

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001**

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1

HOUSE BILL 30*

Short Title: HMO Patient Protection.

(Public)

Sponsors: Representatives Nye; Allred, Cole, Crawford, Dedmon, Luebke, Smith, Wainwright, Warwick, Weiss, and Womble.

Referred to: Rules, Calendar, and Operations of the House.

February 1, 2001

A BILL TO BE ENTITLED

1
2 AN ACT TO PROVIDE THAT A MANAGED CARE ENTITY PROVIDING A
3 HEALTH BENEFIT PLAN IS LIABLE FOR DAMAGES FOR HARM TO ITS
4 INSUREDS OR ENROLLED CAUSED BY THE MANAGED CARE ENTITY'S
5 FAILURE TO EXERCISE ORDINARY CARE AND TO PROVIDE
6 STANDARDS FOR THE ESTABLISHMENT AND MAINTENANCE OF
7 EXTERNAL REVIEW PROCEDURES IN HEALTH INSURANCE AND
8 MANAGED CARE TO ASSURE THAT COVERED PERSONS HAVE THE
9 OPPORTUNITY FOR AN INDEPENDENT REVIEW OF APPEALS OF
10 NONCERTIFICATION DECISIONS AND SECOND LEVEL GRIEVANCE
11 REVIEW DECISIONS MADE BY THE INSURER OR MANAGED CARE PLAN
12 AND TO MAKE CONFORMING AMENDMENTS TO EXISTING LAW ON
13 UTILIZATION REVIEW AND GRIEVANCES.

14 The General Assembly of North Carolina enacts:

15 **SECTION 1.** The title of Article 50 of Chapter 58 of the General Statutes
16 reads as rewritten:

"ARTICLE 50.

"General Accident and Health Insurance Regulations."

17
18
19 **SECTION 2.** Article 50 of Chapter 58 of the General Statutes is amended as
20 follows:

- 21 (1) By designating G.S. 58-50-1 through G.S. 58-50-45 as Part 1 with the
22 heading "Miscellaneous Provisions."
- 23 (2) By designating G.S. 58-50-50 through G.S. 58-50-64 as Part 2 with the
24 heading "PPOs, Utilization Review and Grievances."
- 25 (3) By designating G.S. 58-50-65 through G.S. 58-50-70 as Part 3 with the
26 heading "Scope and Sanctions."

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

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

5 **SECTION 3.** G.S. 58-50-151 is recodified as G.S. 58-51-116.

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

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

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

11 "Part 4. Health Benefit Plan External Review.

12 **"§ 58-50-75. Purpose, scope, and definitions.**

13 (a) The purpose of this Part is to provide standards for the establishment and
14 maintenance of external review procedures to assure that covered persons have the
15 opportunity for an independent review of an appeal decision upholding a
16 noncertification or a second-level grievance review decision upholding a
17 noncertification, as defined in this Part.

18 (b) This Part applies to all persons that provide or perform utilization review.
19 With respect to second-level grievance review decisions, this Part applies only to
20 second-level grievance review decisions involving noncertification decisions.

21 (c) In addition to the definitions in G.S. 58-50-61(a), as used in this Part:

22 (1) 'Covered benefits' or 'benefits' means those benefits consisting of
23 medical care, provided directly through insurance or otherwise and
24 including items and services paid for as medical care, under the terms
25 of a health benefit plan.

26 (2) 'Disclose' means to release, transfer, or otherwise divulge protected
27 health information to any person other than the individual who is the
28 subject of the protected health information or his or her legal guardian,
29 including the custodial parent(s) of a minor child.

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

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

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

44 **"§ 58-50-76:** Reserved for future codification.

1 "§ 58-50-77. Notice of right to external review.

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

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

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

9 (b) The insurer shall include in the notice required under subsection (a) of this
10 section for a notice related to an appeal decision under G.S. 58-50-61, a statement
11 informing the covered person that:

12 (1) If the covered person has a medical condition where the time frame for
13 completion of an expedited review of a grievance involving an appeal
14 decision under G.S. 58-50-61 would reasonably be expected to
15 seriously jeopardize the life or health of the covered person or
16 jeopardize the covered person's ability to regain maximum function,
17 the covered person may file a request for an expedited external review
18 under G.S. 58-50-82 at the same time the covered person files a
19 request for an expedited review of a grievance involving an appeal
20 decision under G.S. 58-50-61 and G.S. 58-50-62, but that the
21 organization assigned to conduct the expedited external review will
22 determine whether the covered person shall be required to complete
23 the expedited review of the grievance before conducting the expedited
24 external review.

25 (2) If the insurer has not issued a written decision to the covered person
26 within 45 days after the date the covered person files the grievance
27 with the insurer pursuant to G.S. 58-50-62 and the covered person has
28 not requested or agreed to a delay, the covered person may file a
29 request for external review under G.S. 58-50-80 of this section and
30 shall be considered to have exhausted the insurer's internal grievance
31 process for purposes of G.S. 58-50-79.

