GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

H D

HOUSE BILL DRH40233-MR-42

Short Title:	The CARE FIRST Act.	(Public)
Sponsors:	Representative Bell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ENACT THE CUT AUTHORIZATION RED TAPE EFFICIENTLY AND FACILITATE INTERVENTIONS RAPIDLY, START TREATMENT ACT.

The General Assembly of North Carolina enacts:

PART I. UPDATES TO HEALTH INSURANCE UTILIZATION REVIEW

SECTION 1.(a) G.S. 58-50-61 reads as rewritten:

"**§ 58-50-61. Utilization review.**

(a) Definitions. – ~~As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:~~The following definitions apply in this section:

(1) ~~"Certificate of coverage" includes a~~ Certificate of coverage. – A policy of insurance issued to an individual person or a franchise policy issued pursuant to G.S. 58-51-90.

(1a) Chronic or long-term condition. – A condition that has an expected duration of one year or more and that (i) requires ongoing medical attention, (ii) limits activities of daily living, or (iii) both.

(1b) ~~"Clinical peer" means a health care~~ Clinical peer. – A healthcare professional who holds an unrestricted license in a state of the United States, in the same or similar ~~specialty,~~ specialty as those subject to utilization review and who also routinely provides the ~~health care~~ healthcare services subject to utilization review.

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

(2a) Closely related service. – A healthcare service subject to utilization review that is closely related in purpose, diagnostic utility, or designated healthcare billing code; that was provided on the same date of service as another healthcare service that was authorized to be performed by a previous utilization review determination; and for which a provider, acting within the scope of the provider's license and expertise, may reasonably be expected to perform in conjunction with, or in lieu of, the originally authorized service due to differences in the observed patient characteristics or needs for diagnostic information that were not readily identifiable until the provider was performing the originally authorized service. The term does not include an order for, or administration of, a prescription drug or any part of a series or course of treatments.

(2b) Course of treatment. – Any prescribed order or all ordered treatments, including all prescription drugs and medical therapies, for a specific covered person with a specific condition that is outlined and decided upon ahead of time with the covered person and healthcare provider.

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

(4) ~~"Emergency~~ Emergency medical ~~condition" means a~~ condition. – 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:

…

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

(6) ~~"Grievance" means a~~ Grievance. – 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~~ healthcare services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the ~~health care~~ service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

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

…

(8) ~~"Health care provider" means any~~ Healthcare provider. – Any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide ~~health care~~ healthcare services in the ordinary care of ~~business or practice or a profession~~ business, practice, or profession, or in an approved education or training program; in a health care ~~facility~~ facility, as defined in G.S. 131E-176(9b) or the laws of another state to operate as a health care facility; or in a pharmacy.

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

(10) ~~"Insurer" means an~~ Insurer. – 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 50A of this Chapter.

(11) ~~"Managed care plan" means a~~ Managed care plan. – 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~~ Medically necessary services or ~~supplies" means those~~ supplies. – Those covered services or supplies that ~~are:~~meet any of the following criteria:

a. ~~Provided~~ Are provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

b. Except as allowed under G.S. 58-3-255, are not for experimental, investigational, or cosmetic purposes.

c. ~~Necessary~~ Are necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

d. ~~Within~~ Provision of the services or supplies is within generally accepted standards of medical care in the community.

e. ~~Not~~ Are not provided solely for the convenience of the insured, the insured's family, or the provider.

…

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

(14) ~~"Participating provider" means a~~ Participating provider. – A provider who, under a contract with an insurer or with an insurer's contractor or subcontractor, has agreed to provide ~~health care~~ healthcare services to covered persons in return for direct or indirect payment from the insurer, other than cost-sharing by the covered person, such as coinsurance, copayments, or deductibles.

(14a) Prior authorization. – The process by which insurers and utilization review organizations determine the medical necessity or medical appropriateness of otherwise covered healthcare services prior to the rendering of those healthcare services. Prior authorization includes any insurer's or utilization review organization's requirement that a covered person or healthcare provider notify the insurer or utilization review organization prior to providing a healthcare service.

