Department of Insurance

State of North Carolina

Jim Long, Commissioner of Insurance

GUIDANCE ON NORTH CAROLINA LAW AS AFFECTED BY U.S. DOL CLAIMS RULES

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TECHNICAL SERVICES GROUP

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MANAGED CARE & HEALTH BENEFITS DIVISION

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The Department has completed a review of North Carolina laws to identify specific provisions that are in conflict with the DOL claims rules. Specifically, we have reviewed NCGS 58-50-61 and 62, which govern utilization review, appeals and grievances and NCGS 58-3-225, which establishes "prompt-pay" requirements.

Based on our review, we believe that there are just a few true conflicts between our laws and the DOL rules. We note that there are large differences between the scope of the DOL rules and North Carolina law (i.e., the DOL rules govern decision-making, notification, and appeals for all claims under employer group health plans, while North Carolina law governs decision-making for medical necessity determinations, appeals, and grievances about most matters including most claim decisions under group or individual health plans). In addition, there are numerous instances where either the federal rules or State laws contain more stringent or additional requirements for making decisions, communicating decisions, or handling appeals. However, neither broader scope nor more/more stringent requirements *per se* constitute conflicts.

We do not believe it is practical to seek any significant amendments to State law in response to the DOL rules in the short term. Rather, we plan to wait until North Carolina's 2003 legislative session to make any changes to remove or reduce the differences in scope or specific detailed requirements for health insurers. By waiting several months before acting, we will have the benefit of seeing what, if any, progress is made on a federal Patients' Bill of Rights, as well as the benefit of additional information that comes to light as plans begin to comply with the DOL rules themselves and from the NAIC's work on amending its model UR and Grievance laws to comply with the DOL rules. We are not yet certain whether we will seek any changes to make North Carolina law more similar to the DOL rules, but simply want to alert you to the possibility that we may do so.

We have not yet decided when we will seek the few small amendments to State law needed to resolve conflicts between State and federal requirements; these will be sought in either the 2002 or 2003 legislative session. These changes, when made, would strictly be to remove or change very specific provisions of State law that are believed to be in conflict with the DOL rules. Whether North Carolina law is amended or not, our expectations of insurers are the same – that they comply with

all North Carolina requirements except where impossible to do so when complying with federal requirements.

In the mean time, we feel it is important to remind insurers of the following points:

- Insurers are responsible for complying with North Carolina law (except for any provisions of law that are preempted by the DOL rules) and the DOL rules.
- In cases where North Carolina law has more numerous or more stringent requirements than the DOL rules have, insurers must comply with North Carolina requirements. In cases where the DOL rules have additional or more stringent requirements compared to North Carolina law, insurers must comply with those additional or more stringent federal requirements.
- The Department expects insurers to remain fully compliant with all North Carolina laws except for specific points where they conflict with the DOL rules.
- The Department believes it is important that citizens of this state receive the protections afforded under the DOL rules, but is responsible for enforcing compliance with North Carolina law.
- The Department does not require insurers to immediately amend their policy forms and other member materials to comply with changes in State law and does not have any standing to require that policy forms immediately be amended to comply with the DOL rules. However, since North Carolina is a prior approval state, when a company does desire to amend its forms for any reason, it must file those forms with the Department's Life and Health Division for review and approval prior to using the amended forms.
- Future market conduct examinations and enforcement actions by this Department will take into account an insurer's good faith efforts to comply with state and federal requirements during this period of flux when considering whether to impose penalties, should noncompliance with State requirements be discovered to have occurred as a result of implementing the DOL rules. **Insurers should notify the Department's Life and Health Division in advance in any case where they believe compliance with a North Carolina requirement will no longer be possible due to federal requirements. Advance notification is not required since companies may not always recognize these cases in advance, but it will be considered in determining good faith on the part of the insurer.**
- The Department will make every effort to work with industry representatives to inform and educate our insurers of new North Carolina requirements or other developments in as timely a manner as possible. However, we are not in a position to educate, offer advice, or enforce with respect to DOL requirements. All companies are responsible for seeking appropriate legal advice and advice from the US DOL regarding federal compliance.
- A list of conflicts and other key differences between North Carolina law and the DOL rules is presented below. In making a form filing, insurers may discover additional points that present a conflict between North Carolina and federal requirements or necessitate some adjustment to avoid conflict. **To facilitate our review of policy forms, insurers are requested to identify changes made as a result of the DOL rules in advance of making a filing or in a cover letter accompanying their filing to the Life and Health Division.**

