



Senate

General Assembly

File No. 291

January Session, 2009

Substitute Senate Bill No. 959

Senate, March 30, 2009

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING EXTERNAL APPEALS OF ADVERSE DETERMINATIONS BY A MANAGED CARE ORGANIZATION, HEALTH INSURER OR UTILIZATION REVIEW COMPANY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-478 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2009*):

3 As used in sections 38a-478 to 38a-478o, inclusive, as amended by
4 this act, and subsection (a) of section 38a-478s:

5 (1) "Adverse determination" means a determination by a managed
6 care organization, health insurer or utilization review company that an
7 admission, service, procedure or extension of stay that is a covered
8 benefit has been reviewed and, based upon the information provided,
9 does not meet the managed care organization's, health insurer's or
10 utilization review company's requirements for medical necessity,
11 appropriateness, health care setting, level of care or effectiveness, and
12 such requested admission, service, procedure or extension of stay, or

13 payment for such admission, service, procedure or extension of stay
14 has been denied, reduced or terminated.

15 [(1)] (2) "Commissioner" means the Insurance Commissioner.

16 (3) "Covered benefit" or "benefit" means a health care service to
17 which an enrollee is entitled under the terms of a health benefit plan.

18 (4) Except as provided in sections 38a-478m and 38a-478n, as
19 amended by this act, "enrollee" means a person who has contracted for
20 or who participates in a managed care plan for such person or such
21 person's eligible dependents.

22 (5) "Health care services" means services for the diagnosis,
23 prevention, treatment, cure or relief of a health condition, illness,
24 injury or disease.

25 [(2)] (6) "Managed care organization" means an insurer, health care
26 center, hospital or medical service corporation or other organization
27 delivering, issuing for delivery, renewing, [or] amending or continuing
28 any individual or group health managed care plan in this state.

29 [(3)] (7) "Managed care plan" means a product offered by a managed
30 care organization that provides for the financing or delivery of health
31 care services to persons enrolled in the plan through: (A)
32 Arrangements with selected providers to furnish health care services;
33 (B) explicit standards for the selection of participating providers; (C)
34 financial incentives for enrollees to use the participating providers and
35 procedures provided for by the plan; or (D) arrangements that share
36 risks with providers, provided the organization offering a plan
37 described under subparagraph (A), (B), (C) or (D) of this subdivision is
38 licensed by the Insurance Department pursuant to chapter 698, 698a or
39 700 and [that] the plan includes utilization review pursuant to sections
40 38a-226 to 38a-226d, inclusive, as amended by this act.

41 (8) "Preferred provider network" has the same meaning as provided
42 in section 38a-479aa.

43 [(4)] (9) "Provider" or "health care provider" means a person licensed
44 to provide health care services under chapters 370 to 373, inclusive, 375
45 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

46 [(5) Except as provided in sections 38a-478m and 38a-478n,
47 "enrollee" means a person who has contracted for or who participates
48 in a managed care plan for himself or his eligible dependents.

49 (6) "Preferred provider network" means a preferred provider
50 network, as defined in section 38a-479aa.]

51 [(7)] (10) "Utilization review" [means utilization review, as defined]
52 has the same meaning as provided in section 38a-226.

53 [(8)] (11) "Utilization review company" [means a utilization review
54 company, as defined] has the same meaning as provided in section
55 38a-226.

56 Sec. 2. Section 38a-478n of the general statutes is repealed and the
57 following is substituted in lieu thereof (*Effective October 1, 2009*):

58 (a) Any enrollee, or any provider acting on behalf of an enrollee
59 with the enrollee's consent, who has exhausted the internal
60 mechanisms provided by a managed care organization, health insurer
61 or utilization review company to appeal the denial of a claim based on
62 medical necessity or a determination not to certify an admission,
63 service, procedure or extension of stay, regardless of whether such
64 determination was made before, during or after the admission, service,
65 procedure or extension of stay, may appeal such denial or
66 determination to the commissioner. As used in this section and section
67 38a-478m, "health insurer" means any entity, other than a managed
68 care organization [, which] that delivers, issues for delivery, renews,
69 [or] amends or continues an individual or group health insurance plan
70 in this state [, "health plan" means a plan of health insurance]
71 providing coverage of the type specified in subdivision (1), (2), (4),
72 (10), (11), (12) and (13) of section 38a-469, [but does not include a
73 managed care plan offered by a managed care organization,] and

74 "enrollee" means a person who has contracted for or who participates
75 in coverage under an individual or group health insurance plan or a
76 managed care plan [or health plan for himself or his] for such person
77 or such person's eligible dependents.