(15) ~~"Provider" means a health care~~ Provider. – A healthcare provider.

(16) ~~"Stabilize" means to~~ Stabilize. – 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)~~ Centers for Medicare and Medicaid Services interpretative

guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency ~~cases (as provided~~ cases under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, ~~42 U.S.C.S. § 1395dd),~~ 42 U.S.C.S. § 1395dd, and including any medically necessary services and supplies to maintain stabilization until the person is transferred.

(16a) Urgent healthcare service. – A healthcare service with respect to which the application of the time periods for making a non-expedited utilization review that, in the opinion of a medical doctor with knowledge of the covered person's medical condition, could either (i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function or (ii) subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. The term urgent healthcare service includes mental and behavioral healthcare services.

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

…

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~~ healthcare setting, level of care, and effectiveness.

d. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of ~~treatment.~~treatment and for which payment will be made for that service.

…

e1. Prior authorization.

…

(18) ~~"Utilization~~ Utilization review ~~organization" or "URO" means an~~ organization or URO. – 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.

…

(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:~~including all of the following:

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

…

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

…

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

…

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

(d) ~~Program Operations.~~ Clinical Review Criteria, Generally. – 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 at least annually to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review ~~criteria.~~ criteria, provided that the clinical review meets, at a minimum, all of the following standards:

(1) The criteria used is based on applicable nationally recognized medical standards.

(2) The clinical review and standards used are consistent with applicable government guidelines.

(3) The clinical review provides for the delivery of a healthcare service in a clinically appropriate type, frequency, and setting and for a clinically appropriate duration.

(4) The criteria used in the clinical review reflects the current medical and scientific evidence regarding emerging procedures, clinical guidelines, and best practices, as articulated in independent, peer-reviewed medical literature.

(5) The clinical review is sufficiently flexible to allow deviations from the norm when justified on a case-by-case basis to ensure access to care.

(d1) Clinical Review Criteria, Substance Use Treatment. – Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be ~~either (i)~~ the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related ~~Disorders or (ii) criteria adopted by the insurer or its URO.~~ Disorders. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

(d2) Administration of Program. – All of the following shall apply in the administration of a utilization review program under this section:

(1) Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. ~~A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications.~~ An insurer and its URO shall ensure that all noncertifications are made by a medical doctor possessing a current and valid license to practice medicine in this State who (i) is of the same specialty as the healthcare provider who typically manages the medical condition or disease or provides the healthcare service involved in the request and (ii) has experience treating patients with the condition or disease for which the healthcare service is being requested. Medical doctors shall issue noncertifications under the clinical direction of one of the insurer's medical directors responsible for the provision of healthcare services provided to covered persons.

(2) Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions.

(3) Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render.

(4) In issuing a utilization review decision, an insurer ~~shall: obtain~~ or its URO shall do all of the following:

a. Obtain all information required to make the decision, including pertinent clinical ~~information; employ~~ information.

b. Employ a process to ensure that utilization reviewers apply clinical review criteria ~~consistently; and issue~~ consistently.

c. Apply the decision in a timely manner pursuant to this section.

(d3) Consultation Prior to Issuing Noncertifications. – If an insurer or its URO is questioning the medical necessity of a healthcare service, then the covered person's relevant provider shall be notified that medical necessity is being questioned within five business days of the date the insurer or its URO received the utilization review request for the healthcare service in question. Prior to issuing a noncertification, the covered person's provider shall be given the opportunity to discuss the medical necessity of the healthcare service by telephonic or tele-video means with the medical doctor who will be responsible for making the utilization review determination of the healthcare service under review. The insurer or its URO is required to make documented personal contact with the covered person's provider, or with the medical staff of that provider, via telephone before the five business days otherwise required under this section for notification.

