FILED SENATE
Mar 17, 2025
S.B. 315
PRINCIPAL CLERK

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

S **D**

SENATE BILL DRS45172-MR-110

Short Title:	More Transparency/Efficiency in Utiliz. Rev.	(Public)
Sponsors:	Senators Burgin, Galey, and Sawrey (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO INCREASE TRANSPARENCY AND EFFICIENCY IN UTILIZATION REVIEWS.

The General Assembly of North Carolina enacts:

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

"**§ 58-50-61. Utilization review.**

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

…

(16a) Urgent health care service. – A health care service with respect to which the application of the time periods for making an urgent care determination that, in the opinion of a physician with knowledge of the covered person's medical condition, meets either of the following criteria:

a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

b. Would 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.

…

(f) Time Lines for Prospective and Concurrent Utilization Reviews Based Upon Type of Health Care 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 time line for completion of a prospective or concurrent utilization review is as follows:

(1) Non-urgent health care services. – If an insurer requires a utilization review of a healthcare service, then the insurer or its URO shall both render a utilization review determination or noncertification and notify the covered person and the covered person's provider within three business days after the insurer obtains all necessary information ~~about the admission, procedure, or health care service.~~ to make the utilization review determination or noncertification.

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

insurer, or the entity conducting the review on behalf of the insurer, do not both have access to the electronic health records of the covered person, then this subdivision shall not apply and the utilization review will be subject to the time line under subdivision (1) of this subsection.

(f1) Utilization Review Determination Notifications. – If an insurer or its URO certifies a health care service, ~~the insurer shall notify~~ notification shall be sent to the covered person's provider. ~~For~~ If an insurer or its URO issues a noncertification, ~~the insurer shall notify the covered person's provider and send~~ then written or electronic confirmation of the noncertification to the covered person's provider and covered ~~person. In~~ person that is in compliance with subsection (h) of this section.

(f2) 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.

…

(j1) Requirements Applicable to Appeals Reviews. – All of the following requirements apply to an appeals review:

(1) Except as otherwise provided, appeals shall be reviewed by a medical doctor who meets all of the following criteria:

a. Possesses a current and valid non-restricted license to practice medicine in any United States jurisdiction.

b. Has practiced for a period of at least three 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 or whose training and experience meets all of the following criteria:

1. Includes treatment of the same condition as the condition of the covered person.

2. Includes treatment of complications that may result from the service or procedure that is the subject of the appeal.

3. Is sufficient for the medical doctor to determine if the service or procedure is medically necessary or clinically appropriate.

c. Had no direct involvement in making any prior adverse determination or noncertification.

d. Has no financial interest, or other conflict of interest, in the outcome of the appeal.

(2) Appeals initiated by a licensed mental health professional for a service provided by a licensed mental health professional may be reviewed by a licensed mental health professional rather than a medical doctor. The requirements of subdivision (1) of this subsection shall apply to the reviewing licensed mental health professional in the same manner that they apply to a medical doctor.

(3) The medical doctor or licensed mental health professional 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.

…

(m) Disclosure of Utilization Review Requirements. – 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 the new or amended requirement 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 prior authorization requirement or amended requirement was not in effect on the date of service of the claim.

…

(n1) Utilization Review Determination Validity. – All of the following apply to the length of time an approved prior authorization shall remain valid under certain circumstances:

(1) If a covered person enrolls in a new health benefit plan offered by the same insurer under which the prior authorization was approved, then the previously approved prior authorization remains valid for the initial 90 days of coverage under the new heath benefit plan. This section does not require coverage of a service if it is not a covered service under the new health benefit plan.

(2) If a healthcare service, other than for in-patient care, requires prior authorization and is for the treatment of a covered person's chronic condition, then the prior authorization shall remain valid for no less than six months from the date the healthcare provider receives notification of the prior authorization approval.

…

(o) Violation. – ~~A~~ In accordance with this Chapter, a violation of this section subjects an insurer and an agent of the insurer to G.S. 58-2-70.

(p) Federal Rule Alignment. – No later than January 1, 2028, an insurer offering a health benefit plan or a utilization review agent acting on behalf of an insurer offering a health benefit plan, shall implement and maintain a prior authorization application programming interface meeting the requirements under 45 C.F.R. § 156.223(b) as it existed on January 1, 2025, which is to be in effect on January 1, 2028.

(q) Reserved for future codification purposes.

(r) Reserved for future codification purposes.

(s) Artificial Intelligence. – An insurer shall not use an artificial intelligence-based algorithm as the sole basis for a utilization review determination to, in whole or in part, deny, delay, or modify any healthcare services for an insured. Only individuals meeting the licensing and qualification requirements for participating in the utilization review process under this section shall make a determination regarding the medical necessity or appropriateness of any healthcare service. Insurers shall verify that all contracts with a third party, including with a pharmacy benefits manager, for conducting any utilization review are not in violation of this subsection."

SECTION 1.(b) 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 2. Section 1(a) of this act becomes effective October 1, 2026, and applies to insurance contracts, including contracts with utilization review organizations, issued, renewed, or amended on or after that date. The remainder of this act is effective when it becomes law.