78 (b) (1) To appeal a denial or determination pursuant to this section,
79 an enrollee or any provider acting on behalf of an enrollee with the
80 enrollee's consent shall, not later than sixty days after receiving final
81 written notice of the denial or determination from the enrollee's
82 managed care organization, health insurer or utilization review
83 company, file a written request with the commissioner. The appeal
84 shall be on forms prescribed by the commissioner and shall include the
85 filing fee set forth in subdivision (2) of this subsection and a general
86 release executed by the enrollee for all medical records pertinent to the
87 appeal. The managed care organization, health insurer or utilization
88 review company named in the appeal shall also pay to the
89 commissioner the filing fee set forth in subdivision (2) of this
90 subsection. If the Insurance Commissioner receives three or more
91 appeals of denials or determinations by the same managed care
92 organization or utilization review company with respect to the same
93 procedural or diagnostic coding, the Insurance Commissioner may, on
94 said commissioner's own motion, issue an order specifying how such
95 managed care organization or utilization review company shall make
96 determinations about such procedural or diagnostic coding.

97 (2) The filing fee shall be twenty-five dollars and shall be deposited
98 in the Insurance Fund established in section 38a-52a. If the
99 commissioner finds that an enrollee is indigent or unable to pay the
100 fee, the commissioner shall waive the enrollee's fee. The commissioner
101 shall refund any paid filing fee to (A) the managed care organization,
102 health insurer or utilization review company if the appeal is not
103 accepted for full review, or (B) the prevailing party upon completion of
104 a full review pursuant to this section.

105 (3) Upon receipt of the appeal together with the executed release
106 and appropriate fee, the commissioner shall assign the appeal for

107 review to [an] a review entity, as defined in subsection [(c)] (g) of this
108 section.

109 (4) Upon receipt of the request for appeal from the commissioner,
110 the review entity conducting the appeal shall conduct a preliminary
111 review of the appeal and accept the appeal if such review entity
112 determines: (A) The individual was or is an enrollee of the managed
113 care organization or health insurer; (B) the benefit or service that is the
114 subject of the complaint or appeal reasonably appears to be a covered
115 service, benefit or service under the agreement provided by contract to
116 the enrollee; (C) the enrollee or provider acting on behalf of the
117 enrollee with the enrollee's consent has exhausted all internal appeal
118 mechanisms provided; (D) the enrollee or provider acting on behalf of
119 the enrollee with the enrollee's consent has provided all information
120 required by the commissioner to make a preliminary determination
121 including the appeal form, a copy of the final decision of denial and a
122 fully-executed release to obtain any necessary medical records from
123 the managed care organization or health insurer and any other
124 relevant provider.

125 (5) Upon completion of the preliminary review, the review entity
126 [conducting such review] shall immediately notify the [member]
127 enrollee or provider, as applicable, in writing as to whether the appeal
128 has been accepted for full review and, if not so accepted, the reasons
129 why the appeal was not accepted for full review.

130 (6) If accepted for full review, (A) the review entity shall conduct
131 such review in accordance with the regulations adopted by the
132 commissioner, after consultation with the Commissioner of Public
133 Health, in accordance with the provisions of chapter 54, and (B) the
134 commissioner shall notify the managed care organization, health
135 insurer or utilization review company of the receipt of a request for an
136 external appeal and provide the name of the review entity assigned to
137 such appeal. Not later than five business days after such notification,
138 the managed care organization, health insurer or utilization review
139 company shall provide to such review entity by electronic mail,

140 telephone, facsimile or other expeditious method all documents and
141 information that were considered in making the adverse determination
142 that is the subject of such appeal.

143 [(c) To provide for such appeal the Insurance Commissioner, after
144 consultation with the Commissioner of Public Health, shall engage
145 impartial health entities to provide for medical review under the
146 provisions of this section. Such review entities shall include (1) medical
147 peer review organizations, (2) independent utilization review
148 companies, provided any such organizations or companies are not
149 related to or associated with any managed care organization or health
150 insurer, and (3) nationally recognized health experts or institutions
151 approved by the commissioner.]

152 [(d)] (c) (1) Not later than five business days after receiving a written
153 request from the commissioner, enrollee or any provider acting on
154 behalf of an enrollee with the enrollee's consent, a managed care
155 organization or health insurer whose enrollee is the subject of an
156 appeal shall provide to the commissioner, enrollee or any provider
157 acting on behalf of an enrollee with the enrollee's consent, written
158 verification of whether the enrollee's plan is fully insured, self-funded,
159 or otherwise funded. If the plan is a fully insured plan or a self-insured
160 governmental plan, the managed care organization or health insurer
161 shall send: (A) Written certification to the commissioner or reviewing
162 entity, as determined by the commissioner, that the benefit or service
163 subject to the appeal is a covered benefit or service; (B) a copy of the
164 entire policy or contract between the enrollee and the managed care
165 organization or health insurer, except that with respect to a self-
166 insured governmental plan, (i) the managed care organization or
167 health insurer shall notify the plan sponsor, and (ii) the plan sponsor
168 shall send, or require the managed care organization or health insurer
169 to send, such copy; or (C) written certification that the policy or
170 contract is accessible to the review entity electronically and clear and
171 simple instructions on how to electronically access the policy or
172 contract.