(e) Insurer Responsibilities. – Every insurer ~~shall:~~shall do all of the following regarding its utilization review process under this section:

…

(7) Maintain a complete, publicly available list of healthcare services for which utilization review is required, including for all healthcare services where utilization review is to be performed by an entity under contract with the insurer.

(8) Ensure that its URO is in compliance with this section.

(f) Time Lines for Prospective and Concurrent Utilization Reviews Based Upon Type of Healthcare Service. – As used in this subsection, the term "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.~~ The time line for completion of a prospective or current utilization review is as follows:

(1) Non-urgent healthcare services. – An insurer or its URO shall both render a utilization review determination or noncertification concerning non-urgent healthcare services and notify the covered person and the covered person's provider of that determination or noncertification within 48 hours of obtaining all necessary information to make the utilization review determination or noncertification.

(2) Urgent healthcare services. – An insurer or its URO shall both render a utilization review determination or noncertification concerning urgent healthcare services and notify the covered person and the covered person's provider of that determination or noncertification not later than 24 hours after receiving all necessary information needed to complete the review of the requested healthcare services.

(3) Emergency services. – All of the following shall apply to utilization review for emergency services:

a. Utilization review shall not be required for prehospital transportation or the provision of emergency services.

b. A minimum period of 24 hours following the provision of emergency services to or an emergency admission of a covered person shall be allowed for a covered person or the relevant provider to notify an insurer or its URO of the admission or provision of emergency services. If the admission or emergency service occurs on a State or federal holiday or on a weekend, then notification shall not be required

until the next business day after the admission or provision of the emergency services.

c. An insurer shall cover emergency services necessary to screen and stabilize a covered person. If a provider attests in writing to an insurer within 72 hours of a covered person's admission that the covered person's condition required emergency services, then that attestation creates a presumption that the emergency services were medically necessary and that presumption may be rebutted only if the insurer is able to establish, with clear and convincing evidence, that the emergency services were not medically necessary.

d. The medical necessity or appropriateness of emergency services shall not be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency services provided by nonparticipating providers cannot be greater than restrictions that apply when those same services are provided by participating providers.

e. If a covered person receives an emergency service that requires one or more immediate post-evaluation or post-stabilization services, then an insurer or its URO shall make a utilization review determination for those services within 60 minutes of receiving a request. If the authorization determination is not made within 60 minutes, then the services for which the utilization review was requested are deemed approved.

(f1) Utilization Review Requests for Additional Information. – If an insurer or its URO requests additional information to process a claim subject to utilization review, then an insurer shall notify the provider of the specific information necessary to complete the utilization review and the specific purpose of the request. The notification shall reference all relevant clinical and administrative criteria and be written in easily understandable language. The notification shall be sent to the provider as soon as possible but not later than 48 hours after receipt of the initial utilization review request. The requesting provider or a member of the requesting provider's clinical or administrative staff may submit the specified additional information within 14 business days of the notification that clinical information is missing. Any claim subject to a request for additional information shall be processed within the time periods for prompt payment of claims pursuant to G.S. 58-3-225.

(f2) Utilization Review Determination Notifications. – If an insurer certifies a ~~health care~~ healthcare service, ~~the insurer shall notify~~ notification shall be sent to the covered person's provider. ~~For~~ If an insurer issues a noncertification, ~~the insurer shall notify the covered person's provider and send~~ then written or electronic confirmation of the noncertification shall be sent to the covered person's provider and covered ~~person. In~~ person that is in compliance with subsection (h) of this section.

(f3) Concurrent Review Liability. – For concurrent reviews, the insurer shall remain liable for ~~health care~~ healthcare services until the covered person has been notified of the noncertification.

(g) Retrospective Reviews. – As used in this subsection, the term "necessary information" includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, an insurer or its URO 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,~~ If a noncertification is issued, then the insurer or its URO shall give written notification to the covered person and the covered person's provider within five business days after ~~making~~ issuing

the noncertification. The notice of the noncertification shall meet all requirements under subsection (h) of this section.

