GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

SESSION LAW 1997-519
SENATE BILL 932

AN ACT TO AMEND THE LAWS GOVERNING HEALTH BENEFIT PLAN REPORTING AND DISCLOSURE REQUIREMENTS; TO MAKE IMPROVEMENTS IN THE OPERATIONS OF HEALTH MAINTENANCE ORGANIZATIONS IN NORTH CAROLINA; TO ESTABLISH STANDARDS FOR COVERAGE AND PROVIDER NETWORKS UNDER HEALTH INSURANCE POLICIES AND MANAGED CARE PLANS; TO REWRITE AND MODERNIZE THE LAWS ON INSURERS OFFERING PREFERRED PROVIDER BENEFIT PLANS, PREFERRED PROVIDER ORGANIZATIONS, AND PREFERRED PROVIDER BENEFIT PLANS WITH RESPECT TO COVERAGE DETERMINATIONS, MEDICAL NECESSITY, NONDISCRIMINATION AGAINST HIGH-RISK POPULATIONS, SERVICES OUTSIDE PROVIDER NETWORKS WHEN PARTICIPATING PROVIDERS ARE NOT REASONABLY AVAILABLE, AND CONTINUING CARE RETIREMENT COMMUNITY RESIDENTS; TO AMEND THE LAWS TO PROVIDE PARITY BETWEEN HEALTH MAINTENANCE ORGANIZATION POINT-OF-SERVICE PRODUCTS AND PREFERRED PROVIDER BENEFIT PLANS WITH RESPECT TO REIMBURSEMENT DIFFERENTIALS FOR COVERAGE OF HEALTH CARE PROVIDED BY NONPARTICIPATING PROVIDERS; AND TO ESTABLISH PROCEDURES AND RIGHTS FOR MANAGED CARE PLAN MEMBERS IN UTILIZATION REVIEW DECISIONS AND GRIEVANCES AGAINST MANAGED CARE ORGANIZATIONS.

Whereas, managed care is increasingly being used to deliver health care services to citizens of this State; and

Whereas, managed care's use of provider networks, precertification, utilization review, and similar features makes it critical that the State regulate the use of managed care to ensure quality, availability, and accessibility of health care services to enrollees and participants; Now, therefore,

PART I. HEALTH PLAN REPORTING AND DISCLOSURE

The General Assembly of North Carolina enacts:

Section 1.1. G.S. 58-3-190, as enacted by Senate Bill 973 of the 1997 Session, is recodified as G.S. 58-3-191 and reads as rewritten:

"**§~~58-3-190.~~ 58-3-191. Managed care reporting and disclosure requirements.**

(a) Each health benefit plan shall annually, on or before the first day of March of each year, file in the office of the Commissioner the following ~~information, to the extent applicable:~~ information for the previous calendar year:

(1) The number of and reasons for ~~complaints~~ grievances received from plan participants regarding medical ~~treatment;~~ treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every health benefit plan shall file with the Commissioner, as part of its annual grievance report, a certificate of compliance stating that the carrier has established and follows, for each of its lines of business, grievance procedures that comply with G.S. 58-50-62.

(2) The number of participants and groups who terminated coverage under the plan for any ~~reason;~~ reason. The report shall include the number of participants who terminated coverage because the group contract under which they were covered was terminated, the number of participants who terminated coverage for reasons other than the termination of the group under which they were enrolled, and the number of group contracts terminated.

(3) The number of provider contracts that were terminated ~~in the preceding year~~ and the reasons for termination. This information shall include the number of providers leaving the plan and the number of new ~~providers;~~ providers. The report shall show voluntary and involuntary terminations separately.

(4) ~~Utilization data that includes statistics~~ Data relating to the utilization, quality, availability, and accessibility of ~~services, as defined by the Commissioner; and~~ services. The report shall include the following:

a. Information on the health benefit plan's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the plan's methodology for:

1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.