32 (c) The insurer shall include in the notice required under subsection (a) of this
33 section for a notice related to a final second-level grievance review decision under G.S.
34 58-50-62, a statement informing the covered person that:

35 (1) If the covered person has a medical condition where the time frame for
36 completion of a standard external review under G.S. 58-50-80 would
37 reasonably be expected to seriously jeopardize the life or health of the
38 covered person or jeopardize the covered person's ability to regain
39 maximum function, the covered person may file a request for an
40 expedited external review under G.S. 58-50-82; or

41 (2) If the second-level grievance review decision concerns an admission,
42 availability of care, continued stay, or health care service for which the
43 covered person received emergency services, but has not been

1 discharged from a facility, the covered person may request an
2 expedited external review under G.S. 58-50-82.

3 (d) In addition to the information to be provided under subsections (b) and (c) of
4 this section, the insurer shall include a copy of the description of both the standard and
5 expedited external review procedures the insurer is required to provide under G.S. 58-
6 50-93, including the provisions in the external review procedures that give the covered
7 person the opportunity to submit additional information.

8 (e) An insurer that has collected protected health information under a valid
9 authorization under this Part may use and disclose the protected health information to a
10 person acting on behalf of or at the direction of the insurer for the performance of the
11 insurer's insurance functions: claims administration, claims adjustment and
12 management, fraud investigation, underwriting, loss control, rate-making functions,
13 reinsurance, risk management, case management, disease management, quality
14 assessment, quality improvement, provider credentialing verification, utilization review,
15 peer review activities, appeal and grievance procedures, policyholder service functions,
16 internal administration of compliance, managerial, and information systems; compliance
17 with the external review process under G.S. 58-50-80 and G.S. 58-50-82; and
18 responding to legal action involving a noncertification by the insurer. Additional
19 insurance functions may be allowed for the purpose of this subsection with the prior
20 approval of the Commissioner. The protected health information shall not be used or
21 disclosed for any purpose other than in those described in this subsection, except with
22 the prior written consent of the covered person or his or her legal guardian, including
23 custodial parent.

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

26 **"§ 58-50-78: Reserved for future codification.**

27 **"§ 58-50-79. Exhaustion of internal grievance process.**

28 (a) Except as provided in subsections (d) and (e) of this section, a request for an
29 external review under G.S. 58-50-80 or G.S. 58-50-82 shall not be made until the
30 covered person has exhausted the insurer's internal grievance process under G.S. 58-50-
31 62.

32 (b) A covered person shall be considered to have exhausted the insurer's internal
33 grievance process for purposes of this section, if the covered person:

34 (1) Has filed a second-level grievance involving a noncertification appeal
35 decision under G.S. 58-50-61 and G.S. 58-50-62.

36 (2) Except to the extent the covered person requested or agreed to a delay,
37 has not received a written decision on the grievance from the insurer
38 within 45 days since the date the covered person filed the grievance
39 with the insurer.

40 (c) Notwithstanding subsection (b) of this section, a covered person may not
41 make a request for an external review of a noncertification involving a retrospective
42 review determination made under G.S. 58-50-61 until the covered person has exhausted
43 the insurer's internal grievance process.

1 (d) At the same time a covered person files a request for an expedited appeal
2 involving a noncertification as set forth in G.S. 58-50-61(l), the covered person may file
3 a request for an expedited external review of the noncertification under G.S. 58-50-82 if
4 the covered person has a medical condition where the time frame for completion of an
5 expedited review of the appeal involving a noncertification set forth in G.S. 58-50-61(l)
6 would be reasonably expected to seriously jeopardize the life or health of the covered
7 person or would jeopardize the covered person's ability to regain maximum function.
8 An insurer may waive its right to conduct an expedited review of an appeal and allow
9 the covered person to proceed with an expedited external review of the noncertification.

10 (e) Upon receipt of a request for an expedited external review under subsection
11 (d) of this section, the organization conducting the external review in accordance with
12 the provisions of G.S. 58-50-82 shall immediately determine whether the covered
13 person shall be required to complete the expedited review process set forth in G.S. 58-
14 50-61(j) before it conducts the expedited external review, unless the insurer has waived
15 its right to conduct an expedited review of the appeal decision.

16 (f) Upon a determination made under subsection (e) of this section that the
17 covered person must first complete the expedited appeal process under G.S. 58-50-61(j),
18 the organization immediately shall notify the covered person and the insurer of this
19 determination and that it will not proceed with the expedited external review under G.S.
20 58-50-82 until completion of the expedited appeal process and the covered person's
21 grievance at the completion of the expedited appeal process remains unresolved.

22 (g) A request for an external review of a noncertification may be made before the
23 covered person has exhausted the insurer's internal grievance procedures under G.S. 58-
24 50-61 and G.S. 58-50-62 whenever the insurer agrees to waive the exhaustion
25 requirement.

26 (h) If the requirement to exhaust the insurer's internal grievance procedures is
27 waived under subsection (g) of this section, the covered person may file a request in
28 writing for a standard external review as set forth in G.S. 58-50-80 or may make a
29 request for an expedited external review as set forth in G.S. 58-50-82.

30 **"§ 58-50-80. Standard external review.**

31 (a) Within 60 days after the date of receipt of a notice of a noncertification
32 appeal decision or a second-level grievance review decision under G.S. 58-50-77, a
33 covered person may file a request for an external review with the Commissioner.