(g1) Retrospective Denial. – Subject to subsection (n1) of this section, an insurer may not revoke, limit, condition, or restrict a utilization review determination if care that has been previously certified by the insurer or its URO is provided within 45 business days from the date the provider received the utilization review determination. An insurer is required to pay a provider at the contracted payment rate for a healthcare service provided by the provider per a utilization review determination unless any of the following apply:

(1) The provider knowingly and materially misrepresented the healthcare service in the utilization review request with the specific intent to deceive and obtain an unlawful payment from the insurer.

(2) The healthcare service was no longer a covered benefit on the day it was provided.

(3) The provider was no longer contracted with the covered person's health benefit plan on the date the care was provided.

(4) The provider failed to meet the insurer's timely filing requirements.

(5) The insurer does not have liability for the claim.

(6) The covered person was no longer eligible for healthcare coverage on the day the care was provided.

(h) Requirements for Notice of Noncertification. – A written notification of a noncertification made in accordance with this section shall include all reasons for the noncertification, including the clinical rationale, the name and medical specialty of all medical doctors that were involved in the noncertification, 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. An insurer shall also inform the covered person in writing about the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~program.

(h1) Failure to Make a Timely Utilization Review Determination. – An insurer or its URO failing to approve, deny, or request additional information for a requested utilization review within the applicable time frames under this section is deemed to have approved the request.

(i) Requests for Informal Reconsideration. – An insurer may establish procedures for informal reconsideration of noncertifications and, if established, the procedures shall be in writing. After a written notice of noncertification has been issued in accordance with ~~subsection (h) of~~ this section, the reconsideration shall be conducted between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section. If, after informal reconsideration, the insurer upholds the noncertification decision, then the insurer shall issue a new notice ~~in accordance with subsection (h)~~ that meets the requirements of this section. If the insurer is unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, ~~it~~ then the insurer shall treat the request for informal reconsideration as a request for an ~~appeal; provided that~~ appeal and the requirements of subsection (k) of this section for acknowledging the request shall apply beginning on the day the insurer determines an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

(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 licensed to practice medicine in this State who was not involved in the noncertification.

(j1) Requirements Applicable to Appeals Reviews. – All appeals shall be reviewed by a medical doctor who meets all of the following criteria:

(1) Possesses a current and valid non-restricted license to practice medicine in this State.

(2) Is currently in active practice for a period of at least five consecutive years in the same or similar specialty as a medical doctor who typically manages the medical condition or disease for which utilization review is required.

(3) Is knowledgeable of, and has experience providing, the healthcare services under appeal.

(4) Has not been directly involved in making the adverse determination.

As part of the appeals review, the medical doctor shall consider all known clinical aspects of the healthcare service under review, including all pertinent medical records and any medical literature that have been provided by the covered person's provider or by a health care facility.

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer or its URO 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 or its URO shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, then the written decision shall ~~contain:~~contain all of the following information:

(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.

(6) Notice of the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~program.

(*l*) Expedited Appeals. – An expedited appeal of a noncertification may be requested by a covered person or ~~his or her~~ the 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 licensed to practice medicine in this State, provide expedited review, and the insurer or its URO 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, then the insurer shall remain liable for the coverage of ~~health care~~

healthcare 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 of Utilization Review Requirements. – Information required to be provided under this section shall be described in detail and in easily understandable language. All of the following apply to an insurer's responsibility to disclose any utilization review procedures:

(1) Coverage and member handbook. – 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 also include in the certificate of coverage and the member handbook information about the availability of assistance from the Department's Health Insurance Smart NC, including the telephone number and address of the ~~Program.~~ program.

(2) Prospective materials. – An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons.

(3) Membership cards. – An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes.

(4) Website. – An insurer shall make any current utilization review requirements and restrictions readily accessible on its website.

(m1) Changes to Utilization Review. – If an insurer intends either to implement a new utilization review requirement or restriction or to amend an existing requirement or restriction, then all of the following apply:

(1) The new or amended requirement or restriction shall not be in effect unless and until the insurer's website has been updated to reflect the new or amended requirement or restriction. A claim shall not be denied for failure to obtain a prior authorization if the new or amended requirement or restriction was not in effect on the date of service of the claim.