173 (2) Failure of the managed care organization or health insurer to
174 provide information or notify the plan sponsor in accordance with
175 subdivision (1) of this subsection within said five-business-day period
176 shall (A) create a presumption on the review entity, solely for purposes
177 of accepting an appeal and conducting the review pursuant to
178 subdivision (4) of subsection (b) of this section, that the benefit or
179 service is a covered benefit under the applicable policy or contract,
180 except that such presumption shall not be construed as creating or
181 authorizing benefits or services in excess of those that are provided for
182 in the enrollee's policy or contract, and (B) entitle the commissioner to
183 require the managed care organization or health insurer from whom
184 the enrollee is appealing a medical necessity determination to
185 reimburse the department for the expenses related to the appeal,
186 including, but not limited to, expenses incurred by the review entity.

187 [(e) The commissioner shall accept the decision of the review entity
188 and the decision of the commissioner shall be binding.]

189 [(f)] (d) Not later than January 1, 2000, the Insurance Commissioner
190 shall develop a comprehensive public education outreach program to
191 educate health insurance consumers of the existence of the appeals
192 procedure established in this section. The program shall maximize
193 public information concerning the appeals procedure and shall
194 include, but not be limited to: (1) The dissemination of information
195 through mass media, interactive approaches and written materials; (2)
196 involvement of community-based organizations in developing
197 messages and in devising and implementing education strategies; and
198 (3) periodic evaluations of the effectiveness of educational efforts. The
199 Healthcare Advocate shall coordinate the outreach program and
200 oversee the education process.

201 (e) (1) (A) Except as provided in subdivision (9) of this subsection,
202 an enrollee or any provider acting on behalf of the enrollee with the
203 enrollee's consent may make a request to the commissioner for an
204 expedited external appeal at the time the enrollee receives an adverse
205 determination if: (i) The time frame for completion of an expedited

206 internal appeal set forth in section 38a-226c, as amended by this act,
207 may cause or exacerbate an emergency or life-threatening situation for
208 the enrollee; and (ii) the enrollee or the provider acting on behalf of the
209 enrollee with the enrollee's consent has filed a request for expedited
210 review as set forth in section 38a-226c, as amended by this act.

211 (B) Upon receipt of such request and all required documentation,
212 including the executed release and appropriate fee set forth in
213 subsection (b) of this section, the commissioner shall immediately
214 assign the appeal for review to a review entity.

215 (2) Upon receipt of the request for an expedited external appeal
216 from the commissioner, the review entity shall, not later than two
217 business days after receipt of such appeal, conduct a preliminary
218 review of the appeal and accept the appeal for expedited review if
219 such review entity determines: (A) The individual was or is an enrollee
220 of the managed care organization or health insurer; (B) the benefit or
221 service that is the subject of the appeal reasonably appears to be a
222 covered service, benefit or service under the agreement provided by
223 contract to the enrollee; (C) the enrollee or provider acting on behalf of
224 the enrollee with the enrollee's consent has provided all information
225 required by the commissioner to make a preliminary determination
226 including the appeal form, a copy of the decision of denial and a fully-
227 executed release to obtain any necessary medical records from the
228 managed care organization or health insurer and any other relevant
229 provider; and (D) the adverse determination may cause or exacerbate
230 an emergency or life-threatening situation for the enrollee if not
231 reviewed in an expedited time period.

232 (3) Upon completion of the preliminary review, the review entity
233 shall immediately notify the enrollee or provider, as applicable, in
234 writing as to whether the appeal has been accepted for full review and,
235 if not so accepted, the reasons why the appeal was not accepted for full
236 review.

237 (4) If accepted for full review, the review entity shall conduct such
238 review to determine whether the adverse determination should be

239 reversed, revised or affirmed. Such review shall be performed by a
240 provider who is a specialist in the field related to the condition that is
241 the subject of the appeal. The review entity may take into
242 consideration: (A) Pertinent medical records; (B) consulting reports
243 from appropriate health care professionals and other documents
244 submitted by the health insurer, the enrollee, the enrollee's authorized
245 representative or the enrollee's provider; (C) practice guidelines
246 developed by the federal government or national, state or local
247 medical societies, boards or associations; and (D) clinical protocols or
248 practice guidelines developed by the managed care organization,
249 health insurer or utilization review company. For the purposes of this
250 subdivision, "authorized representative" means (i) a person to whom
251 an enrollee has given express written consent to represent such
252 enrollee in an external appeal, (ii) a person authorized by law to
253 provide substituted consent for an enrollee, or (iii) a family member of
254 the enrollee when such enrollee is unable to provide consent.

