Article 1G.

Health Care Liability.

§ 90-21.50. Definitions.

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a self-insured indemnity program or prepaid hospital and medical benefits plan offered under the State Health Plan for Teachers and State Employees and subject to the requirements of Article 3 of Chapter 135 of the General Statutes, a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any of the following kinds of insurance:
   a. Accident.
   b. Credit.
   c. Disability income.
   d. Long-term or nursing home care.
   e. Medicare supplement.
   f. Specified disease.
   g. Dental or vision.
   h. Coverage issued as a supplement to liability insurance.
   i. Workers' compensation.
   j. Medical payments under automobile or homeowners.
   k. Hospital income or indemnity.
   l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
   m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) "Health care decision" means a determination that is made by a managed care entity and is subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes and is also a determination that:
   a. Is a noncertification, as defined in G.S. 58-50-61, of a prospective or concurrent request for health care services, and
   b. Affects the quality of the diagnosis, care, or treatment provided to an enrollee or insured of the health benefit plan.

(3) "Health care provider" means:
   a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or

b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

"Health care provider" includes: (i) an agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services; (ii) the officers and directors of a health care facility; and (iii) an agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(4) "Health care service" means a health or medical procedure or service rendered by a health care provider that:

a. Provides testing, diagnosis, or treatment of a health condition, illness, injury, or disease; or

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a health condition, illness, injury, or disease.

(5) "Insured or enrollee" means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, a self-insured health maintenance organization or managed care entity operated or administered by or under contract with the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees pursuant to Article 3 of Chapter 135 of the General Statutes, a multiple employer welfare arrangement subject to Article 50A of Chapter 58 of the General Statutes, or the State Health Plan for Teachers and State Employees.

(7) "Managed care entity" means an insurer that:

a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services or assumes the risk for the delivery of health care services; and

b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

Except for the State Health Plan for Teachers and State Employees, "managed care entity" does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) "Ordinary care" means that degree of care that, under the same or similar circumstances, a managed care entity of ordinary prudence would have used at the time the managed care entity made the health care decision.

(9) "Physician" means:

a. An individual licensed to practice medicine in this State;

b. A professional association or corporation organized under Chapter 55B of the General Statutes; or

c. A person or entity wholly owned by physicians.

(10) "Successor external review process" means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 that is approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law, in whole or in part. (2001-446, s. 4.7; 2007-323, s. 28.22A(o); 2007-345, s. 12; 2019-202, s. 8; 2021-62, ss. 4.2(a), 4.2(b).)

§ 90-21.51. Duty to exercise ordinary care; liability for damages for harm.

(a) Each managed care entity for a health benefit plan has the duty to exercise ordinary care when making health care decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care.

(b) In addition to the duty imposed under subsection (a) of this section, each managed care entity for a health benefit plan is liable for damages for harm to an insured or enrollee proximately caused by decisions regarding whether or when the insured or enrollee would receive a health care service made by:

(1) Its agents or employees; or

(2) Representatives that are acting on its behalf and over whom it has exercised sufficient influence or control to reasonably affect the actual care and treatment of the insured or enrollee which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action brought under this section against a managed care entity for a health benefit plan that:

(1) The managed care entity and its agents or employees, or representatives for whom the managed care entity is liable under subsection (b) of this section, did not control or influence or advocate for the decision regarding whether or when the insured or enrollee would receive a health care service; or

(2) The managed care entity did not deny or delay payment for any health care service or treatment prescribed or recommended by a physician or health care provider to the insured or enrollee.

(d) In an action brought under this Article against a managed care entity, a finding that a physician or health care provider is an agent or employee of the managed care entity may not be based solely on proof that the physician or health care provider appears in a listing of approved physicians or health care providers made available to insureds or enrollees under the managed care entity's health benefit plan.

(e) An action brought under this Article is not a medical malpractice action as defined in Article 1B of this Chapter. A managed care entity may not use as a defense in an action brought under this Article any law that prohibits the corporate practice of medicine.

(f) A managed care entity shall not be liable for the independent actions of a health care provider, who is not an agent or employee of the managed care entity, when that health care provider fails to exercise the standard of care required by G.S. 90-21.12. A health care provider shall not be liable for the independent actions of a managed care entity when the managed care entity fails to exercise the standard of care required by this Article.