2. Determining when changes in plan membership will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the health benefit plan's provider network; and an evaluation of actual plan performance against performance targets.

b. The health benefit plan's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.

c. Information on the health benefit plan's program to determine the level of provider network accessibility necessary to serve its membership. This information shall include the health benefit plan's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:

1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

d. A statement of the health benefit plan's methods and standards for determining whether in-network services are reasonably available and accessible to a covered person, for the purpose of determining whether a covered person should receive the in-network level of coverage for services received from a nonnetwork provider.

e. A description of the health benefit plan's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, plan performance, and network provider performance.

f. A summary of the health benefit plan's utilization review program activities for the previous calendar year. The report shall include the number of: each type of utilization review

performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of covered persons. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with G.S. 58-50-61.

(5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Commissioner.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:

(1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;

(2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;

(3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

(4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental.

(b1) Effective March 1, 1998, insurers shall make the reports that are required under subsection (a) of this section and that have been filed with the Commissioner available on their business premises and shall provide any insured access to them upon request.

(c) For purposes of this section, 'health benefit plan' or 'plan' means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans in which utilization review or quality management programs are used to manage the provision of

covered health care services, and enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those provided by participating providers."

Section 1.2. Article 67 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-67-11. Additional HMO application information.**

(a) In addition to the information filed under G.S. 58-67-10(c), each application shall include a description of the following:

(1) The program to be used to evaluate whether the applicant's provider network is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay.

(2) The program to be used for verifying provider credentials.

(3) The quality management program to assure quality of care and health care services managed and provided through the health care plan.

(4) The utilization review program for the review and control of health care services provided or paid for.

(5) The applicant's provider network and evidence of the ability of that network to provide all health care services to the applicant's prospective enrollees.

(b) G.S. 58-67-10(d) applies to the information specified in this section."

Section 1.3. G.S. 58-67-50(e) reads as rewritten:

"(e) Effective ~~on~~ January 1, 1989, every health maintenance organization shall provide at least minimum cost and utilization information for group contracts of 100 or more subscribers on an annual basis when requested by the group. Such information shall be compiled in accordance with the Data Collection Form developed by the Standardized HMO Date Form Task Force as endorsed by the Washington Business Group on Health and the Group Health Association of America on November 19, 1986, and any subsequent amendments. In addition, beginning with data for the calendar year 1998, every HMO, for group contracts of 1,000 or more members, shall provide cost, use of service, prevention, outcomes, and other group-specific data as collected in accordance with the latest edition of the Health Plan Employer Data and Information Set (HEDIS) guidelines, as published by the National Committee for Quality Assurance. Beginning with data for the calendar year 1998, every HMO shall file with the Commissioner and make available to all employer groups, not later than July 1 of the following calendar year, a report of health benefit plan-wide experience on its costs, use of services, and other aspects of performance, in the HEDIS format."

Section 1.4. G.S. 58-67-100 reads as rewritten:

"**§ 58-67-100. Examinations.**

(a) The Commissioner may make an examination of the affairs of any health maintenance organization and the contracts, agreements or other arrangements pursuant to its health care plan as often as ~~he~~ the Commissioner deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years. Examinations shall otherwise be conducted under G.S. 58-2-131, 58-2-132, and 58-2-133.

~~(b) Every health maintenance organization shall submit its books and records relating to the health care plan to such examinations and in every way facilitate them. For the purpose of examinations, the Commissioner may administer oaths to, and examine the officers and agents of the health maintenance organization concerning their business.~~

(c) Repealed by Session Laws 1995, c. 360, s. 2(m).

(d) ~~In lieu of such~~ Instead of conducting an examination, the Commissioner may accept the report of an examination made by the ~~Commissioner of Insurance or Commissioner of Public Health~~ HMO regulator of another state."