34 (b) Upon receipt of a request for an external review under subsection (a) of this
35 section, the Commissioner immediately shall notify and send a copy of the request to
36 the insurer that made the decision which is the subject of the request. The insurer shall
37 immediately submit to the Commissioner the information required for the preliminary
38 review under subsection (c) of this section.

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

- 42 (1) The individual is or was a covered person in the health benefit plan at
43 the time the health care service was requested or, in the case of a

1 retrospective review, was a covered person in the health benefit plan at
2 the time the health care service was provided.

3 (2) The health care service that is the subject of the noncertification appeal
4 decision or the second-level grievance review decision upholding a
5 noncertification reasonably appears to be a covered service under the
6 covered person's health benefit plan.

7 (3) The covered person has exhausted the insurer's internal appeal and
8 grievance processes under G.S. 58-50-61 and 58-50-62 unless the
9 covered person is not required to exhaust the insurer's internal appeal
10 or grievance process under G.S. 58-50-79.

11 (4) The covered person has provided all the information and forms
12 required by the Commissioner that are necessary to process an external
13 review, including the authorization form provided under G.S. 58-50-
14 77(e).

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

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

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

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

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

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

36 (f) If the request is not complete, the Commissioner shall request from the
37 covered person the information or materials needed to make the request complete. The
38 covered person shall furnish the Commissioner with the requested information or
39 materials within 90 days after the date of the insurer's decision for which external
40 review is requested. If the request is not accepted for external review, the Commissioner
41 shall inform the covered person and the insurer in writing of the reasons for its
42 nonacceptance.

43 (g) If the insured does not select an organization of his or her choice and notify
44 the Commissioner of the selection within five days after receipt of the Commissioner's

1 notice under subsection (e) of this section, the Commissioner shall systematically assign
2 an appropriate independent review organization that has been approved under G.S. 58-
3 50-85 to conduct the external review. In reaching a decision, the assigned organization
4 is not bound by any decisions or conclusions reached during the insurer's utilization
5 review process or the insurer's internal grievance process under G.S. 58-50-61 and G.S.
6 58-50-62.

7 (h) Within seven days after the date of receipt of the notice provided under
8 subsection (e) of this section, the insurer or its designee utilization review organization
9 shall provide to the assigned organization, the documents and any information
10 considered in making the noncertification appeal decision or the second-level grievance
11 review decision. Except as provided in subsection (i) of this section, failure by the
12 insurer or its designee utilization review organization to provide the documents and
13 information within the time specified in this subsection shall not delay the conduct of
14 the external review.

15 (i) If the insurer or its utilization review organization fails to provide the
16 documents and information within the time specified in subsection (h) of this section,
17 the assigned organization may terminate the external review and make a decision to
18 reverse the noncertification appeal decision or the second-level grievance review
19 decision. Immediately upon making the decision under this subsection, the organization
20 shall notify the covered person, the insurer, and the Commissioner.

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

28 (k) Upon receipt of the information required to be forwarded under subsection (j)
29 of this section, the insurer may reconsider its noncertification appeal decision or second-
30 level grievance review decision that is the subject of the external review.
31 Reconsideration by the insurer of its noncertification appeal decision or second-level
32 grievance review decision under this subsection shall not delay or terminate the external
33 review. The external review shall be terminated if the insurer decides, upon completion
34 of its reconsideration, to reverse its noncertification appeal decision or second-level
35 grievance review decision and provide coverage or payment for the requested health
36 care service that is the subject of the noncertification appeal decision or second-level
37 grievance review decision.

38 (l) Immediately upon making the decision to reverse its noncertification appeal
39 decision or second-level grievance review decision under subsection (k) of this section,
40 the insurer shall notify the covered person, the organization, and the Commissioner in
41 writing of its decision. The organization shall terminate the external review upon receipt
42 of the notice from the insurer sent under this subsection.

43 (m) In addition to the documents and information provided under subsections (h)
44 and (i) of this section, the assigned organization, to the extent the documents or

1 information are available and the organization considers them appropriate, shall
2 consider the following in reaching a decision:

- 3 (1) The covered person's medical records.
- 4 (2) The attending health care provider's recommendation.
- 5 (3) Consulting reports from appropriate health care providers and other
6 documents submitted by the insurer, covered person, or the covered
7 person's treating provider.
- 8 (4) The terms of coverage under the covered person's health benefit plan
9 with the insurer to ensure that the organization's decision shall not be
10 contrary to the terms of coverage under the covered person's health
11 benefit plan with the insurer.
- 12 (5) The most appropriate practice guidelines, which may include generally
13 accepted practice guidelines, evidence-based practice guidelines, or
14 any other practice guidelines developed by the federal government,
15 national or professional medical societies, boards, and associations.
16 Local practice guidelines may be used when appropriate.
- 17 (6) Any applicable clinical review criteria developed and used by the
18 insurer or its designee utilization review organization.
- 19 (7) Medical necessity, as defined in G.S. 58-3-200(b).

