

**GENERAL ASSEMBLY OF NORTH CAROLINA**  
**SESSION 2003**

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**HOUSE BILL 744\***

Short Title: Managed Care Patient Assistance. (Public)

Sponsors: Representatives Hackney; Alexander, Glazier, Harrell, Insko, Lucas, Luebke, McLawhorn, Rapp, Ross, Wainwright, Weiss, and Womble.

Referred to: Insurance.

March 27, 2003

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) The professional qualifications and licensure of the person or persons reviewing the appeal.

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

17 ...

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

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

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

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

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

43 ...

1 (2) An insurer shall issue a written decision, in clear terms, to the covered  
2 person and, if applicable, to the covered person's provider, within 30  
3 days after receiving a grievance. The person or persons reviewing the  
4 grievance shall not be the same person or persons who initially  
5 handled the matter that is the subject of the grievance and, if the issue  
6 is a clinical one, at least one of whom shall be a medical doctor with  
7 appropriate expertise to evaluate the matter. Except as provided in  
8 subdivision (3) of this subsection, if the decision is not in favor of the  
9 covered person, the written decision issued in a first-level grievance  
10 review shall contain:

- 11 a. The professional qualifications and licensure of the person or  
12 persons reviewing the grievance.  
13 b. A statement of the reviewers' understanding of the grievance.  
14 c. The reviewers' decision in clear terms and the contractual basis  
15 or medical rationale in sufficient detail for the covered person  
16 to respond further to the insurer's position.  
17 d. A reference to the evidence or documentation used as the basis  
18 for the decision.  
19 e. A statement advising the covered person of his or her right to  
20 request a second-level grievance review and a description of the  
21 procedure for submitting a second-level grievance under this  
22 section.  
23 f. Notice of the availability of assistance from the Managed Care  
24 Patient Assistance Program, including the telephone number  
25 and address of the Program."

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

27 "(f) **Second-Level Grievance Review.** – An insurer shall establish a second-level  
28 grievance review process for covered persons who are dissatisfied with the first-level  
29 grievance review decision or a utilization review appeal decision. A covered person or  
30 the covered person's provider acting on the covered person's behalf may submit a  
31 second-level grievance.

32 ...

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

1 representative, or attorney. If the covered person chooses to be  
2 represented by an attorney, the insurer may also be represented  
3 by an attorney.

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

7 ..."

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

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

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

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

41 "**§ 58-50-80. Standard external review.**

42 ...

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

1           ...

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

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