(2) The insurer shall provide participating providers written notice of the new or amended requirement or restriction no less than 60 calendar days before the requirement or restriction is implemented.

This subsection does not apply if an insurer removes a utilization review requirement or restriction or amends a requirement or restriction to be less restrictive.

(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 five years or, for domestic companies, 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.

(n1) Utilization Review Statistics. – An insurer using utilization review shall make statistics available regarding utilization review approvals and noncertifications on its website in a readily accessible format and shall update the information available, at a minimum, on a monthly basis. These statistics shall include the most recent 12-month rolling data reported separately for medications and procedural codes for all of the following:

(1) The total number of medications and procedural codes subject to utilization review, and specifically prior authorization.

(2) The percentage of medications and procedural codes requiring prior authorization.

(3) The reasons for any noncertifications issued.

(4) The number and percentage of utilization review determinations that are appealed and the number and percentage of appeals that are approved or denied at each stage of the appeal process.

(5) The average time and distribution by percentile of number of days between submission and response of each stage of the appeal process.

(6) The number and percentage of providers who qualify for an exemption from the utilization review process under this section.

(n2) Utilization Review Determination Validity. – A utilization review determination shall be valid for the entire duration of the approved course of treatment and shall be effective regardless of any changes in dosage for a prescription drug prescribed by a provider. If an insurer requires a utilization review determination for a healthcare service for the treatment of a chronic or long-term care condition, then the utilization review determination shall remain valid for the length of the treatment and the insurer may not require the covered person to obtain a utilization review determination again for the healthcare service.

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

(p) Continuity of Care. – The following requirements shall apply to ensure continuity of care for covered persons:

(1) On receipt from a covered person or the covered person's provider of information documenting a prior utilization review determination, an insurer shall honor a utilization review determination granted to the covered person from a previous insurer for at least 90 calendar days of a covered person's coverage under a new health benefit plan. During this 90-day time period, an insurer may perform its own utilization review.

(2) If the insurer makes a change in coverage of, or approval criteria for, a previously authorized healthcare service, then the change in coverage or approval criteria shall not affect a covered person who received a utilization review determination before the effective date of the change for the remainder of that covered person's health benefit plan year.

(3) An insurer shall continue to honor a utilization review determination that the insurer or its URO certified for a covered person when that covered person changes products or health benefit plans under the same insurer, provided that the medically necessary services or supplies subject to the utilization review determination do not change.

(4) If a provider performs a healthcare service that is closely related to the service for which certification has already been granted by an insurer or its URO, then that insurer or its URO shall not deny a claim for the closely related service for failure of the provider to seek or obtain a utilization review so long as the provider had notified the insurer or its URO of the performance of the closely related service both no later than three business days following the completion of the closely related service and prior to the submission of a claim for payment for that service. The submission of the notification shall include the submission of all relevant clinical information necessary for the insurer to evaluate the medical necessity of the service. Nothing in this subsection shall be construed to limit an insurer's retrospective review of medical necessity of the closely related service nor limit the need for verification of the covered person's eligibility for coverage under the health benefit plan.

(5) An insurer shall not restrict benefits for any hospital stay of a covered person in connection with childbirth for the mother or newborn child (i) following a normal vaginal delivery to less than 48 hours or (ii) following a cesarean section to less than 96 hours. An insurer shall not require that a provider obtain

a utilization review determination from an insurer for prescribing the length of stay required under this subdivision.

(q) Exemptions. – This subsection shall not apply to utilization review requests that are pending review by an insurer or its URO. An insurer may not require a provider to request a utilization review for a healthcare service in order for the covered person to whom the healthcare service is being provided to receive coverage for the service if, within the most recent 12-month period, the insurer or its URO has issued certifications, or would have issued certifications, for not less than eighty percent (80%) of the utilization review requests submitted by the provider for that healthcare service. An insurer may evaluate whether a provider continues to qualify for this exemption not more than once every 12 months. All of the following apply to an exemption under this subsection:

(1) A provider is not required to request an exemption in order to qualify for the exemption.

