

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

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HOUSE DRH60173-LN-92A* (3/20)

Short Title: Managed Care Patient Assistance.

(Public)

Sponsors: Representative Hackney.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURERS TO INFORM COVERED PERSONS ABOUT ASSISTANCE AVAILABLE FROM THE MANAGED CARE PATIENT ASSISTANCE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61(h), (k), and (m) read as rewritten:

"§ 58-50-61. Utilization review.

...

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

...

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:

- 1 (1) The professional qualifications and licensure of the person or persons
2 reviewing the appeal.
- 3 (2) A statement of the reviewers' understanding of the reason for the
4 covered person's appeal.
- 5 (3) The reviewers' decision in clear terms and the medical rationale in
6 sufficient detail for the covered person to respond further to the
7 insurer's position.
- 8 (4) A reference to the evidence or documentation that is the basis for the
9 decision, including the clinical review criteria used to make the
10 determination, and instructions for requesting the clinical review
11 criteria.
- 12 (5) A statement advising the covered person of the covered person's right
13 to request a second-level grievance review and a description of the
14 procedure for submitting a second-level grievance under G.S.
15 58-50-62.
- 16 (6) Notice of the availability of assistance from the Managed Care Patient
17 Assistance Program, including the telephone number and address of
18 the Program.

19 ...

20 (m) Disclosure Requirements. – In the certificate of coverage and member
21 handbook provided to covered persons, an insurer shall include a clear and
22 comprehensive description of its utilization review procedures, including the procedures
23 for appealing noncertifications and a statement of the rights and responsibilities of
24 covered persons, including the voluntary nature of the appeal process, with respect to
25 those procedures. An insurer shall also include in the certificate of coverage and the
26 member handbook information about the availability of assistance from the Managed
27 Care Patient Assistance Program, including the telephone number and address of the
28 Program. An insurer shall include a summary of its utilization review procedures in
29 materials intended for prospective covered persons. An insurer shall print on its
30 membership cards a toll-free telephone number to call for utilization review purposes."

31 **SECTION 2.(a)** G.S. 58-50-62(c) reads as rewritten:

32 "(c) Grievance Procedures. – Every insurer shall have written procedures for
33 receiving and resolving grievances from covered persons. A description of the grievance
34 procedures shall be set forth in or attached to the certificate of coverage and member
35 handbook provided to covered persons. The description shall include a statement
36 informing the covered person that the grievance procedures are voluntary and shall also
37 inform the covered person about the availability of the Commissioner's office for
38 assistance, including the telephone number and address of the office. The description
39 shall also inform the covered person about the availability of assistance from the
40 Managed Care Patient Assistance Program, including the telephone number and address
41 of the Program."

42 **SECTION 2.(b)** G.S. 58-50-62(e)(2) reads as rewritten:

43 "(e) First-Level Grievance Review. – A covered person or a covered person's
44 provider acting on the covered person's behalf may submit a grievance.

- 1 ...
- 2 (2) An insurer shall issue a written decision, in clear terms, to the covered
- 3 person and, if applicable, to the covered person's provider, within 30
- 4 days after receiving a grievance. The person or persons reviewing the
- 5 grievance shall not be the same person or persons who initially
- 6 handled the matter that is the subject of the grievance and, if the issue
- 7 is a clinical one, at least one of whom shall be a medical doctor with
- 8 appropriate expertise to evaluate the matter. Except as provided in
- 9 subdivision (3) of this subsection, if the decision is not in favor of the
- 10 covered person, the written decision issued in a first-level grievance
- 11 review shall contain:
- 12 a. The professional qualifications and licensure of the person or
- 13 persons reviewing the grievance.
- 14 b. A statement of the reviewers' understanding of the grievance.
- 15 c. The reviewers' decision in clear terms and the contractual basis
- 16 or medical rationale in sufficient detail for the covered person
- 17 to respond further to the insurer's position.
- 18 d. A reference to the evidence or documentation used as the basis
- 19 for the decision.
- 20 e. A statement advising the covered person of his or her right to
- 21 request a second-level grievance review and a description of the
- 22 procedure for submitting a second-level grievance under this
- 23 section.
- 24 f. Notice of the availability of assistance from the Managed Care
- 25 Patient Assistance Program, including the telephone number
- 26 and address of the Program."

