HOUSE BILL 434:
The CARE FIRST Act.

2025-2026 General Assembly

Committee:	House Health. If favorable, re-refer to Insurance. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	April 8, 2025
Introduced by:	Reps. Bell, Reeder, Cotham, Campbell	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	First Edition		

OVERVIEW: House Bill 434 would make the following changes to the utilization review requirements in Chapter 58 (Insurance), which would also apply to the State Health Plan:

- ***Require clear standards for clinical review.***
- ***Require experienced physicians to review denials.***
- ***Establish deadlines for review decisions.***
- ***Establish requirements for physicians conducting determination appeals.***
- ***Make review procedures and policies readily available and require notice prior to changing those policies and procedures.***
- ***Ensure continuity of care.***
- ***Grant review exemptions to certain providers.***

The bill would also establish reporting requirements and penalties for private insurers, clarify conducting a utilization review is the practice of medicine, and make conforming changes.

CURRENT LAW: Under current law, insurers must give insureds the results of utilization reviews within three business days. Results for retroactive reviews must be given within 30 days. Insurers may determine their own clinical review criteria for reviews, and physicians licensed in North Carolina must review any denials. The results of review appeals must be made within 30 days for regular appeals and 4 days for expedited appeals.

BILL ANALYSIS:

Part I of the bill would make the following changes to the utilization review provisions in Chapter 58 (Insurance).

- Definitions for "closely related service," "course of treatment," "prior authorization," and "urgent healthcare service" are added to G.S. 58-50-61(a).
- Standards are required of clinical review criteria. They must be based on recognizable national standards, consistent with government guidelines, clinically appropriate, reflect current medical best practices, and flexible enough to allow deviations when necessary.

- Certification denials must be reviewed by a physician licensed in North Carolina who is in the same specialty as the provider who typically manages the condition and has experience in treating the condition.
- If the insurer questions the medical necessity of a procedure, it must give the insured's provider the opportunity to discuss the necessity of the procedure with the individual conducting the utilization review.
- Insurers must maintain a publicly available list of services which require utilization review.
- Review determinations must be delivered to the insured and the insured's provider within 48 hours for non-emergency services and 24 hours for emergency services. Services will be deemed to be approved if these deadlines are not met.
- Emergency services to screen and stabilize an insured must be covered. A provider's certification that emergency services were necessary to screen and stabilize an insured can only be rebutted by the insurer by clear and convincing evidence. Utilization review determinations for post-screening and post-stabilization emergency procedures must be made within 60 minutes. Services will be deemed to be approved if these deadlines are not met.
- If additional information is needed for the review, the insurer must notify the provider of the specific information needed within 48 hours. The provider must submit that information within 14 business days.
- Certifications cannot be retrospectively denied unless the service is not covered on the day it is provided, the provider is not in-network on the day the service is provided, coverage is not in force on the day the service is provided, or the provider knowingly misrepresented something in the utilization review request.
- Appeals must be reviewed by a physician who (i) possesses a current unrestricted license to practice medicine in North Carolina, (ii) has practiced in the same specialty area as the insured's provider for at least 5 years, (iii) is knowledgeable about the service under appeal, and (iv) was not directly involved in making the original decision. All evidence submitted by the insured's provider must be considered as part of the appeals process.
- All utilization review procedures must be made available to the insured and be posted on the insurer's website. Changes to the utilization review procedures or requirements must be posted on the insurer's website before they can be effective. Changes must also be sent to all in-network providers 60 days prior to implementation.
- Insurers must post rolling, 12-month statistics on their website about the procedures requiring utilization review, the reasons for denials, percentages of denials overturned on appeal, the time to process reviews, and the number and percentage of providers who qualify for an exemption.
- A utilization review approval must remain valid for the entire course of treatment.
- Once an approval has been given, the following apply:
    - It remains in effect for 90 days if the insured changes to a new insurer.
    - It remains in effect until the end of the plan year if the insurer adopts new approval criteria.
    - It remains in effect for the entire course of treatment if the insured switches to a new plan with the same insurer.

  - If a new service is closely related to the approved service, the new service cannot be denied solely on the basis of failing to undergo a utilization review.

- An insurer must offer exemptions to utilization review for a provider if it granted, or would have granted, at least 80% of the utilization review requests from that provider for that same service in the last 12 months. This exemption must be granted to the provider automatically, and it can only be reviewed once every 12 months.
- Failure to follow these utilization review provisions will result in the service being reviewed to be deemed approved.
- The State Health Plan must adopt utilization review procedures which are substantially similar by the start of the next Plan year.
- Insurers must annually submit information about the procedures requiring utilization review, the reasons for denials, percentages of denials overturned on appeal, the time to process reviews, and the number and percentage of providers who qualify for an exemption to the Insurance Commissioner, who must compile a report and submit it to the Joint Legislative Commission on Governmental Operations by April 1 of each year. Failure to provide information may subject the insurer to a fine of $5,000 per day, in addition to other penalties allowed under law.

Part II of the bill would clarify that performing any part of the utilization review process constitutes the practice of medicine in North Carolina. The North Carolina Medical Board may take disciplinary action against any physician taking part in the utilization review process and may subpoena State Health Plan records to conduct any investigation of violations of the utilization review process.

Part III of the bill would make technical and conforming changes throughout Chapter 58 (Insurance) and Chapter 90 (Medicine and Allied Occupations).

EFFECTIVE DATE: The provisions governing utilization review requirements for private insurers become effective October 1, 2025, and apply to insurance contracts issued, renewed, or amended on or after that date. The remainder of the bill is effective when it becomes law.