(2) No more than once per year per healthcare service, a provider who does not receive an exemption under this subsection may request from the insurer evidence to support the insurer's decision. A healthcare provider may appeal an insurer's decision to deny the exemption.

(3) An insurer may only revoke an exemption at the end of the applicable 12-month period if the insurer does all of the following:

a. Makes a determination that the provider would not have met the eighty percent (80%) approval criteria based on a retrospective review of the claims for the particular service for which the exemption applies for the previous three months or for a longer period if needed to reach a minimum of 10 claims for review.

b. Provides the provider with the information the insurer relied upon in making the determination to revoke the exemption.

c. Provides the provider a plain language explanation of how to appeal the decision.

(4) If an insurer revokes an exemption, then that exemption will remain in effect until the thirtieth calendar day after the date the insurer notifies the provider of its revocation of the exemption unless the provider appeals the revocation. If the provider appeals the revocation, then the exemption shall remain in effect until the fifth calendar day after the revocation is upheld on appeal.

(5) An insurer shall provide a healthcare provider that receives an exemption all of the following:

a. A statement that the provider qualifies for an exemption from preauthorization requirements.

b. A list of services for which the exemption applies.

c. A statement of the duration of the exemption.

(6) An insurer shall not deny or reduce payment for a healthcare service exempted from a utilization review requirement under this subsection, including a healthcare service performed or supervised by another provider when the provider who ordered the service received an exemption, unless the rendering provider meets one of the following criteria:

a. Knowingly and materially misrepresented the healthcare service as a part of the request for payment submitted to the insurer with the specific intent to deceive and obtain an unlawful payment from the insurer.

b. Failed to substantially perform the healthcare service.

Nothing in this subsection requires an insurer to evaluate an existing exemption or prevents an insurer from establishing a longer exemption period.

(r) Deemed Approval. – Any failure by an insurer or its URO to comply with the deadlines and other requirements specified in this section will result in any healthcare services subject to review to be automatically deemed authorized by the insurer."

SECTION 1.(b) Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-500. Reports due regarding health benefit plans.**

(a) Health Benefit Plan Reporting Requirements. – All insurers offering health benefits shall be required to provide the following information to the Commissioner no later than March 1 of each year:

(1) Utilization review. – At a minimum, and subject to any rules adopted by the Commissioner, insurers shall provide information regarding utilization review approvals and noncertifications for the previous calendar year, reported separately for medications and procedural codes, for all of the following:

a. The total number of medications and procedural codes subject to utilization review, and specifically prior authorization.

b. The percentage of medications and procedural codes requiring prior authorization.

c. The reasons for any noncertifications issued.

d. The number and percentage of utilization review determinations that are appealed and the number and percentage of appeals that are approved or denied at each stage of the appeal process.

e. The average time and distribution by percentile of number of days between submission and response of each stage of the appeal process.

f. The number and percentage of providers who qualify for an exemption from the utilization review process under this section.

(2) Reserved for future codification purposes.

(b) Commissioner Authority Over Required Information. – The Commissioner is authorized to adopt rules related to this section. By rule, the Commissioner is authorized to require additional information related to the subject of the required report. By rule, the Commissioner is authorized to clarify or define further any information required under this section to be the subject of a report.

(c) Commissioner Reporting Requirements. – No later than April 1 of each year, the Commissioner shall compile the information received under subsection (a) of this section and submit a report containing that compiled information to the Joint Legislative Commission on Governmental Operations.

(d) Notwithstanding the penalty limits under G.S. 58-2-70, the failure of an insurer to provide information required under this section is a violation subject to a fine of five thousand dollars ($5,000) per day that the information is not provided."