20 (n) Within 45 days after the date of receipt by the Commissioner of the request
21 for external review, the assigned organization shall provide written notice of its decision
22 to uphold or reverse the noncertification appeal decision or second-level grievance
23 review decision to the covered person, the insurer, and the Commissioner.

24 (o) The organization shall include in the notice sent under subsection (n) of this
25 section:

- 26 (1) A general description of the reason for the request for external review.
- 27 (2) The date the organization received the assignment from the
28 Commissioner to conduct the external review.
- 29 (3) The date the organization received information and documents
30 submitted by the covered person and by the insurer.
- 31 (4) The date the external review was conducted.
- 32 (5) The date of its decision.
- 33 (6) The principal reason or reasons for its decision.
- 34 (7) The clinical rationale for its decision.
- 35 (8) References to the evidence or documentation, including the practice
36 guidelines, considered in reaching its decision.
- 37 (9) The professional qualifications and licensure of the clinical peer
38 reviewers.
- 39 (10) Notice to the covered person that he or she is not liable for the cost of
40 the external review.

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

1 "§ 58-50-81: Reserved for future codification.

2 "§ 58-50-82. Expedited external review.

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

6 (1) An appeal decision under G.S. 58-50-61(k) or (l) upholding a
7 noncertification if:

8 a. The noncertification appeal decision involves a medical
9 condition of the covered person for which the time frame for
10 completion of an expedited second-level grievance review of a
11 noncertification set forth in G.S. 58-50-62(i) would reasonably
12 be expected to seriously jeopardize the life or health of the
13 covered person or jeopardize the covered person's ability to
14 regain maximum function; and

15 b. The covered person has filed a request for an expedited second-
16 level review of a noncertification as set forth in G.S. 58-50-
17 61(i); or

18 (2) A second-level grievance review decision under G.S. 58-60-62(h) or
19 (i) upholding a noncertification:

20 a. If the covered person has a medical condition where the time
21 frame for completion of a standard external review under G.S.
22 58-50-80 would reasonably be expected to seriously jeopardize
23 the life or health of the covered person or jeopardize the
24 covered person's ability to regain maximum function; or

25 b. If the second-level grievance concerns a noncertification of an
26 admission, availability of care, continued stay, or health care
27 service for which the covered person received emergency
28 services, but has not been discharged from a facility.

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

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

34 (2) For a request that the Commissioner has determined meets the
35 reviewability requirements set forth in G.S. 58-50-80(c), assign an
36 organization that has been approved under G.S. 58-50-87. The
37 organization shall immediately determine whether the request should
38 be reviewed on an expedited basis because the time frame for
39 completion of a standard external review under G.S. 58-50-80 would
40 reasonably be expected to seriously jeopardize the life or health of the
41 covered person or would jeopardize the covered person's ability to
42 regain maximum function. The organization shall then inform the
43 covered person, insurer, and Commissioner of its determination and

1 conduct a review and make a decision on the review within the
2 appropriate time frame.

3 (c) In reaching a decision, the assigned organization is not bound by any
4 decisions or conclusions reached during the insurer's utilization review process or
5 internal grievance process under G.S. 58-50-61 and G.S. 58-50-62.

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

11 (e) In addition to the documents and information provided or transmitted under
12 subsection (d) of this section, the assigned organization, to the extent the information or
13 documents are available and the organization considers them appropriate, shall consider
14 the following in reaching a decision:

15 (1) The covered person's pertinent medical records.

16 (2) The attending health care provider's recommendation.

17 (3) Consulting reports from appropriate health care providers and other
18 documents submitted by the insurer, covered person, or the covered
19 person's treating provider.

20 (4) The terms of coverage under the covered person's health benefit plan
21 with the insurer to ensure that the organization's decision shall not be
22 contrary to the terms of coverage under the covered person's health
23 benefit plan with the insurer.

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

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

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

33 (f) As expeditiously as the covered person's medical condition or circumstances
34 require, but not more than four days after the date of receipt of the request for an
35 expedited external review, the assigned organization shall make a decision to uphold or
36 reverse the noncertification appeal decision or second-level grievance review decision
37 and notify the covered person, the insurer, and the Commissioner of the decision.

38 (g) If the notice provided under subsection (f) of this section was not in writing,
39 within two days after the date of providing that notice, the assigned organization shall
40 provide written confirmation of the decision to the covered person, the insurer, and the
41 Commissioner and include the information set forth in G.S. 58-50-80(o). Upon receipt
42 of the notice, a decision under subsection (f) of this section reversing the
43 noncertification appeal decision or second-level grievance review decision, the insurer
44 immediately shall approve the coverage that was the subject of the noncertification.

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

3 **"§ 58-50-83: Reserved for future codification.**

4 **"§ 58-50-84. Binding nature of external review decision.**

5 (a) An external review decision is binding on the insurer.

6 (b) An external review decision is binding on the covered person except to the
7 extent the covered person has other remedies available under applicable federal or State
8 law.

9 (c) A covered person may not file a subsequent request for external review
10 involving the same noncertification appeal decision or second-level grievance review
11 decision for which the covered person has already received an external review decision
12 under this Part.