27 **SECTION 2.(c)** G.S. 58-50-62(f)(1) reads as rewritten:

28 "(f) Second-Level Grievance Review. – An insurer shall establish a second-level

29 grievance review process for covered persons who are dissatisfied with the first-level

30 grievance review decision or a utilization review appeal decision. A covered person or

31 the covered person's provider acting on the covered person's behalf may submit a

32 second-level grievance.

- 33 ...
- 34 (1) An insurer shall, within 10 business days after receiving a request for a
- 35 second-level grievance review, make known to the covered person:
- 36 a. The name, address, and telephone number of a person
- 37 designated to coordinate the grievance review for the insurer.
- 38 b. A statement of a covered person's rights, which include the
- 39 right to request and receive from an insurer all information
- 40 relevant to the case; attend the second-level grievance review;
- 41 present his or her case to the review panel; submit supporting
- 42 materials before and at the review meeting; ask questions of any
- 43 member of the review panel; and be assisted or represented by a
- 44 person of his or her choice, which person may be without

1 limitation to: a provider, family member, employer
2 representative, or attorney. If the covered person chooses to be
3 represented by an attorney, the insurer may also be represented
4 by an attorney.

5 c. The availability of assistance from the Managed Care Patient
6 Assistance Program, including the telephone number and
7 address of the Program.

8 ..."

9 **SECTION 2.(d)** G.S. 58-50-62(h) reads as rewritten:

10 "(h) Second-Level Grievance Review Decisions. – An insurer shall issue a written
11 decision to the covered person and, if applicable, to the covered person's provider,
12 within seven business days after completing the review meeting. The decision shall
13 include:

- 14 (1) The professional qualifications and licensure of the members of the
15 review panel.
- 16 (2) A statement of the review panel's understanding of the nature of the
17 grievance and all pertinent facts.
- 18 (3) The review panel's recommendation to the insurer and the rationale
19 behind that recommendation.
- 20 (4) A description of or reference to the evidence or documentation
21 considered by the review panel in making the recommendation.
- 22 (5) In the review of a noncertification or other clinical matter, a written
23 statement of the clinical rationale, including the clinical review
24 criteria, that was used by the review panel to make the
25 recommendation.
- 26 (6) The rationale for the insurer's decision if it differs from the review
27 panel's recommendation.
- 28 (7) A statement that the decision is the insurer's final determination in the
29 matter. In cases where the review concerned a noncertification and the
30 insurer's decision on the second-level grievance review is to uphold its
31 initial noncertification, a statement advising the covered person of his
32 or her right to request an external review and a description of the
33 procedure for submitting a request for external review to the
34 Commissioner of Insurance.
- 35 (8) Notice of the availability of the Commissioner's office for assistance,
36 including the telephone number and address of the Commissioner's
37 office.
- 38 (9) Notice of the availability of assistance from the Managed Care Patient
39 Assistance Program, including the telephone number and address of
40 the Program."

41 **SECTION 3.** G.S. 58-50-80(b)(3) reads as rewritten:

42 "§ 58-50-80. Standard external review.

43 ...

1 "(b) Upon receipt of a request for an external review under subsection (a) of this
2 section, the Commissioner shall, within 10 business days, complete all of the following:

3 ...

4 (3) Notify in writing the covered person and the covered person's provider
5 who performed or requested the service whether the request is
6 complete and whether the request has been accepted for external
7 review. If the request is complete and accepted for external review, the
8 notice shall include a copy of the information that the insurer provided
9 to the Commissioner pursuant to subdivision (b)(1) of this section, and
10 inform the covered person that the covered person may submit to the
11 assigned independent review organization in writing, within seven
12 days after the receipt of the notice, additional information and
13 supporting documentation relevant to the initial denial for the
14 organization to consider when conducting the external review. If the
15 covered person chooses to send additional information to the assigned
16 independent review organization, then the covered person shall at the
17 same time and by the same means, send a copy of that information to
18 the insurer. The Commissioner shall also notify the covered person in
19 writing of the availability of assistance from the Managed Care Patient
20 Assistance Program, including the telephone number and address of
21 the Program."

22 **SECTION 4.** This act becomes effective October 1, 2003, and applies to
23 actions taken by the insurer under the subsections of G.S. 58-50-61, 58-50-62, and
24 58-50-80 amended by this act, on and after that date. G.S. 58-50-61, as amended by this
25 act, applies to member handbooks printed after October 1, 2003.