Compliance Discussion Points from North Carolina Regulatory Perspective

We offer this discussion to alert you to certain issues and also to assure you that we are cognizant of certain changes that the DOL rules will require insurers to make to their policy forms and will not disapprove or question changes relating to these issues unless we believe it is absolutely necessary. Many of these issues also impact insurers' policies and procedures that are reviewed as part of the Department's market conduct examinations. Thus, our stated expectations regarding policy language would also apply to company operations, policies, and procedures. This list represents our best information and understanding of the DOL rules as of this date and therefore may ultimately prove not to be complete. The Department does not in any way purport to speak on behalf of DOL.

Time Allowed for UR Determination

First, we recognize that the DOL rules apply to all claim determinations, while NCGS 58-50-61 applies only to medical necessity determinations made under a UR program – a subset of all claim determinations. The time period allowed in North Carolina for making each type of UR determination as compared to federal time frames presents some differences and conflicts that will have to be reconciled and will cause insurers to file policy language that looks quite "different" from what the Department has been approving. These differences and conflicts are as follows:

- "Urgent requests" - Not defined in North Carolina law and would be treated as any other precertification or concurrent review request. Pursuant to NCGS 58-50-61(f), the insurer's decision must be made within 3 business days "after the insurer obtains all necessary information about the admission, procedure, or health care service." DOL rules require a decision to be made as soon as possible, taking into account medical exigencies, but "not later than 72 hours after receipt of the claim by the plan", but allows the plan to request within 24 hours of receipt additional information needed to make the determination. A request for additional information must allow the insured at least 48 hours to provide it, and the plan must issue a determination within 48 hours of receiving the additional information or within 48 hours of the expiration of the time allowed the insured to submit the information, whichever is sooner.

  Though there may be some specific instances where North Carolina's time standard for issuing a decision might happen to meet DOL time standards for the claim in question, State law clearly would not be within DOL time standards in a case where additional information was not needed by the plan and the request was made just prior to a weekend or holiday, because three business days would extend over a period greater than 72 hours. In cases where additional information is needed, North Carolina's requirements clearly appear to fall short of DOL requirements since the decision must be made within 72 hours of receiving requested additional information and State law does not address how insurers should handle requests which are incomplete. The Department expects that insurers will modify provisions for precertification of "urgent requests" to reflect the DOL time standard as well as specific provisions for the insurer to request additional information and associated time standards for providing the information and making the claim determination. Therefore, we will keep this in mind when reviewing policy forms. Insurers must otherwise comply with North Carolina requirements for handling requests for precertification or concurrent review.

- "Pre-service claims" – Equivalent to "precertification" in North Carolina law. Pursuant to NCGS 58-50-61(f), the insurer's decision must be made within three business days "after the insurer obtains all necessary information about the admission, procedure, or health care service." DOL rules require a decision to be made within a reasonable period of time considering the medical circumstances, but "not later than 15 days after receipt of the claim by the plan", but allows the plan to request within that 15 days following receipt any additional information needed to make the determination. Such request for additional information must allow the insured at least 45 days following receipt of the request to provide the information, and (according to a Q&A document published by DOL) the plan must issue a determination within 15 days of receiving the additional information or within 15 days of the expiration of the time allowed the insured to submit the information, whichever is sooner.

  North Carolina's time standard for making a precertification is shorter than DOL's standards for making a non-urgent precertification. However because North Carolina's time tolls only when the insurer has received all necessary information about the admission, etc., it may not comport with DOL requirements in every case. The Department expects that insurers will modify provisions for "non-urgent" precertification decisions to reflect specific provisions for the insurer to request additional information and associated time standards for providing the information and making the claim determination. Therefore, we will keep this in mind when reviewing policy forms. However, insurers must continue to make decisions within three business days of receiving all information about the service in question in order to maintain compliance with North Carolina law.