13 **"§ 58-50-85. Approval of independent review organizations.**

14 (a) The Commissioner shall approve independent review organizations eligible to
15 be assigned to conduct external reviews under this Part to ensure that an organization
16 satisfies the minimum qualifications established under G.S. 58-50-87. The
17 Commissioner shall develop an application form for initially approving and for
18 reapproving organizations to conduct external reviews.

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

23 (c) The Commissioner may, in his discretion, determine that accreditation by a
24 nationally recognized private accrediting entity with established and maintained
25 standards for independent review organizations that meet the minimum qualifications
26 established under G.S. 58-50-87 will cause an independent review organization to be
27 deemed to have met, in whole or in part, the requirements of this section and G.S. 58-
28 50-87. A decision by the Commissioner to recognize an accreditation program for the
29 purpose of granting deemed status may be made only after reviewing the accreditation
30 standards and program information submitted by the accrediting body. An independent
31 review organization seeking deemed status due to its accreditation shall submit original
32 documentation issued by the accrediting body to demonstrate its accreditation.

33 (d) The Commissioner may charge an application fee that independent review
34 organizations shall submit to the Commissioner with an application for approval and
35 reapproval.

36 (e) An approval is effective for two years, unless the Commissioner determines
37 before expiration of the approval that the independent review organization is not
38 satisfying the minimum qualifications established under G.S. 58-50-87.

39 (f) Whenever the Commissioner determines that an independent review
40 organization no longer satisfies the minimum requirements established under G.S. 58-
41 50-87, the Commissioner shall terminate the approval of the independent review
42 organization and remove the independent review organization from the list of
43 independent review organizations approved to conduct external reviews under this Part
44 that is maintained by the Commissioner under subsection (g) of this section.

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

3 "§ 58-50-86: Reserved for future codification.

4 "§ 58-50-87. Minimum qualifications for independent review organizations.

5 (a) As a condition of approval under G.S. 58-50-85 to conduct external reviews,
6 an independent review organization shall have and maintain written policies and
7 procedures that govern all aspects of both the standard external review process and the
8 expedited external review process set forth in G.S. 58-50-80 and G.S. 58-50-82 that
9 include, at a minimum:

10 (1) A quality assurance mechanism in place that ensures:

11 a. That external reviews are conducted within the specified time
12 frames and required notices are provided in a timely manner.

13 b. The selection of qualified and impartial clinical peer reviewers
14 to conduct external reviews on behalf of the independent review
15 organization and suitable matching of reviewers to specific
16 cases.

17 c. The confidentiality of medical and treatment records and
18 clinical review criteria.

19 d. That any person employed by or under contract with the
20 independent review organization adheres to the requirements of
21 this Part.

22 (2) A toll-free telephone service to receive information on a 24-hour-day,
23 seven-day-a-week basis related to external reviews that is capable of
24 accepting, recording, or providing appropriate instruction to incoming
25 telephone callers during other than normal business hours.

26 (3) Agree to maintain and provide to the Commissioner the information
27 set out in G.S. 58-50-90.

28 (4) A program for credentialing clinical peer reviewers.

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

31 (b) All clinical peer reviewers assigned by an independent review organization to
32 conduct external reviews shall be medical doctors or other appropriate health care
33 providers who meet the following minimum qualifications:

34 (1) Be an expert in the treatment of the covered person's injury, illness, or
35 medical condition that is the subject of the external review.

36 (2) Be knowledgeable about the recommended health care service or
37 treatment through recent or current actual clinical experience treating
38 patients with the same or similar injury, illness, or medical condition
39 of the covered person.

40 (3) If the covered person's treating provider is a medical doctor, hold a
41 nonrestricted license from the North Carolina Medical Board and, if a
42 specialist medical doctor, a current certification by a recognized
43 American medical specialty board in the area or areas appropriate to
44 the subject of the external review.

1 (4) If the covered person's treating provider is not a medical doctor, hold a
2 nonrestricted North Carolina license, registration, or certification in the
3 same allied health occupation as the covered person's treating provider.

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

9 (c) In addition to the requirements set forth in subsection (a) of this section, an
10 independent review organization may not own or control, be a subsidiary of or in any
11 way be owned or controlled by, or exercise control with a health benefit plan, a national,
12 State, or local trade association of health benefit plans, or a national, State, or local trade
13 association of health care providers.

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

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

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

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

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

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

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

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

1 "§ 58-50-88: Reserved for future codification.

2 "§ 58-50-89. Hold harmless for independent review organizations.

3 No independent review organization or clinical peer reviewer working on behalf of
4 an organization shall be liable in damages to any person for any opinions rendered
5 during or upon completion of an external review conducted under this Part, unless the
6 opinion was rendered in bad faith or involved gross negligence.

7 "§ 58-50-90. External review reporting requirements.

8 (a) An organization assigned under G.S. 58-50-80 or G.S. 58-50-82 to conduct
9 an external review shall maintain written records in the aggregate and by insurer on all
10 requests for external review for which it conducted an external review during a calendar
11 year and submit a report to the Commissioner, as required under subsection (b) of this
12 section.