255 (5) To the extent the following information or documents are
256 available and the review entity considers them appropriate, such
257 review entity shall consider:

258 (A) The terms of coverage under the agreement provided by
259 contract to the enrollee to ensure the review entity's decision is not
260 contrary to the terms of coverage under such agreement;

261 (B) Medical or scientific evidence. For the purposes of this
262 subparagraph, "medical or scientific evidence" means evidence found
263 in the following sources:

264 (i) Peer-reviewed scientific studies published in or accepted for
265 publication by medical journals that meet nationally recognized
266 requirements for scientific manuscripts and that submit most of their
267 published articles for review by experts who are not part of the
268 editorial staff;

269 (ii) Peer-reviewed medical literature, including literature relating to
270 therapies reviewed and approved by a qualified institutional review

271 board, biomedical compendia and other medical literature that meet
272 the criteria of the National Institutes of Health's National Library of
273 Medicine for indexing in Index Medicus (MEDLINE) or Elsevier
274 Science for indexing in Excerpta Medica (EMBASE);

275 (iii) Medical journals recognized by the Secretary of Health and
276 Human Services under Section 1861(t)(2) of the Social Security Act;

277 (iv) The following standard reference compendia: (I) The American
278 Hospital Formulary Service - Drug Information; (II) Drug Facts and
279 Comparisons; (III) the American Dental Association's Accepted Dental
280 Therapeutics; and (IV) the United States Pharmacopoeia - Drug
281 Information; and

282 (v) Findings, studies or research conducted by or under the auspices
283 of federal government agencies or nationally recognized federal
284 research institutes including (I) the Agency for Healthcare Research
285 and Quality, (II) the National Institutes of Health, (III) the National
286 Cancer Institute, (IV) the National Academy of Sciences, (V) the
287 Centers for Medicare and Medicaid Services, (VI) the Food and Drug
288 Administration, (VII) any national board recognized by the National
289 Institutes of Health to evaluate the medical value of health care
290 services, and (VIII) any other source that is comparable to those listed
291 in subparagraphs (B)(v)(I) to (B)(v)(V), inclusive, of this subdivision;

292 (C) Any applicable clinical review criteria developed and used by
293 the managed care organization, health insurer or utilization review
294 company in making adverse determinations; and

295 (D) After considering subparagraphs (A) to (C), inclusive, of this
296 subdivision, the opinion of the review entity's clinical reviewer or
297 reviewers.

298 (6) The review entity shall complete its full review not later than
299 two business days after the completion of its preliminary review and
300 shall forward its decision to reverse, revise or affirm the adverse
301 determination together with its report of the full review to the

302 commissioner. The review entity may request from the commissioner
303 an extension of time to complete its review due to circumstances
304 beyond its control. If an extension is granted, the review entity shall
305 provide written notice to the enrollee or the enrollee's provider, setting
306 forth the status of the review, the specific reasons for the delay and the
307 anticipated date of completion of the review.

308 (7) In reaching a decision under subdivision (6) of this subsection, a
309 review entity shall not be bound by any decisions or conclusions
310 reached by the managed care organization, health insurer or utilization
311 review company pursuant to section 38a-226c, as amended by this act,
312 or this section.

313 (8) The commissioner shall notify the managed care organization,
314 health insurer or utilization review company of the receipt of a request
315 for an expedited external appeal and provide the name of the review
316 entity assigned to such appeal. Not later than one business day after
317 such notification, the managed care organization, health insurer or
318 utilization review company shall provide to such review entity by
319 electronic mail, telephone, facsimile or other expeditious method all
320 documents and information that were considered in making the
321 adverse determination that is the subject of such appeal.

322 (9) The commissioner shall not provide an expedited external
323 appeal if the health care services that are the subject of the appeal have
324 already been provided to the enrollee.

325 (10) If a request for an expedited external appeal is denied, an
326 enrollee or any provider acting on behalf of the enrollee with the
327 consent of the enrollee may submit such request for a standard
328 external appeal as set forth in subsection (b) of this section.

329 (11) The commissioner shall assign review entities to appeals on a
330 random basis and shall choose such entities from among those
331 approved by the Insurance Commissioner, after consultation with the
332 Commissioner of Public Health, as set forth in subsection (g) of this
333 section.

334 (f) (1) An external appeal decision shall be binding on the managed
335 care organization, health insurer, utilization review company and
336 enrollee. Nothing in this subdivision shall be construed to limit or
337 prohibit any other remedy available under federal or state law.

338 (2) No enrollee or provider acting on behalf of the enrollee with the
339 enrollee's consent shall file a subsequent request for external appeal
340 involving the same adverse determination for which the enrollee has
341 already received an external appeal pursuant to this section.

342 (g) (1) After consultation with the Commissioner of Public Health,
343 the Insurance Commissioner shall engage independent review entities
344 to provide medical review under the provisions of this section. For the
345 purposes of this section, "review entity" means an entity that conducts
346 independent external reviews of adverse determinations. Such review
347 entities include, but are not limited to, medical peer review
348 organizations, independent utilization review companies, provided
349 such organizations or companies are not related to or associated with
350 any managed care organization or health insurer, and nationally
351 recognized health experts or institutions approved by the Insurance
352 Commissioner.

353 (2) (A) (i) To be eligible for approval by the commissioner, a review
354 entity shall have received approval or accreditation by a nationally
355 recognized private accrediting review entity approved by the
356 commissioner, or shall demonstrate to the commissioner that such
357 review entity adheres to qualifications that are substantially similar to,
358 and do not provide less protection to enrollees than, those set forth in
359 subsection (h) of this section.