Section 1.5. G.S. 58-67-140 reads as rewritten:

"**§ 58-67-140. Suspension or revocation of ~~certificate of authority.~~ license.**

(a) The Commissioner may ~~suspend or revoke any certificate of authority issued to a health maintenance organization under this Article if he finds that any of the following conditions exist:~~ suspend, revoke, or refuse to renew an HMO license if the Commissioner finds that the HMO:

(1) ~~The health maintenance organization is~~ Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-67-10, unless amendments to such submissions have been filed with and approved by the Commissioner.

(2) ~~The health maintenance organization issues evidence~~ Issues evidences of coverage or uses a schedule of premiums for health care services ~~which~~ that do not comply with ~~the requirements of~~ G.S. 58-67-50.

(3) ~~The health maintenance organization no~~ No longer maintains the financial reserve specified in G.S. 58-67-40 or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(4) ~~The health maintenance organization, or any person on its behalf, has~~ Has itself or through any person on its behalf advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner.

(5) ~~The continued operation of the health maintenance organization~~ Is operating in a manner that would be hazardous to its enrollees.

(6) ~~The health maintenance organization has otherwise failed to substantially comply with this Article.~~ Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the HMO or with any order issued by the Commissioner after notice and opportunity for a hearing.

(7) Has knowingly published or made to the Department or to the public any false statement or report, including any report or any data that serves as the basis for any report, required to be submitted under G.S. 58-3-210.

(b) A ~~certificate of authority~~ license shall be suspended or revoked only after compliance with ~~the requirements of~~ G.S. 58-67-155.

(c) When ~~the certificate of authority of a health maintenance organization~~ an HMO license is suspended, the ~~health maintenance organization~~ HMO shall not, during the ~~period of such~~ suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or ~~solicitation whatsoever.~~ solicitation.

(d) When ~~the certificate of authority of a health maintenance organization~~ an HMO license is revoked, ~~such organization~~ the HMO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of ~~such organization.~~ the HMO. ~~It~~ The HMO shall engage in no advertising or ~~solicitation whatsoever.~~ solicitation. The Commissioner may, by written order, permit such further operation of the ~~organization as he~~ HMO as the Commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage."

PART II. PROVIDER NETWORKS AND COVERAGE STANDARDS

Section 2.1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-200. Miscellaneous insurance and managed care coverage and network provisions.**

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

(1) 'Health benefit plan' means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.

l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define 'medically necessary services or supplies' in its health benefit plan as those covered services or supplies that are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and not for experimental, investigational, or cosmetic purposes.

(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

(3) Within generally accepted standards of medical care in the community.

(4) Not solely for the convenience of the insured, the insured's family, or the provider.

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

(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

(d) Services Outside Provider Networks. – No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.

(e) Nondiscrimination Against High-Risk Populations. – No insurer shall establish provider selection or contract renewal standards or procedures that are designed to avoid or otherwise have the effect of avoiding enrolling high-risk populations by excluding providers because they are located in geographic areas that contain high-risk populations or because they treat or specialize in treating populations that present a risk of higher-than-average claims or health care services utilization. This subsection does not prohibit an insurer from declining to select a provider or from not renewing a contract with a provider who fails to meet the insurer's selection criteria.

(f) Continuing Care Retirement Community Residents. – As used in this subsection, 'Medicare benefits' means medical and health products, benefits, and

services used in accordance with Title XVIII of the Social Security Act. If an insured with coverage for Medicare benefits or similar benefits under a plan for retired federal government employees is a resident of a continuing care retirement community regulated under Article 64 of this Chapter, and the insured's primary care physician determines that it is medically necessary for the insured to be referred to a skilled nursing facility upon discharge from an acute care facility, the insurer shall not require that the insured relocate to a skilled nursing facility outside the continuing care retirement community if the continuing care retirement community:

(1) Is a Medicare-certified skilled nursing facility.

(2) Agrees to be reimbursed at the insurer's contract rate negotiated with similar providers for the same services and supplies.

(3) Agrees not to bill the insured for fees over and above the insurer's contract rate.