13 (b) Each organization required to maintain written records on all requests for
14 external review under subsection (a) of this section for which it was assigned to conduct
15 an external review shall submit to the Commissioner, at least annually, a report in the
16 format specified by the Commissioner.

17 (c) The report shall include in the aggregate and for each insurer:

18 (1) The total number of requests for external review.

19 (2) The number of requests for external review resolved and, of those
20 resolved, the number resolved upholding the noncertification appeal
21 decision or second-level grievance review decision and the number
22 resolved reversing the noncertification appeal decision or second-level
23 grievance review decision.

24 (3) The average length of time for resolution.

25 (4) A summary of the types of coverages or cases for which an external
26 review was sought, as provided in the format required by the
27 Commissioner.

28 (5) The number of external reviews under G.S. 58-50-80(k) and (l) that
29 were terminated as the result of a reconsideration by the insurer of its
30 noncertification appeal decision or second-level grievance review
31 decision after the receipt of additional information from the covered
32 person.

33 (6) Any other information the Commissioner may request or require.

34 (d) The organization shall retain the written records required under this section
35 for at least three years.

36 (e) Each insurer shall maintain written records in the aggregate and for each type
37 of health benefit plan offered by the insurer on all requests for external review of which
38 the insurer receives notice from the Commissioner under this Part. The insurer shall
39 retain the written records required under this section for at least three years.

40 "§ 58-50-91: Reserved for future codification.

41 "§ 58-50-92. Funding of external review.

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

1 **"§ 58-50-93. Disclosure requirements.**

2 (a) Each insurer shall include a description of the external review procedures in
3 or attached to the policy, certificate, membership booklet, outline of coverage, or other
4 evidence of coverage it provides to covered persons.

5 (b) The description required under subsection (a) of this section shall include a
6 statement that informs the covered person of the right of the covered person to file a
7 request for an external review of a noncertification appeal decision or a second-level
8 grievance review decision upholding a noncertification with the Commissioner. The
9 statement shall include the telephone number and address of the Commissioner.

10 (c) In addition to subsection (b) of this section, the statement shall inform the
11 covered person that, when filing a request for an external review, the covered person
12 will be required to authorize the release of any medical records of the covered person
13 that may be required to be reviewed for the purpose of reaching a decision on the
14 external review.

15 **"§ 58-50-94. Competitive selection of independent review organizations.**

16 (a) The Commissioner shall prepare and publish requests for proposals from
17 independent review organizations that want to be approved under G.S. 58-50-85. All
18 proposals shall be sealed. The Commissioner shall open all proposals in public.

19 (b) After the public opening, the Commissioner shall review the proposals,
20 examining the costs and quality of the services offered by the independent review
21 organizations, the reputation and capabilities of the independent review organizations
22 submitting the proposals, and the provisions in G.S. 58-50-85 and G.S. 58-50-87. The
23 Commissioner shall determine which proposal or proposals would satisfy the provisions
24 of this Part. The Commissioner shall make his determination in consultation with an
25 evaluation committee whose membership includes representatives of insurers subject to
26 Part 4 of Article 50 of Chapter 58 of the General Statutes, health care providers, and
27 insureds. In selecting the review organizations, in addition to considering cost, quality,
28 and adherence to the requirements of the request for proposals, the Commissioner shall
29 consider the desirability and feasibility of contracting with multiple review
30 organizations in order to allow insureds a choice of review organizations and shall
31 ensure that at least one review organization is available to and capable of reviewing
32 cases involving highly specialized services and treatments of any nature. The
33 Commissioner may reject any or all proposals.

34 (c) An independent review organization may seek to modify or withdraw a
35 proposal only after the public opening and only on the basis that the proposal contains
36 an unintentional clerical error as opposed to an error in judgment. An independent
37 review organization seeking to modify or withdraw a proposal shall submit to the
38 Commissioner a written request, with facts and evidence in support of its position,
39 before the determination made by the Commissioner under subsection (b) of this
40 section, but not later than two days after the public opening of the proposals. The
41 Commissioner shall promptly review the request, examine the nature of the error, and
42 determine whether to permit or deny the request.

43 (d) The provisions of Article 3C of Chapter 143 of the General Statutes do not
44 apply to this Part.

1 **"§ 58-50-95. Report by Commissioner.**

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

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

8 "(13) 'Noncertification' means a determination by an insurer or its
9 designated utilization review organization that an admission,
10 availability of care, continued stay, or other health care service has
11 been reviewed and, based upon the information provided, does not
12 meet the insurer's requirements for medical necessity,
13 appropriateness, health care setting, level of care or effectiveness,
14 or does not meet the prudent layperson standard for coverage of
15 emergency services in G.S. 58-3-190, and the requested service is
16 therefore denied, reduced, or terminated. A 'noncertification' is not
17 a decision rendered solely on the basis that the health benefit plan
18 does not provide benefits for the health care service in question, if
19 the exclusion of the specific service requested is clearly stated in
20 the certificate of coverage. A 'noncertification' includes any
21 situation in which an insurer or its designated agent makes an
22 evaluation or review of medical information about a covered
23 person's condition to determine whether a requested treatment is
24 experimental, investigational, or cosmetic and the extent to which
25 coverage under the health benefit plan is affected by that decision."

