information

that identifies a provider as part of mutually agreed upon terms and conditions of the contract or agreement;

c. If the data or information does not identify either the covered person or prospective insured or the health care provider, the data or information may be disclosed upon request for use for statistical purposes or research;

d. Pursuant to statute or court order for the production or discovery of evidence; or

e. In the event of a claim or litigation between the covered person or prospective insured and the insurer in which the data or information is pertinent.

2. An insurer may claim any statutory privileges against disclosure that the health care provider who furnished the information to the insurer is entitled to claim.

3. This section may not be construed to prevent disclosure necessary for an insurer to conduct utilization review or management consistent with the standards imposed by chapter 26.1-26.4, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with health care providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law. Nor may this section be construed to limit the insurance commissioner's access to records of the insurer for purposes of enforcement or other activities related to compliance with state or federal laws; however, medical records acquired by the commissioner as part of an examination of an insurer's business practices under section 26.1-03-19.2 or any other regulatory action or proceeding commenced by the commissioner are confidential.

SECTION 7. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Contract limitations.

1. An insurance company as defined by section 26.1-02-01 issuing a health and accident policy, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not terminate a

practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose sanctions on any practitioner solely for an excessive or inappropriate practice pattern unless the requirements of this section are met. If a practitioner engages in an excessive or inappropriate practice pattern for the practitioner's specialty, the entity shall inform the practitioner, in writing, as to the manner in which the practitioner's practice is excessive or inappropriate. The entity shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the practitioner's practice pattern. If the excessive or inappropriate practice pattern continues, the entity may impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable. If considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner as nonpayable in the absence of the committee's recommendation to do so. All reports, practice profiles, data, and proceedings of the entity relative to a practitioner who is sanctioned, terminated, or considered for designation as nonpayable are confidential and may not be disclosed or be subject to subpoena or other legal process. Nonpayable status under this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section "practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice in this state.

2. If the entity uses a practice profile as a factor to evaluate a practitioner's practice pattern, the entity shall provide upon request of the practitioner at any time, a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the practitioner and the manner in which the practice profile is used to evaluate the practitioner. An entity may not sanction a practitioner, terminate a practitioner's participating contract, or designate a practitioner as nonpayable on the basis of a practice profile without informing the

practitioner of the specific data underlying those findings. For purposes of this section, a "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning the cost, quality, or quantity of services rendered by an individual practitioner, group of practitioners, or preferred provider. In addition, an entity in developing practice profiles or otherwise measuring practitioner performance shall:

a. Make severity adjustments, including allowances for the severity of illness or condition of the patient mix and allowances for patients with multiple illnesses or conditions;

b. Periodically evaluate, with input from specialty-specific practitioners as appropriate, the quality and accuracy of practice profiles, data sources, and methodologies;

c. Develop and implement safeguards to protect against the unauthorized use or disclosure of practice profiles; and

d. Provide the opportunity for any practitioner at any time to examine the accuracy, completeness, or validity of any practice profile concerning the practitioner and to prepare a written response to the profile. The entity shall negotiate in good faith with the practitioner to correct any inaccuracies or to make the profile complete. If the inaccuracies or deficiencies are not corrected to the satisfaction of the practitioner, the entity shall submit the written response prepared by the practitioner along with the profile at the time the profile is used pursuant to subsection 1 or provided to any third party consistent with section 6 of this Act.

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

Grievance procedures.

1. An accident and health insurance policy may not be delivered or issued for delivery by an insurance company, as defined in section 26.1-02-01, or any other entity providing a plan of health insurance subject to state insurance regulation to a person in this state unless the entity establishes and maintains a grievance procedure for resolving complaints by covered persons and providers and

addressing questions and concerns regarding any aspect of the plan, including access to and availability of services, quality of care, choice and accessibility of providers, and network adequacy. The procedure must include a system to record and document all grievances since the date of its last examination of the grievances.

2. The procedure must be approved by the insurance commissioner. The commissioner may examine the grievance procedures.

SECTION 9. AMENDMENT. Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

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

1. Preferred provider arrangements must:
   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.
   b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to ~~minimize the cost of the health benefit plan. These mechanisms may:~~
      ~~(1)~~ ~~Provide for the~~ review and control ~~of~~ the utilization of health care services~~.~~
      ~~(2)~~ ~~Establish~~ and establish a procedure for determining whether health care services rendered are medically necessary.
   c. Include mechanisms which are designed to preserve the quality of health care.
   d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated

in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.