(4) Meets all guidelines established by the insurer related to quality of care, including:

a. Quality assurance programs that promote continuous quality improvement.

b. Standards for performance measurement for measuring and reporting the quality of health care services provided to insureds.

c. Utilization review, including compliance with utilization management procedures.

d. Confidentiality of medical information.

e. Insured grievances and appeals from adverse treatment decisions.

f. Nondiscrimination.

(5) Agrees to comply with the insurer's procedures for referral authorization, risk assumption, use of insurer services, and other criteria applicable to providers under contract for the same services and supplies.

A continuing care retirement community that satisfies subdivisions (1) through (5) of this subsection shall not be obligated to accept, as a skilled nursing facility, any patient other than a resident of the continuing care retirement community, and neither the insurer nor the retirement community shall be allowed to list or otherwise advertise the skilled nursing facility as a participating network provider for Medicare benefits for anyone other than residents of the continuing care retirement community."

PART III. PREFERRED PROVIDER AMENDMENTS

Section 3.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

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

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

(1) 'Insurer' means an insurer or service corporation subject to this Chapter.

(2) 'Preferred provider' means a health care provider who has agreed to accept special reimbursement or other terms for health care services from an insurer for health care services on a fee-for-service basis. A 'preferred provider' is not a health care provider participating in any prepaid health service or capitation arrangement implemented or administered by the Department of Human Resources or its representatives.

(3) 'Preferred provider benefit plan' means a health benefit plan offered by an insurer in which both of the following features are present:

a. Utilization review or quality management programs are used to manage the provision of covered health care services; and

b. Enrollees are given incentives through benefit differentials to limit the receipt of covered health care services to those furnished by participating providers, and health care services are provided by preferred providers under a contract pursuant to this section.

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

(b) Insurers may enter into preferred provider contracts or enter into other cost containment arrangements approved by the Commissioner to reduce the costs of providing health care services. These contracts or arrangements may be entered into with licensed health care providers of all kinds without regard to specialty of services or limitation to a specific type of practice.

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

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

(e) Except where specifically prohibited either by this section or by rules adopted by the Commissioner, the contractual terms and conditions for special reimbursements shall be those that the parties find mutually agreeable.

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

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

(1) Accessibility of preferred provider services to individuals within the insured group.

(2) The adequacy of the number and locations of health care providers.

(3) The availability of services at reasonable times.

(4) Financial solvency.

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

(1) The name by which the preferred provider benefit plan is known and its business address.

(2) The name, address, and nature of any PPO or other separate organization that administers the preferred provider benefit plan for the insurer.

(3) The terms of the agreements entered into by the insurer with preferred providers.

(4) Any other information necessary to determine compliance with this section, rules adopted under this section, or other requirements applicable to preferred provider benefit plans.

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

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

(k) Publications or advertisements of preferred provider benefit plans or organizations shall not refer to the quality or efficiency of the services of nonparticipating providers."

Section 3.2. Article 63 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-63-70. Health care service discount practices by insurers and service corporations.**

(a) It is an unfair trade practice for any insurer or service corporation subject to this Chapter to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged for medical services, procedures, or supplies provided by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees.

(b) It is an unfair trade practice for any person with knowledge that an insurer or service corporation intends to make the type of misrepresentation prohibited in subsection (a) of this section to provide substantial assistance to that insurer or service corporation in accomplishing that misrepresentation."

Section 3.3. G.S. 58-51-57(a) reads as rewritten:

"(a) Every policy or contract of accident or health insurance, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for pap smears and low-dose screening mammography."

Section 3.4. G.S. 58-51-58(a) reads as rewritten:

"(a) Every policy or contract of accident and health insurance, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer."

Section 3.5. G.S. 58-51-59(a) reads as rewritten:

"(a) No policy or contract of accident or health insurance, and no preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;

(2) The American Hospital Formulary Service Drug Information; or

(3) The United States Pharmacopeia Drug Information."