(g) Nothing in this Article shall be construed to create an obligation on the part of a managed care entity to provide to an insured or enrollee a health care service or treatment that is not covered under its health benefit plan.

(h) A managed care entity shall not enter into a contract with a health care provider, or with an employer or employer group organization, that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. Any such indemnification or hold harmless clause is void and unenforceable to the extent of the restriction. (2001-446, s. 4.7.)

§ 90-21.52. No liability under this Article on the part of an employer or employer group organization that purchases coverage or assumes risk on behalf of its employees or a physician or health care provider; liability of State Health Plan under State Tort Claims Act.

(a) Except as otherwise provided in subsection (b) of this section, this Article does not create any liability on the part of an employer or employer group purchasing organization that purchases health care coverage or assumes risk on behalf of its employees.

(b) Liability in tort of the State Health Plan for Teachers and State Employees for its health care decisions shall be under Article 31 of Chapter 143 of the General Statutes.

(c) This Article does not create any liability on the part of a physician or health care provider in addition to that otherwise imposed under existing law. No managed care entity held liable under this Article shall be entitled to contribution under Chapter 1B of the General Statutes. No managed care entity held liable under this Article shall have a right to indemnity against physicians, health care providers, or entities wholly owned by physicians or health care providers or any combination thereof, except when:

(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 under G.S. 58-50-61(13) with respect to certain insureds or enrollees; and

(2) The managed care entity has not controlled or influenced or advocated for the decision regarding whether or when payment or reimbursement should be made or whether or when the insured or enrollee should receive a health care service.

The right to indemnity set forth herein shall not apply to professional medical or health care services provided by a physician or health care provider, and shall only apply where the agreement to assume responsibility for making noncertification decisions for the managed care entity is shown to have been undertaken voluntarily and the managed care organization has not adversely affected the terms and conditions of the relationship with the health care provider based upon the willingness to execute or refusal to execute an agreement under G.S. 58-50-61(13). (2001-446, s. 4.7; 2001-508, s. 2; 2007-323, s. 28.22A(o); 2007-345, s. 12.)

§ 90-21.53. Separate trial required.

Upon motion of any party in an action that includes a claim brought pursuant to this Article involving a managed care entity, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against any physician or other health care provider. (2001-446, s. 4.7.)

§ 90-21.54. Exhaustion of administrative remedies and appeals.

No action may be commenced under this Article until the plaintiff has exhausted all administrative remedies and appeals, including those internal remedies and appeals established under G.S. 58-50-61 through G.S. 58-50-62, and G.S. 58-50-75 through G.S. 58-50-95, and including those established under any successor external review process. (2001-446, s. 4.7.)

§ 90-21.55. External review decision.

(a) Either the insured or enrollee or the personal representative of the insured or enrollee or the managed care entity may use an external review decision made in accordance with G.S. 58-50-75 through G.S. 58-50-95, or made in accordance with any successor external review process, as evidence in any cause of action which includes an action brought under this Part, provided that an adequate foundation is laid for the introduction of the external review decision into evidence and the testimony is subject to cross-examination.

(b) Any information, documents, or other records or materials considered by the Independent Review Organization licensed under Part 4 of Article 50 of Chapter 58 of the General Statutes, or the successor review process, in conducting its review shall be admissible in any action commenced under this Article in accordance with Chapter 8 of the General Statutes and the North Carolina Rules of Evidence. (2001-446, s. 4.7.)

§ 90-21.56. Remedies.

(a) Except as provided in G.S. 90-21.52(b), an insured or enrollee who has been found to have been harmed by the managed care entity pursuant to an action brought under this Article may recover actual or nominal damages and, subject to the provisions and limitations of Chapter 1D of the General Statutes, punitive damages.

(b) This Article does not limit a plaintiff from pursuing any other remedy existing under the law or seeking any other relief that may be available outside of the cause of action and relief provided under this Article.

(c) The rights conferred under this Article as well as any rights conferred by the Constitution of North Carolina or the Constitution of the United States may not be waived, deferred, or lost pursuant to any contract between the insured or enrollee and the managed care entity that relates to a dispute involving a health care decision. Arbitration or mediation may be used to settle the controversy if, after the controversy arises, the insured or enrollee, or the estate of the insured or enrollee, voluntarily and knowingly consents in writing to use arbitration or mediation to settle the controversy. (2001-446, s. 4.7.)