SECTION 1.(c) In accordance with G.S. 135-48.24(b) and G.S. 135-48.30(a)(7), which require the State Treasurer to implement procedures that are substantially similar to the provisions of G.S. 58-50-61 for the North Carolina State Health Plan for Teachers and State Employees (State Health Plan), the State Treasurer and the Executive Administrator of the State Health Plan shall review all practices of the State Health Plan and all contracts with, and practices of, any third party conducting any utilization review on behalf of the State Health Plan to ensure compliance with subsection (a) of this section no later than the start of the next plan year.

SECTION 1.(d) Subsections (a) and (b) of this section become effective October 1, 2025, and apply to insurance contracts issued, renewed, or amended on or after that date.

PART II. ENFORCEMENT OF LICENSING REQUIREMENTS FOR HEALTH INSURANCE UTILIZATION REVIEW

SECTION 2.(a) G.S. 90-1.1(5) reads as rewritten:

"(5) The practice of medicine or surgery. – Except as otherwise provided by this subdivision, the practice of medicine or surgery, for purposes of this Article, includes any of the following acts:

…

g. Performing any portion of the utilization review process under G.S. 58-50-51 that is required under that section to be performed by a physician licensed to practice medicine, including making a final utilization review decision, issuing a noncertification, and participating on behalf of an insurer in the utilization reconsideration and appeal process.

…."

SECTION 2.(b) Part 2 of Article 50 of Chapter 58 of the General Statues is amended by adding a new section to read:

"**§ 58-50-64. Utilization review disciplinary actions; North Carolina Medical Board.**

(a) Performing any portion of the utilization review process under G.S. 58-50-61 that is required to be performed by a licensed physician, including making a final utilization review decision, issuing a noncertification, and participating on behalf of the insurer in the utilization reconsideration and appeal process, is the practice of medicine under G.S. 90-1.1(5).

(b) The North Carolina Medical Board has the authority to subpoena an insurer, or a utilization review organization acting on behalf of an insurer, for any records, documents, or other materials pertaining to the involvement of any physician licensed in this State in the utilization review process under G.S. 58-50-61.

(c) If an insurer, or a utilization review organization acting on behalf of an insurer, fails to comply with a subpoena issued in accordance with this section, the North Carolina Medical Board shall report the failure to comply and any information supporting the failure to the Commissioner.

(d) Notwithstanding the penalty minimum limit under G.S. 58-2-70, the failure of an insurer, or a utilization review organization acting on behalf of an insurer, to provide information required by a subpoena issued in accordance with this section is a violation subjecting the insurer to a fine of no less than five hundred dollars ($500.00) for each 90-day period in which the information is not produced.

(e) If the North Carolina Medical Board takes any disciplinary action under G.S. 90-14(a) against a licensed physician as a result of that physician's involvement in the utilization review process under G.S. 58-50-61, then any noncertifications that were issued that are related, in whole or in part, to the disciplinary action shall be subject to reconsideration or appeal under G.S. 58-50-61 so long as the noncertification had not been reversed prior to the disciplinary action. The North Carolina Medical Board shall notify the insurer of the disciplinary action and the utilization determinations involved."

SECTION 2.(c) G.S. 135-48.10 reads as rewritten:

"**§ 135-48.10. Confidentiality of information and medical records; provider contracts.**

(a) Any information described in this section that is in the possession of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State agencies to be made public or accessible to the public. This section shall apply to all information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan participant, including Claim Payment Data and any documents or other materials derived from the Claim Payment Data. This information may, however, be released to the State ~~Auditor or to the~~ Auditor, the Attorney ~~General~~ General, or the North Carolina Medical Board in furtherance of ~~their~~ the respective statutory duties and ~~responsibilities,~~ responsibilities

of each party or to ~~such~~ persons or organizations as may be designated and approved by the State Treasurer. Any information ~~so~~ that is released shall remain confidential ~~as stated above and any~~ as stipulated by this section. Any party obtaining ~~such~~ information under this section shall assume the same level of responsibility for maintaining such confidentiality as that of the State Health Plan for Teachers and State Employees.