- "Concurrent care decisions" – Equivalent to "concurrent review" in North Carolina law. NCGS 58-50-61(f) as described above also applies to concurrent review decisions. In addition, the law states that "in concurrent reviews, the insurer shall remain liable for health care services until the covered person has been notified of the noncertification." The DOL rules distinguish between concurrent care decisions that involve the termination of a course of treatment that is in progress and a request to extend a course of treatment that is in progress. In the case of the former, the plan must inform the insured of its adverse benefit determination (noncertification decision) "sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated." In the case of a request for extension of treatment, <u>if the request involves urgent care</u>, the request shall be decided within 24 hours of receipt of the request, provided that the request (claim) is made to the plan within at least 24 hours prior to the expiration of the prescribed treatment or treatment period in progress. DOL's requirements for handling requests to extend treatment in cases where the care involved is not urgent and in cases where the care involved is urgent but the request is not made at least 24 hours prior to the expiration of the prescribed treatment are not evident to the Department.

It would appear that, at a minimum, DOL requirements for handling urgent requests for extending care or treatment in a concurrent review situation are more stringent than North Carolina's and would therefore must be complied with in lieu of this particular point of State law. Thus, the Department expects that insurers will reference to a 24-hour time frame for making concurrent review decisions for at least these types of concurrent reviews. Furthermore, we would expect insurers to add provisions necessary to meet DOL requirements for advance notification of termination of treatment that is in progress. However, in implementing this requirement, insurers must still comply with NCGS 58-3-200(c), which prohibits an insurer from retracting an initial finding that a service or supply is medically necessary if services or supplies were furnished based on reliance upon such determination, unless it was based on false or intentionally misrepresented information. In either type of concurrent review, the insurer will continue to remain liable for coverage of health care services received until the covered person has been notified of the noncertification decision, in accordance with NCGS 58-50-61(f).

- "Post-service claims"- Equivalent to "retrospective review" in North Carolina law. Pursuant to NCGS 58-50-61(g), the insurer's decision must be made "within 30 days after receiving all necessary information". DOL rules require a decision to be made within a reasonable period of time but "not later than 30 days after receipt of the claim by the plan", but allows the plan to request within that 30 days following receipt any additional information needed to make the determination. Such request for additional information must allow the insured at least 45 days following of receipt of the request to provide the information, and (presumably) the plan must issue a determination within 30 days of receiving the additional information or within 30 days of the expiration of the time allowed the insured to submit the information, whichever is sooner.

  North Carolina's time standards for making a retrospective decision are the same as DOL's standards for making a post-service claim decision. However, North Carolina law does not address the process for obtaining additional information and would not require a decision on cases where the insurer did not receive all information. Therefore, the Department expects that insurers will modify provisions for retrospective review decisions to reflect specific provisions for the insurer to request additional information, for associated time standards for providing the information and for making the claim determination even if all information is not received, while otherwise complying with North Carolina law. Therefore, we will keep this in mind when reviewing policy forms. Furthermore, in accordance with NCGS 58-3-225(d), insurers must allow insureds up to at least 90 days (versus the 45 days allowed under the DOL rules) to submit additional information requested to make a retrospective review decision.

Contents of Notice of Noncertification

NCGS 58-50-61(h) specifies what information must be included in insurers' written notice of noncertification. DOL rules require the inclusion of the following statement in notices of adverse benefit determinations: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available in your state is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency *[optional, per NCDOI* – ', the North Carolina Department of Insurance'*]*."

Although not being required by the Department, we anticipate that insurers will include this statement in notices of adverse benefit determinations and may also choose to include this same statement in the description of utilization review and appeal processes required under NCGS 58-50-61(m) to be disclosed in certificates of coverage and member handbooks. Therefore, we will keep this in mind when reviewing policy forms and will not question it if this exact wording is used.