Section 3.6. G.S. 58-65-92(a) reads as rewritten:

"(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for pap smears and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for pap smears and low-dose screening mammography."

Section 3.7. G.S. 58-65-93(a) reads as rewritten:

"(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer."

Section 3.8. G.S. 58-65-94(a) reads as rewritten:

"(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) The American Medical Association Drug Evaluations;

(2) The American Hospital Formulary Service Drug Information; or

(3) The United States Pharmacopeia Drug Information."

Section 3.9. G.S. 58-51-61(a), as enacted by S.L. 1997-312, reads as rewritten:

"(a) Every policy or contract of accident and health insurance, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-60 that is issued, renewed, or amended on or after January 1, 1998, and that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other

limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician."

Section 3.10. G.S. 58-65-96(a), as enacted by S.L. 1997-312, reads as rewritten:

"(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56 that is issued, renewed, or amended on or after January 1, 1998, that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician."

Section 3.11. G.S. 58-51-61(a), as enacted by S.L. 1997-225, reads as rewritten:

"(a) Every policy or contract of accident or health insurance, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ benefit plan under G.S. 58-50-56 that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The insurer shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section."

Section 3.12. G.S. 58-65-91(a), as enacted by S.L. 1997-225, reads as rewritten:

"(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider ~~contract, policy, or plan as defined and regulated under G.S. 58-50-50 and G.S. 58-50-55,~~ plan under G.S. 58-50-56 that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures

used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The hospital or medical service plan shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section."

Section 3.13. If Senate Bill 843 becomes law, G.S. 58-50-65(a), as amended by Section 59 of Senate Bill 843, reads as rewritten:

"(a) Except as provided in this subsection, nothing in Articles 50 through 55 of this Chapter applies to any liability or workers' compensation insurance policy. ~~Except for G.S. 58-50-55(a), the~~ The provisions of this Article and Articles 65 and 67 of this Chapter and any administrative rules adopted under those Articles relating to preferred providers and utilization review apply to workers' compensation insurance policies and to individual and group self-funded workers' compensation insurance plans. If there is any conflict between managed care rules adopted by the Commissioner under this Chapter and managed care rules adopted by the Industrial Commission under G.S. 97-25.2, the Industrial Commission's rules govern. If there is any conflict between managed care provisions in this Chapter and in Chapter 97 of the General Statutes with respect to workers' compensation, the provisions in Chapter 97 govern."

Section 3.14. G.S. 90-14.13 reads as rewritten:

"**§ 90-14.13. Reports of disciplinary action by health care institutions; immunity from liability.**

The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in ~~G.S. 58-50-50,~~ G.S. 58-50-56, and all other provider organizations that issue credentials to physicians who practice medicine in the State, shall, after consultation with the chief of staff of such institution, report to the Board any revocation, suspension, or limitation of a physician's privileges to practice in that institution. Each such institution shall also report to the Board resignations from practice in that institution by persons licensed under this Article. The Board shall report all violations of this subsection known to it to the licensing agency for the institution involved.

Any licensed physician who does not possess professional liability insurance shall report to the Board any award of damages or any settlement of any malpractice complaint affecting his or her practice within 30 days of the award or settlement.

The chief administrative officer of each insurance company providing professional liability insurance for physicians who practice medicine in North Carolina, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund operated by a hospital authority, group, or provider shall report to the Board within 30 days:

(1) Any award of damages or settlement affecting or involving a physician it insures, or

(2) Any cancellation or nonrenewal of its professional liability coverage of a physician, if the cancellation or nonrenewal was for cause.

The Board may request details about any action and the officers shall promptly furnish the requested information. The reports required by this section are privileged and shall not be open to the public. The Board shall report all violations of this paragraph to the Commissioner of Insurance.

Any person making a report required by this section shall be immune from any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in reckless disregard of whether the report was false."