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

27 "g. Retrospective review. – Utilization review of medically
28 necessary services and supplies that is conducted after
29 services have been provided to a patient, but not the review of
30 a claim that is limited to an evaluation of reimbursement
31 levels, veracity of documentation, accuracy of coding, or
32 adjudication for payment. Retrospective review includes the
33 review of claims for emergency services to determine
34 whether the prudent layperson standard in G.S. 58-3-190 has
35 been met."

36 **SECTION 8.** G.S. 58-50-61(i) reads as rewritten:

37 "(i) Requests for Informal Reconsideration. – An insurer may establish
38 procedures for informal reconsideration of noncertifications and if established, such
39 procedures shall be in writing. The reconsideration shall be conducted between the
40 covered person's provider and a medical doctor licensed to practice medicine in this
41 State designated by the ~~insurer~~ insurer, after a written notice of noncertification has
42 been issued in accordance with subsection (h) of this section. An insurer shall not
43 require a covered person to participate in an informal reconsideration before the covered
44 person may appeal a noncertification under subsection (j) of this section. If, after

1 informal reconsideration the insurer upholds the noncertification decision, the insurer
2 shall issue a new notice in accordance with subsection (h) of this section. If the insurer
3 is unable to render an informal reconsideration decision in fewer than 10 business days,
4 it shall treat the request for informal reconsideration as a request for an appeal, except
5 that the requirements of subsection (k) of this section shall apply on or before the 10th
6 business day after receipt of the request for an informal reconsideration."

7 **SECTION 9.** G.S. 58-50-62 is amended by adding a new subsection to read:

8 "(b1) Informal Consideration of Grievances. – If the insurer provides procedures
9 for informal considerations of grievances, the procedures shall be in writing and the
10 following requirements apply:

11 (1) If the grievance concerns a clinical issue and the informal
12 consideration decision is not in favor of the covered person, the insurer
13 shall treat the request as a request for a first-level grievance review,
14 except that the requirements of subdivision (e)(1) of this section shall
15 apply on the 10th business day after receipt of the grievance.

16 (2) If the grievance concerns a nonclinical issue and the informal
17 consideration decision is not in favor of the covered person, the insurer
18 shall issue a written decision that includes the information set forth in
19 G.S. 58-50-62(c).

20 (3) If the insurer is unable to render an informal consideration decision
21 within 10 business days of receipt of the grievance, the insurer shall
22 treat the request as a request for a first-level grievance review, except
23 that the requirements of subdivision (e)(1) of this section shall apply
24 on the 10th business day after receipt of the grievance."

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

26 "(5) A statement advising the covered person of the covered person's
27 right to request a second-level grievance review and a description of
28 the procedure for submitting a second-level grievance under ~~G.S. 58-~~
29 ~~50-62.~~ G.S. 58-50-62 if the insurer's decision on the appeal is to
30 uphold its noncertification."

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

32 "e. A statement advising the covered person of his or her right to
33 request a second-level grievance review and a description of
34 the procedure for submitting a second-level grievance under
35 this ~~section.~~ section if the insurer's decision on the first-level
36 grievance review is not in favor of the covered person."

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

38 "(7) A statement that the decision is the insurer's final determination in
39 the matter. In cases where the review concerned a noncertification
40 and the insurer's decision on the second-level grievance review is to
41 uphold its initial noncertification, a statement advising the covered
42 person of his or her right to request an external review and a
43 description of the procedure for submitting a request for external
44 review to the Commissioner of Insurance."

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

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

10 **SECTION 15.** Chapter 90 of the General Statutes is amended by adding a
11 new Article to read:

12 "Article 1G.

13 "Health Care Liability.

14 "§ 90-21.50. Legislative findings and intent.

15 (a) The General Assembly finds that a wide variety of entities are integrating the
16 functions of paying for health care, determining what health care is paid for, and
17 providing the care. This integration of functions is breaking down traditional
18 distinctions. Increasingly, payor determinations are governing health care and
19 controlling decisions that in the past were the exclusive domain of health care providers
20 and patients. The General Assembly further finds that this integration of functions
21 makes it imperative that managed care entities be held fully responsible for the
22 consequences of their decisions, much as health care professionals have been held
23 responsible for the consequences of their decisions.

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

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

35 "§ 90-21.51. Definitions.

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

37 (1) 'Health benefit plan' means an accident and health insurance policy or
38 certificate; a nonprofit hospital or medical service corporation
39 contract; a health maintenance organization subscriber contract; a plan
40 provided by a multiple employer welfare arrangement; or a plan
41 provided by another benefit arrangement. 'Health benefit plan' does not
42 mean any plan implemented or administered by the North Carolina or
43 United States Department of Health and Human Services, or any

1 successor agency, or its representatives. 'Health benefit plan' does not
2 mean any of the following kinds of insurance:

- 3 a. Accident.
4 b. Credit.
5 c. Disability income.
6 d. Long-term or nursing home care.
7 e. Medicare supplement.
8 f. Specified disease.
9 g. Dental or vision.
10 h. Coverage issued as a supplement to liability insurance.
11 i. Workers' compensation.
12 j. Medical payments under automobile or homeowners'.
13 k. Hospital income or indemnity.
14 l. Insurance under which benefits are payable with or without
15 regard to fault and that is statutorily required to be contained in
16 any liability policy or equivalent self-insurance.
17 m. Short-term limited duration health insurance policies as defined
18 in Part 144 of Title 45 of the Code of Federal Regulations.