Informal Reviews

The offering of informal reconsideration of a medical necessity noncertification decision pursuant to NCGS 58-50-61(i) would appear to conflict with the DOL rules, even if it is on a voluntary basis, since the rules provide only for up to two levels of appeal, each of which meet all DOL requirements for appeal. The very idea of an "informal" process appears to be at odds with the fact that each level of review must meet all DOL requirements for process, standard of review, etc.

Although not being required by the Department, it is our expectation that insurers will no longer offer informal reconsideration. Therefore, we will keep this in mind when reviewing policy forms.

The offering of voluntary informal consideration of a grievance pursuant to NCGS 58-50-62(b) would appear to present the same problem as described for informal reconsideration of medical necessity noncertifications in those cases where the matter that is raised under the grievance process is considered a claim determination.

Although not being required by the Department, it is our expectation that insurers will no longer offer informal consideration for claim determination matters eligible for consideration under North Carolina's grievance process. From a practical standpoint, offering informal consideration only for grievances that are about matters other than claim determinations may not be worthwhile for insurers. Therefore, we will keep this in mind when reviewing policy forms.

Timing of Appeal Process/Number of Levels of Internal Review

It appears that the biggest challenge insurers will face in complying with current North Carolina laws and the DOL rules is meeting the time frames within which appeals must be reviewed. According to the DOL rules, if two levels of internal review are required by the insurer, both would have to be completed within the total time allowed for appeal under the DOL rules (72 hours for appeal of an urgent care claim, 30 days for a pre-service claim, and 60 days for a post-service claim), with each level completed within one-half the total time allowed. As a result, each level of review would have to be completed within a very short period of time. Currently, NCGS 58-50-62 requires insurers to offer a second-level grievance review and establishes standards for that review. However, our external review law, which becomes effective July 1, 2002, gives insurers the option to eliminate this second level of internal review. (See NCGS 58-50-79(d).)

Eliminating the second-level review is one way of complying with North Carolina and DOL requirements. Insurers adopting this approach must ensure that they comply with those DOL requirements for appeals that are above what is required in NCGS 58-50-61 - much of which could be achieved by using the current second-level grievance as a the single level of internal review or including certain elements of the current second-level internal review in the single level of review.

At least one insurer has indicated to us that it intends to continue to use the appeal and first-level grievance processes, using the time frames and other provisions of NCGS 58-50-61 and 62(e) (except for making changes as needed to comply with DOL's requirements for appeal). This first-level review would be mandatory for the insured. The insurer would also continue to offer a second-level grievance review exactly as it has been offering it in compliance with NCGS 58-50-62, but make the process voluntary on the part of the insured for the purpose of bringing suit under ERISA. This is based on the belief that, as a voluntary process, the second-level grievance would not be subject to the DOL rules. The insurer indicated to us that it would continue to expect exhaustion of this second-level review prior to an insured qualifying for external review under North Carolina's external review law. (In turn, insureds are required to exhaust external review before suing an insurer under North Carolina's new Health Plan Liability Law, which will also go into effect on July 1, 2002.) *The Department will not object to this approach, since it will not present any compliance problems from the State perspective. We also note that this approach is currently under discussion by the NAIC's Regulatory Framework Task Force, which is charged with amending NAIC model laws in order to avoid conflict with the DOL rules. All provisions of NCGS 58-50-61(f) through (h) would continue to apply to the voluntary second-level grievance. Further, the requirements of Section 503-1(c)(3) of the DOL rules, which contains stipulations on the use of voluntary review procedures, would also have to be met.* [*]

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* 29 CFR Section 2560.503-1(c):
"*Group health plans.* The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section - …
(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of the section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c) (2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgement about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal."

Insurers certainly may retain two levels of mandatory internal review (appeal or first-level grievance plus second-level grievance), so long as each level meets all North Carolina requirements and all DOL requirements for timing and process. Note that, in addition to using time standards equal to one-half of the DOL total time standards for review, NCGS 58-50-62(h)'s allowance of seven business days after a second-level decision has been made to inform the insured of the decision will no longer be permitted since this would result in noncompliance with the DOL rules.