Section 3.15. G.S. 135-39.5(12) reads as rewritten:

"(12) Determining basis of payments to health care providers, including payments in accordance with ~~G.S. 58-50-55.~~ G.S. 58-50-56."

Section 3.16. G.S. 58-65-140 is repealed.

Section 3.17. G.S. 58-50-50 and G.S. 58-50-55 are repealed.

Section 3.18. G.S. 58-67-35(a)(6) reads as rewritten:

"(6) The offering and contracting for the provision or arranging of, in addition to health care services, of:

a. Additional health care services;

b. Indemnity benefits, covering out-of-area or emergency services;

c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and

d. Point-of-service products, for which the Commissioner shall adopt rules governing:

1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);

2. Product ~~limitations;~~ limitations, which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d).

3. Deposit and other financial requirements; and

4. Other requirements for marketing and administering those products."

Section 3.19. Except as modified by G.S. 58-50-56(i), as enacted in this Part, any administrative rules that were adopted by the Commissioner under the authority of G.S. 58-50-50 or G.S. 58-50-55 and that were effective before January 1, 1998, are not affected by the repeals in Section 3.17 of this act.

PART IV. UTILIZATION REVIEW AND GRIEVANCES

Section 4.1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-61. Utilization review.**

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

(1) 'Clinical peer' means a health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.

(2) 'Clinical review criteria' means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine medically necessary services and supplies.

(3) 'Covered person' means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. 'Covered person' includes another person, other than the covered person's provider, who is authorized to act on behalf of a covered person.

(4) 'Emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(5) 'Emergency services' means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(6) 'Grievance' means a written complaint submitted by a covered person about any of the following:

a. An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services.

b. Claims payment or handling; or reimbursement for services.

c. The contractual relationship between a covered person and an insurer.

d. The outcome of an appeal of a noncertification under this section.

(7) Health benefit plan' means any of the following if offered by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. 'Health benefit plan' does not mean any plan implemented or administered through the Department

of Human Resources or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

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

(8) 'Health care provider' means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9b); or a pharmacy.

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

(10) 'Insurer' means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 49 of this Chapter.

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

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

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

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

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

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

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

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

(17) 'Utilization review' means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.

b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

c. Certification. – A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.

e. Discharge planning. – The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

f. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.

g. Retrospective review. – Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

h. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

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

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

(1) A written description of the URO's activities and responsibilities, including reporting requirements.

(2) Evidence of formal approval of the utilization review organization program by the insurer.

(3) A process by which the insurer evaluates the performance of the URO.

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

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services.

(2) Data sources and clinical review criteria used in decision making.

(3) The process for conducting appeals of noncertifications.

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions.

(5) Data collection processes and analytical methods used in assessing utilization of health care services.

(6) Provisions for assuring confidentiality of clinical and patient information in accordance with State and federal law.

(7) The organizational structure (e.g., utilization review committee, quality assurance, or other committee) that periodically assesses utilization review activities and reports to the insurer's governing body.

(8) The staff position functionally responsible for day-to-day program management.

(9) The methods of collection and assessment of data about underutilization and overutilization of health care services and how the assessment is used to evaluate and improve procedures and criteria for utilization review.

(d) Program Operations. – In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section.

(e) Insurer Responsibilities. – Every insurer shall:

(1) Routinely assess the effectiveness and efficiency of its utilization review program.

(2) Coordinate the utilization review program with its other medical management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management.

(3) Provide covered persons and their providers with access to its review staff by a toll-free or collect call telephone number whenever any provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.

(4) Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care services.

(5) Have written procedures for making utilization review decisions and for notifying covered persons of those decisions.

(6) Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review. If a provider or covered person fails to release necessary information in a timely manner, the insurer may deny certification.

(f) Prospective and Concurrent Reviews. – As used in this subsection, 'necessary information' includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the covered person's provider within three business days after the insurer obtains all necessary information about the admission, procedure, or health care service. If an insurer certifies a health care service, the insurer shall notify the covered person's provider. For a noncertification, the insurer shall notify the covered person's provider and send written or electronic confirmation of the noncertification to the covered person. In concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification.