360 (ii) A review entity that is accredited by a nationally recognized
361 private accrediting review entity that has independent review
362 accreditation standards, which the commissioner has determined are
363 equivalent to or exceed the minimum qualifications of subsection (h) of
364 this section, shall be deemed to be eligible for approval by the
365 commissioner.

366 (B) Each review entity shall provide a statement of qualifications to
367 the commissioner in accordance with state and Insurance Department
368 contracting requirements.

369 (3) Each approval shall be effective for two years, unless the
370 commissioner determines before its expiration that the review entity is
371 not satisfying the minimum qualifications set forth in subsection (h) of
372 this section. If the commissioner determines that a review entity is not
373 satisfying such minimum qualifications, the commissioner shall
374 terminate the review entity's contract.

375 (h) (1) Each review entity approved by the commissioner pursuant
376 to subsection (g) of this section shall have and maintain written
377 policies and procedures that govern all aspects of the standard and
378 expedited external appeal processes set forth in subsections (b) and (e)
379 of this section, including, but not limited to:

380 (A) A quality assurance mechanism that ensures: (i) That external
381 appeals are conducted within the time frames specified and required
382 notices are provided in a timely manner; (ii) the selection and
383 employment of qualified, impartial and sufficient number of clinical
384 reviewers to conduct external appeals on behalf of the review entity
385 and suitable matching of reviewers to specific cases; (iii) the
386 confidentiality of medical and treatment records and clinical review
387 criteria; and (iv) that any person employed by or under contract with
388 the review entity complies with the provisions of this section.

389 (B) A toll-free facsimile service or electronic mail that is able to
390 receive information related to external appeals on a twenty-four-hours-
391 per-day, seven-days-per-week basis; and

392 (C) An agreement to maintain and provide to the commissioner the
393 information required in subsection (j) of this section.

394 (2) Each clinical reviewer assigned by a review entity to conduct
395 external appeals shall be a physician or other health care provider who
396 meets the following minimum qualifications:

397 (A) Is an expert in the treatment of the enrollee's medical condition
398 that is the subject of the external appeal;

399 (B) Is knowledgeable about the recommended health care service or
400 treatment through recent or current actual clinical experience treating
401 patients with the same or similar medical condition as the enrollee;

402 (C) Holds a nonrestricted license in a state of the United States and,
403 for a physician, holds a current certification by a recognized American
404 medical specialty board in the area or areas appropriate to the subject
405 of the external appeal; and

406 (D) Has no history of disciplinary actions or sanctions, including
407 loss of staff privileges or participation restrictions, taken or pending by
408 any hospital, governmental agency or unit or regulatory body, that
409 raise a substantial question as to the physical, mental or professional
410 competence or moral character of such reviewer.

411 (3) In addition to the requirements set forth in subdivision (1) of this
412 subsection, a review entity shall not own or control, be a subsidiary of
413 or be owned or controlled by, or exercise control over a managed care
414 organization, health insurer, utilization review company, health plan, a
415 national, state or local trade association of managed care organizations
416 or health insurers or a national, state or local trade association of health
417 care providers.

418 (4) (A) Neither the review entity assigned by the commissioner to
419 conduct an external appeal nor any clinical reviewer assigned by the
420 review entity to conduct such appeal shall have a material
421 professional, familial or financial conflict of interest with any of the
422 following:

423 (i) The managed care organization, health insurer or utilization
424 review company that is the subject of the external appeal;

425 (ii) The enrollee whose treatment is the subject of the external
426 appeal or the provider acting on behalf of the enrollee with the
427 enrollee's consent;

428 (iii) Any officer, director or management employee of the managed
429 care organization, health insurer or utilization review company that is
430 the subject of the external appeal;

431 (iv) The health care provider, the health care provider's medical
432 group or independent practice association recommending the health
433 care service or treatment that is the subject of the external appeal;

434 (v) The facility at which the recommended health care service or
435 treatment would be provided. For the purposes of this subparagraph,
436 "facility" means an institution providing health care services or a
437 health care setting, including, but not limited to, hospitals and other
438 licensed inpatient centers, ambulatory surgical or treatment centers,
439 skilled nursing centers, residential treatment centers, diagnostic,
440 laboratory and imaging centers, and rehabilitative or other therapeutic
441 health settings; or

442 (vi) The developer or manufacturer of the principal drug, device,
443 procedure or other therapy being recommended for the enrollee whose
444 treatment is the subject of the external appeal.

445 (B) When determining whether a review entity or clinical reviewer
446 has a material professional, familial or financial conflict of interest, the
447 commissioner shall take into consideration situations in which the
448 review entity or clinical reviewer to be assigned to conduct an external
449 appeal may have an apparent professional, familial or financial
450 relationship or connection with a person described in subparagraph
451 (A) of this subdivision but that the characteristics of such relationship
452 or connection are such that they do not constitute a material conflict of
453 interest that disqualifies the review entity or clinical reviewer from
454 being assigned to the specific case.