(b) The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record under Chapter 132 of the General Statutes. No provision of law, however, shall be construed to prevent or restrict the release of any information in a Plan contract to the State Treasurer, the State Auditor, the Attorney General, the North Carolina Medical Board, the Director of the State Budget, the Plan's Board of Trustees, and the Plan's Executive Administrator solely and exclusively for their use in the furtherance of their duties and responsibilities.

(c) Performing any portion of the utilization review process under G.S. 58-50-61 that is required to be performed by a licensed physician, including making a final utilization review decision, issuing a noncertification, and participating on behalf of the insurer in the utilization reconsideration and appeal process, is the practice of medicine under G.S. 90-1.1(5). Subject to this section, all of the following shall apply:

(1) The North Carolina Medical Board has the authority to subpoena the Plan, or a utilization review organization acting on behalf of the Plan, for any records, documents, or other materials pertaining to the involvement of any physician licensed in this State in the utilization review process under the Plan.

(2) If the North Carolina Medical Board takes any disciplinary action under G.S. 90-14(a) against a licensed physician as a result of that physician's involvement in the Plan's utilization review process, then any noncertifications that were issued that are related, in whole or in part, to the disciplinary action shall be subject to reconsideration or appeal so long as the noncertification had not been reversed prior to the disciplinary action. The North Carolina Medical Board shall notify the Plan of the disciplinary action and the utilization determinations involved."

PART III. TECHNICAL AND CONFORMING CHANGES

SECTION 3.(a) G.S. 58-50-62 is amended by adding a new subsection to read:

"(a1) The definitions under G.S. 58-50-61(a) apply in this section."

SECTION 3.(b) G.S. 58-50-61(a)(7) is repealed.

SECTION 3.(c) G.S. 58-50-75 reads as rewritten:

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

…

(b) This Part applies to all insurers that offer a health benefit plan and that provide or perform utilization review pursuant to ~~G.S. 58-50-61, the State Health Plan for Teachers and State Employees,~~ G.S. 58-50-61 and any optional plans or programs operating under Part 2 of Article 3A of Chapter 135 of the General Statutes. With respect to second-level grievance review decisions, this Part applies only to second-level grievance review decisions involving noncertification decisions.

(c) ~~In addition to the~~ The definitions ~~in G.S. 58-50-61(a), as used in this Part:~~ under G.S. 58-50-61(a) and the following definitions apply in this Part:

(1) ~~"Covered benefits" or "benefits" means those~~ Covered benefits or benefits. – Those benefits consisting of medical care, provided directly through insurance or ~~otherwise~~ otherwise, and ~~including~~ items and services paid for as medical ~~care, under~~ care under the terms of a health benefit plan.

~~(2) "Covered person" means a policyholder, subscriber, enrollee, or other individual covered by a health benefit plan. "Covered person" includes~~

~~another person, including the covered person's health care provider, acting on behalf of the covered person. Nothing in this subdivision shall require the covered person's health care provider to act on behalf of the covered person.~~

(3) ~~"Independent~~ Independent review ~~organization" or "organization" means an~~ organization or organization. – An entity that conducts independent external reviews of appeals of noncertifications and second-level grievance review decisions."

SECTION 3.(d) G.S. 90-21.52(c)(1) reads as rewritten:

"(1) The liability of the managed care entity is based on an administrative decision to approve or disapprove payment or reimbursement for, or denial, reduction, or termination of coverage, for a health care service and the physician organizations, health care providers, or entities wholly owned by physicians or health care providers or any combination thereof, which have made the decision at issue, have agreed explicitly, in a written addendum or agreement separate from the managed care organization's standard professional service agreement, to assume responsibility for making noncertification ~~decisions~~ decisions, as defined under ~~G.S. 58-50-61(13)~~ G.S. 58-50-61, with respect to certain insureds or enrollees; and"

PART IV. EFFECTIVE DATE

SECTION 4. Except as otherwise provided, this act is effective when it becomes law.