19 (2) 'Health care provider' means:

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

27 'Health care provider' includes:

- 28 1. An agent or employee of a health care facility that is
29 licensed, certified, or otherwise authorized to provide
30 health care services;
31 2. The officers and directors of a health care facility; and
32 3. An agent or employee of a health care provider who is
33 licensed, certified, or otherwise authorized to provide
34 health care services.

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

- 37 a. Provides testing, diagnosis, or treatment of a human disease or
38 dysfunction; or
39 b. Dispenses drugs, medical devices, medical appliances, or
40 medical goods for the treatment of a human disease or
41 dysfunction.

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

- 43 a. Is made by a managed care entity;

- 1 b. Governs the extent to which health care services are provided
2 for, arranged for, paid for, or reimbursed under a health benefit
3 plan; and
4 c. Affects the quality of the diagnosis, care, or treatment provided
5 under the health benefit plan to an enrollee or insured of the
6 health benefit plan.
- 7 (5) 'Insured or enrollee' means a person that is insured by or enrolled in a
8 health benefit plan under a policy, plan, certificate, or contract issued
9 or delivered in this State by an insurer.
- 10 (6) 'Insurer' means any entity that is or should be licensed under Article 6,
11 7, 16, 49, 65, or 67 of this Chapter.
- 12 (7) 'Managed care entity' means an insurer that:
13 a. Delivers, administers, or undertakes to provide for, arrange for,
14 or reimburse for health care services, or assumes the risk for
15 the delivery of health care services; and
16 b. Has a system or technique to control or influence the quality,
17 accessibility, utilization, or costs and prices of health care
18 services delivered or to be delivered to a defined enrollee
19 population.
- 20 'Managed care entity' does not include: (i) an employer purchasing coverage
21 or acting on behalf of its employees or the employees of one or more subsidiaries or
22 affiliated corporations of the employer, or (ii) a health care provider.
- 23 (8) 'Ordinary care' means:
24 a. For a carrier or managed care entity, that degree of care that a
25 carrier or managed care entity of ordinary prudence would use
26 under the same or similar circumstances.
27 b. For a person that is an agent or employee of a carrier or
28 managed care entity, that degree of care that a person of
29 ordinary prudence in the same profession, specialty, or area of
30 practice as the person would use in the same or similar
31 circumstances.
- 32 (9) 'Physician' means:
33 a. An individual licensed as a medical doctor under Article 1 of
34 this Chapter to practice medicine in this State;
35 b. A professional association or corporation comprising medical
36 doctors and organized under Chapter 55B of the General
37 Statutes; or
38 c. A person or entity wholly owned by medical doctors.

39 **"§ 90-21.52. Duty to exercise ordinary care; liability for damages for harm.**

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

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

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

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

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

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

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

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

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

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

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

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

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

1 **"§ 90-21.53. No liability under this Article on the part of an employer or employer**
2 **group purchasing organization that purchases coverage or assumes risk**
3 **on behalf of its employees or a physician or health care provider.**

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

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

14 (c) This Article does not create any liability on the part of a physician or health
15 care provider in addition to that otherwise imposed under existing law. No managed
16 care entity held liable under this Article shall be entitled to contribution under Chapter
17 1B of the General Statutes from a physician or health care provider.

18 **"§ 90-21.54. Separate trial required.**

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

23 **"§ 90-21.55. Punitive damages.**

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

26 **"§ 90-21.56. Exhaustion of administrative remedies and appeals.**

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

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

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

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

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

40 **SECTION 16.** G.S. 1A-1, Rule 42, reads as rewritten:

41 **"Rule 42. Consolidation; separate trials.**

42 (a) Consolidation – ~~When~~ Except as provided in subdivision (b)(2) of this
43 section, when actions involving a common question of law or fact are pending in one
44 division of the court, the judge may order a joint hearing or trial of any or all the matters

1 in issue in the actions; he may order all the actions consolidated; and he may make such
2 orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.
3 When actions involving a common question of law or fact are pending in both the
4 superior and the district court of the same county, a judge of the superior court in which
5 the action is pending may order all the actions consolidated, and he may make such
6 orders concerning proceedings therein as may tend to avoid unnecessary costs or delay.

7 (b) Separate trials. –

8 (1) The court may in furtherance of convenience or to avoid prejudice and
9 shall for considerations of venue upon timely motion order a separate
10 trial of any claim, ~~crossclaim~~, ~~cross-claim~~, counterclaim, or third-party
11 claim, or of any separate issue or of any number of claims,
12 ~~crossclaims~~, ~~cross-claims~~, counterclaims, third-party claims, or issues.

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

19 **SECTION 17.** This act becomes effective December 1, 2002.