455 (5) A review entity shall be unbiased and shall establish and
456 maintain written procedures to ensure such impartiality, in addition to
457 any other procedures required to be maintained by this section.

458 (i) No review entity or clinical reviewer working on behalf of a

459 review entity, or an employee, agent or contractor of a review entity
460 shall be liable in damages to any person for any opinion rendered or
461 act or omission performed within the scope of the review entity's or
462 such employee's, agent's or contractor's duties during or upon
463 completion of an external appeal conducted pursuant to this section,
464 unless such opinion was rendered or act or omission was performed in
465 bad faith or involved gross negligence.

466 (j) (1) Each review entity shall maintain written records for review
467 by a managed care organization, health insurer or utilization review
468 company on all requests for standard and expedited external appeals
469 for which such entity conducted such reviews during a calendar year.
470 The review entity shall retain such written records for at least six years.

471 (2) Each review entity shall submit a report to the commissioner
472 upon request, in a format prescribed by the commissioner. Such report
473 shall include, for each managed care organization, health insurer and
474 utilization review company:

475 (A) The total number of requests for standard external appeals and
476 the total number of requests for expedited external appeals;

477 (B) The number of standard external appeals and the number of
478 expedited external appeals that were resolved, and of those resolved,
479 the number reversing the adverse determination, the number revising
480 the adverse determination and the number affirming the adverse
481 determination;

482 (C) The length of time for resolution of each external appeal;

483 (D) A summary of the procedure and diagnosis codes for which an
484 external appeal was sought; and

485 (E) Any other information the commissioner may require.

486 Sec. 3. Subdivision (2) of subsection (a) of section 38a-226c of the
487 general statutes is repealed and the following is substituted in lieu
488 thereof (*Effective October 1, 2009*):

489 (2) Each utilization review company shall maintain and make
 490 available a written description of the appeal procedure by which either
 491 the enrollee or the provider of record may seek review of
 492 determinations not to certify an admission, service, procedure or
 493 extension of stay. An appeal by the provider of record shall be deemed
 494 to be made on behalf of the enrollee and with the consent of such
 495 enrollee if the admission, service, procedure or extension of stay has
 496 not yet been provided or if such determination not to certify creates a
 497 financial liability to the enrollee. The procedures for appeals shall
 498 include the following:

499 (A) Each utilization review company shall notify in writing the
 500 enrollee and provider of record of its determination on the appeal as
 501 soon as practical, but in no case later than thirty days after receiving
 502 the required documentation on the appeal.

503 (B) On appeal, all determinations not to certify an admission,
 504 service, procedure or extension of stay shall be made by a licensed
 505 practitioner of the healing arts.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2009	38a-478
Sec. 2	October 1, 2009	38a-478n
Sec. 3	October 1, 2009	38a-226c(a)(2)

Statement of Legislative Commissioners:

Section 1 (1) was rewritten for clarity, in the last sentence of section 2(a), "such" was inserted before "person's" for clarity, and in the last sentence of section 2(e)(4), "subdivision" was substituted for "subparagraph" for accuracy.

INS *Joint Favorable Subst.-LCO*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

This bill creates an expedited external review process for qualifying denials of healthcare coverage and does not result in a fiscal impact.

The Out Years

None

OLR Bill Analysis**sSB 959*****AN ACT CONCERNING EXTERNAL APPEALS OF ADVERSE DETERMINATIONS BY A MANAGED CARE ORGANIZATION, HEALTH INSURER OR UTILIZATION REVIEW COMPANY.*****SUMMARY:**

This bill establishes an “expedited external appeal process” for a health plan enrollee, of his or her health care provider, to use after his or her health insurer or similar entity denies coverage for a procedure or treatment that has not yet been received and the time frame for completing the entity’s expedited internal appeal could cause or worsen a life-threatening or emergency situation.

The bill adopts (1) standards, criteria, and record maintenance and reporting requirements for review entities and (2) qualifications for clinical reviewers. The review entities and clinical reviewers review and decide the appeals. The bill makes a review entity’s decision regarding an external review (standard or expedited) binding on an enrollee and insurer, or similar entity. It specifies that it does not limit or prohibit any other remedy available under federal or state law.

By law, a licensed health care provider may appeal an adverse determination on the enrollee’s behalf with his or her consent. The bill specifies that an enrollee’s provider of record is deemed to be acting on the enrollee’s behalf and with his or her consent if (1) the admission, service, procedure, or extension of stay in question has not yet occurred or (2) the entity’s coverage denial makes the enrollee financially liable for its cost if it were to be provided.

It also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2009

DEFINITIONS

The bill defines “adverse determination” as a managed care organization’s (MCO), health insurer’s, or utilization review (UR) company’s determination, having reviewed information provided, that (1) an admission, service, procedure, or extension of stay that is a covered benefit does not meet its requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and (2) payment (i.e., coverage) for it is denied, reduced, or terminated.