Regardless of the approach that is used to comply with DOL time standards for appeals, the Department expects that insurers will eliminate use of two levels of mandatory internal review (i.e., appeal and second-level grievance) that use the time currently allowed under North Carolina law since this would not comply with the DOL rules.

Eligibility for Expedited Review for Appeals Involving "Urgent Care"

NCGS 58-50-61(l) sets out the circumstances under which an insured may request expedited review of an appeal. Those conditions are when "the insurer's issuance of a decision on a standard nonexpedited basis 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 DOL rules include the same provisions as North Carolina law and also include a provision for cases where the insured has severe pain that cannot be managed without the requested treatment and where a physician with knowledge of the insured's medical condition determines the claim to be urgent. The DOL rules also establish a prudent layperson standard for determining whether a request should be handled on an urgent basis when the request is from the insured or non-physician acting on behalf of the insured.

Although not being required by the Department, we anticipate that insurers will modify provisions for expedited appeal (which typically contained verbatim statutory language regarding eligibility for expedited review) to include the additional provisions from DOL. Therefore, we will keep this in mind when reviewing policy forms.

Timing of Expedited Appeals

NCGS 58-50-61(l) allows insurers up to "four days after receiving the information justifying expedited review" to issue a decision on an expedited appeal. The DOL rules require a plan to issue a decision as soon as possible but "not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan." The DOL rules do not address the issue of whether the request for expedited treatment was justified or even whether information justifying the request was received by the insurer. Also, the rules do not allow for the insurer to request additional information on an appeal. Therefore, insurers will have to make a decision on the request based on whatever information, if any, was received to support the need for expedited handling. North Carolina's time standards for issuing a decision on an expedited appeal are not as strict as DOL's requirements, so insurers must comply with this provision of the DOL rules in lieu of this point of State law.

The Department expects that insurers will modify their policy language with respect to this particular point of North Carolina law in order to comply with the DOL requirements for issuing a decision on expedited appeals.

Contents of Notice of Decisions on Appeals and Grievances

NCGS 58-50-61(k) specifies what information must be included in insurers' written notice of a decision on appeal when the decision is not in favor of the insured. DOL rules require the inclusion of the following statement in these notices: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available in your state is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency *[optional, per NCDOI* – , the North Carolina Department of Insurance*]*."

Although not being required by the Department, we anticipate that insurers will include this statement in notices of adverse benefit determinations and may also choose to include this same statement in the description of utilization review and appeal processes required under NCGS 58-50-61(m) to be disclosed in certificates of coverage and member handbooks. Therefore, we will keep this in mind when reviewing policy forms and will not question it so long as this exact wording is used.

The same would apply to NCGS 58-50-62(e), which specifies the information to be included in a notice of decision on first-level grievances, when a grievance is about a claim determination.

Form and Format of Grievance Requests

NCGS 58-50-61(a)(6) defines a grievance as a "written complaint" regarding specified issues in dispute. The DOL rules expressly allow for verbal requests for appeal.

Although not being required by the Department, we anticipate that insurers will no longer require at least certain requests for grievances (requests for expedited review of claim determinations) to be in writing. Therefore, we will keep this in mind when reviewing policy forms.

Time Allowed to Request Appeals and First-Level Grievances

NCGS 58-50-61 and 62 are silent on the question of how long covered persons must be allowed to submit an appeal or first-level grievance request. The DOL rules mandate that covered persons have at least 180 days to request review of an adverse benefit determination.

The Department expects that insurers will modify their policy forms to provide for at least 180 days for a covered person to appeal a noncertification decision or request a first-level grievance review of a decision that is an adverse benefit determination in order to comply with the DOL rules.

This document will be updated as needed. Please check the Department's web site, www.NCDOI.com, for updates. Contact Louis Belo, Deputy Commissioner, Life and Health Division, at 919-733-5060 or lbelo@ncdoi.net for questions.