CHAPTER 26.1-47
PREFERRED PROVIDER ORGANIZATIONS

26.1-47-01. Definitions. As used in this chapter, unless the context indicates otherwise:

1. "Commissioner" means the insurance commissioner of the state of North Dakota.

2. "Covered person" means any person on whose behalf the health care insurer is obligated to pay for or provide health care services.

3. "Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the services covered.

4. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

5. "Health care provider" means licensed providers of health care services in this state.

6. "Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes hospital, medical, surgical, dental, vision, chiropractic, and pharmaceutical services or products.

7. "Preferred provider" means a duly licensed health care provider or group of providers who have contracted with the health care insurer, under this chapter, to provide health care services to covered persons under a health benefit plan.

8. "Preferred provider arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter.

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

1. Preferred provider arrangements must:

   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

   b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care services and establish a procedure for determining whether health care services rendered are medically necessary.

   c. Include mechanisms which are designed to preserve the quality of health care.

   d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in

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

e. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.

f. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.

g. Provide that either party terminating the contract without cause provide the other party at least sixty days' advance written notice of the termination.

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

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

4. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

5. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.

6. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

26.1-47-03. Health benefits plans.

1. Health care insurers may issue policies or subscriber agreements which provide for incentives for covered persons to use the health care services of preferred providers. These policies or subscriber agreements must contain all of the following provisions:

a. A provision that if a covered person receives emergency care and cannot reasonably reach a preferred provider that care will be reimbursed as though the covered person had been treated by a preferred provider.

b. A provision that if covered services are not available through a preferred provider, reimbursement for those services will be made as though the covered person had been treated by a preferred provider.

c. A provision which clearly discloses differentials between benefit levels for health care services of preferred providers and benefit levels for health care services of other providers.

d. A provision that entitles the covered person, if any health care services covered under the health benefit plan are not available through a preferred provider

within fifty miles [80.47 kilometers] of the policyholder's legal residence, to the provision of those covered services under the health benefit plan by a health care provider not under contract with the health care insurer and located within fifty miles [80.47 kilometers] of the policyholder's legal residence. For the covered person to be eligible for benefits under this subdivision, the health care provider not under contract with the health care insurer must furnish the health care services at the same cost or less that would have been incurred had the covered person secured the health care services through a preferred provider.

2. If the policy or subscriber agreement provides differences in benefit levels payable to preferred providers compared to other providers, the differences may not unfairly deny payment for covered services and may be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

26.1-47-04. Preferred provider participation requirements. Health care insurers may place reasonable limits on the number of classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against any providers on the basis of religion, race, color, national origin, age, sex, or marital status, and further provided that selection of preferred providers is made on the combined basis of least cost and highest quality of service.

26.1-47-05. General requirements. Health care insurers complying with this chapter are subject to all other applicable laws, rules, and regulations of this state.

26.1-47-06. Rules. The commissioner may adopt rules necessary to enforce and administer this chapter.

26.1-47-07. Penalty. The commissioner may levy an administrative penalty not to exceed ten thousand dollars for a violation of this chapter. Any person who violates this chapter is guilty of a class A misdemeanor.