It defines a “covered benefit” as a health care service to which an enrollee is entitled under the terms of a health benefit plan. It defines “health care services” as services rendered to diagnose, prevent, treat, cure, or relieve a health condition, illness, injury, or disease.

EXPEDITED EXTERNAL APPEAL PROCESS

The bill establishes an expedited external appeal process that supplements the external appeal process in existing law. By law, a health plan enrollee, or a licensed health care provider acting on the enrollee’s behalf with his or her consent (“provider”), must exhaust the MCO’s, insurer’s or UR company’s internal appeal process before applying for an external appeal. (Internal appeal processes usually include an appeal and a grievance and allow for an expedited appeal in certain circumstances.)

The bill permits enrollees and providers, in certain situations, to ask the insurance commissioner for an expedited external appeal of an adverse determination before exhausting the internal appeal process. The enrollee or provider may request the expedited external appeal if (1) the time to complete an expedited internal appeal could cause, or exacerbate, an emergency or life-threatening situation for the enrollee and (2) he or she files the request in accordance with the law’s provisions applicable to external appeals generally.

The bill requires the commissioner to assign an expedited appeal request to a review entity immediately upon receiving an expedited external appeal request, which must include the applicable filing fee

and necessary documentation, including a signed release. He must assign appeals to review entities randomly from among the list of approved review entities, which is established in accordance with the bill.

But the bill prohibits the commissioner from granting an expedited external appeal if the health care services in question have already been provided to the enrollee.

It requires the commissioner to notify the insurer, MCO, or UR company that made the adverse determination in question (1) that he received an expedited external appeal request and (2) of the name of the review entity assigned to the appeal.

The bill requires the insurer or other entity, within one business day after receiving the commissioner's notice, to provide the review entity all documents and information it considered in making the adverse determination. It may provide this information to the review entity via e-mail, telephone, fax, or other expeditious method.

Preliminary Review

Upon receiving the expedited external appeal from the commissioner, the bill requires the review entity to conduct a preliminary review within two business days to determine whether to accept it for full review. The review entity must accept the appeal for full review if it determines the:

1. patient involved is or was the involved health insurer's MCO's enrollee;
2. benefit or service at issue reasonably appears to be a covered service or benefit under the health care plan;
3. enrollee or provider has provided all information the commissioner requires to make a preliminary determination, including the appeal form, a copy of the coverage denial, and a fully-executed release to obtain any necessary medical records

from the insurer, MCO, and any relevant provider; and

4. adverse determination may cause or exacerbate an emergency or life-threatening situation for the enrollee if the appeal is not reviewed expeditiously.

The review entity must, upon completing the preliminary review, immediately notify the enrollee or provider, as applicable, in writing whether or not the appeal is accepted for full review. If it is not accepted for full review, the written notification must include the reasons for the decision.

Full Review

The bill requires the review entity, if it accepts the appeal for full review, to review the coverage denial to determine whether it should be reversed, revised, or affirmed. Under the bill, the person performing the review must be a provider specializing in the field related to the affected patient's condition.

Information to Consider

In conducting the full review, the review entity may consider:

1. pertinent medical records;
2. consulting reports from appropriate health care professionals;
3. documents the insurer, MCO, enrollee, the enrollee's authorized representative, or the enrollee's provider submitted;
4. practice guidelines the federal government or national, state, or local medical societies, boards, or associations developed; and
5. clinical protocols or practice guidelines the MCO, insurer, or UR company developed.

The bill defines "authorized representative" as (1) a person to whom an enrollee gives express written consent to represent him or her in an external appeal, (2) a person the law authorizes to provide "substituted

consent” for the enrollee, or (3) the enrollee’s family member when the enrollee is unable to provide consent.

The bill requires the review entity to consider, to the extent it is available and, in the review entity’s opinion, appropriate, the relevant health plan coverage terms, to ensure the review entity’s decision is not contrary to those terms, and medical or scientific evidence. The bill defines “medical or scientific evidence” as evidence found in:

1. peer-reviewed scientific studies published in, or accepted for publication by, medical journals (a) meeting nationally-recognized requirements for scientific manuscripts and (b) that submit most of their published articles for review by experts who are not part of the editorial staff;
2. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus (MEDLINE) or Elsevier Science for indexing in Excerpta Medica (EMBASE);
3. medical journals the secretary of health and human services recognizes under federal Social Security law;
4. the following standard reference compendia: (a) the American Hospital Formulary Service - Drug Information, (b) Drug Facts and Comparisons, (c) the American Dental Association's Accepted Dental Therapeutics, and (d) the U.S. Pharmacopoeia - Drug Information;
5. findings, studies, or research conducted by, or under the auspices of, federal government agencies or nationally-recognized federal research institutes, including (a) the Agency for Healthcare Research and Quality, (b) the National Institutes of Health, (c) the National Cancer Institute, (d) the National

Academy of Sciences, (e) the Centers for Medicare and Medicaid Services, (f) the Food and Drug Administration, (g) any national board the National Institutes of Health recognizes to evaluate the medical value of health care services, and (h) any other source comparable to (a) through (e); and

6. any applicable clinical review criteria the insurer, MCO, or UR company develops and uses in making adverse determinations.