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

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request.

(i) Requests for Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications. The reconsideration shall be conducted between the covered person's provider and a medical doctor designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section.

(j) Appeals of Noncertifications. – Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to

seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor who was not involved in the noncertification.

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. The written decision shall contain:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.

(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.

(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.

(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.

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

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to

those procedures. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

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

(o) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70."

Section 4.2. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-62. Insurer grievance procedures.**

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

(b) Availability of Grievance Process. – Every insurer shall have a grievance process whereby a covered person may voluntarily request a review of any decision, policy, or action of the insurer that affects that covered person. The grievance process may provide for an immediate informal consideration by the insurer of a grievance. If the insurer does not have a procedure for informal consideration or if an informal consideration does not resolve the grievance, the grievance process shall provide for first- and second-level reviews of grievances; except that an appeal of a noncertification that has been reviewed under G.S. 58-50-61 shall be reviewed as a second-level grievance under this section.

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

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

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

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

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

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

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

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be

represented by an attorney, the insurer may also be represented by an attorney.

(2) An insurer shall convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the insurer or URO, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, an insurer that uses a clinical peer on an appeal of a noncertification under G.S. 58-50-61 or on a first-level grievance review panel under this section may use one of the insurer's employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

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

(1) The review panel shall schedule and hold a review meeting within 45 days after receiving a request for a second-level review.

(2) The covered person shall be notified in writing at least 15 days before the review meeting date.

(3) The covered person's right to a full review shall not be conditioned on the covered person's appearance at the review meeting.

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

(1) The professional qualifications and licensure of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.

(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.

(7) A statement that the decision is the insurer's final determination in the matter.

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

(i) Expedited Second-Level Procedures. – An expedited second-level review shall be made available where medically justified as provided in G.S. 58-50-61(l), whether or not the initial review was expedited. The provisions of subsections (f), (g), and (h) of this section apply to this subsection except for the following timetable: When a covered person is eligible for an expedited second-level review, the insurer shall conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

(j) No insurer shall discriminate against any provider based on any action taken by the provider under this section or G.S. 58-50-61 on behalf of a covered person.

(k) Violation. – A violation of this section subjects an insurer to G.S. 58-2-70."

Section 4.3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.22A. Medical review committees.**

(a) As used in this section, 'medical review committee' means a committee composed of health care providers licensed under this Chapter that is formed for the purpose of evaluating the quality of, cost of, or necessity for health care services, including provider credentialing. 'Medical review committee' does not mean a medical review committee established under G.S. 131E-95.

(b) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(c) The proceedings of a medical review committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1 or G.S. 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this Chapter or a hospital licensed under Chapter 122C or Chapter 131E of the General Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about his or her testimony before the committee or any opinions formed as a result of the committee hearings.

(d) This section applies to a medical review committee, including a medical review committee appointed by one of the entities licensed under Articles 1 through 67 of Chapter 58 of the General Statutes.

(e) Subsection (c) of this section does not apply to proceedings initiated under G.S. 58-50-61 or G.S. 58-50-62."

Section 4.4. G.S. 58-50-60 is repealed.

PART V. EFFECTIVE DATE AND APPLICABILITY

Section 5. This act becomes effective January 1, 1998. Part II of this act applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 1998. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan. Insurers other than health maintenance organizations that are subject to Part IV of this act have until July 1, 1998, to implement the procedures for grievances that are contained in Section 4.2 of Part IV of this act; provided, however, that insurers other than health maintenance organizations shall comply with the second-level grievance review procedures in Section 4.2 of Part IV of this act for appeals of noncertifications effective January 1, 1998.

In the General Assembly read three times and ratified this the 28th day of August, 1997.

Approved 10:40 a.m. this 17th day of September, 1997