The bill requires the review entity, after considering the above information, to also consider its own clinical reviewers' opinions.

Appeal Decision

The bill requires the review entity to (1) complete the full review within two business days after the preliminary review is completed and (2) forward the commissioner its decision (i.e., to reverse, revise, or affirm the adverse determination) and a report of the full review.

The bill permits the review entity to ask the commissioner for an extension to complete its review if circumstances exist beyond its control. If the commissioner grants the extension, the review entity must notify the enrollee or provider in writing of the (1) review status, (2) specific reasons for the delay, and (3) anticipated completion date.

The bill specifies that a review entity is not bound by any decisions or conclusions the insurer, MCO, or UR company made during a utilization review process.

EXTERNAL APPEALS GENERALLY

When a review entity accepts an external appeal for full review, the bill requires the commissioner to notify the insurer, MCO, or UR company that made the adverse determination (1) that he received an external appeal request and (2) of the name of the review entity assigned to the appeal.

The bill requires the insurer or other entity, within five business days after receiving the commissioner's notice, to provide the review

entity all documents and information it considered in making the adverse determination. It may provide this information to the review entity by e-mail, telephone, fax, or other expeditious method. By law, it must, within five days of receiving a request from the commissioner, provider, or enrollee, provide information regarding the benefit plan to which the appeal relates (e.g., whether it is fully-insured or self-insured, if the service to which the appeal relates is a covered service or benefit under the plan).

Subsequent Appeal Prohibited

The bill prohibits an enrollee or provider from requesting a subsequent external appeal of the same adverse determination that was already the subject of an external appeal. Except, when an expedited external appeal request is denied, an enrollee or provider may submit a request for a non-expedited external appeal, in accordance with law.

Binding Decision

The bill makes a review entity's external review decision binding on the insurer, MCO, UR company, and enrollee (but apparently not the provider). Current law requires the commissioner to accept the review entity's decision and makes his acceptance binding (but does not specify on whom).

The bill specifies that it does not limit or prohibit any other remedy available under federal or state law.

REVIEW ENTITIES

Under current law, the insurance commissioner, after consulting with the public health commissioner, must contract with impartial review entities to review appeals. The bill requires him, instead, to contract with independent review entities that meet specified criteria.

By law, the review entities must include (1) medical peer review organizations and independent UR companies that are not related to, or associated with, any insurer or MCO and (2) nationally-recognized health experts or institutions the insurance commissioner approves.

Qualifications for Selection

Under the bill, to be selected, (1) a nationally-recognized private accrediting review entity the commissioner approves must have approved or accredited the review entity or (2) the review entity must demonstrate to the commissioner that it adheres to qualifications substantially similar to, and that do not provide less protection to enrollees than, the policies and procedures it must have in place if selected (see below).

The bill deems as eligible a review entity accredited by a nationally-recognized private accrediting review entity with independent review accreditation standards that the commissioner determines are equivalent to or exceed the minimum qualifications below.

The bill requires each review entity to provide the commissioner a statement of qualifications in accordance with state and Insurance Department contracting requirements.

Under the bill, when the commissioner approves a review entity for purposes of the external review process, each approval is effective for two years, unless he determines before the end of the two years that the review entity is not satisfying the minimum qualifications below, in which case he must terminate the contract with the review entity.

Written Policies and Procedures Required

The bill requires each review entity the commissioner approves (and apparently engages) to have and maintain written policies and procedures governing all aspects of the external appeal processes, including expedited appeals.

The review entity's policies and procedures must include a quality assurance mechanism ensuring that the review entity:

1. conducts external appeals within the required time frames and provides required notices in a timely manner;
2. selects and employs a sufficient number of qualified, impartial

clinical reviewers to conduct external appeals on its behalf;

3. suitably assigns reviewers to specific cases;
4. maintains the confidentiality of medical and treatment records and clinical review criteria; and
5. ensures its employees and contractors comply with the bill's provisions.

The review entity's policies and procedures also must include:

1. a toll-free fax service or e-mail that can receive information related to external appeals 24-hours a day and seven days a week and
2. an agreement to maintain and provide to the commissioner specified information in accordance with the bill's record-keeping and reporting requirements (see below).

Clinical Reviewers' Qualifications

The bill requires each clinical reviewer that a review entity assigns to an external appeal to be a physician or other health care provider who is, at a minimum:

1. an expert in treating the enrollee's medical condition that is the subject of the external appeal;
2. knowledgeable about the recommended health care service or treatment through his or her recent or current clinical experience treating patients with the same or similar condition;
3. holds a nonrestricted provider license in a U.S. state;
4. if a physician, currently certified by a recognized American medical specialty board in the area or areas appropriate to the subject of the external appeal; and
5. has no history of disciplinary actions or sanctions, including loss

of staff privileges or participation restrictions, that a hospital or governmental agency, unit, or regulatory body took, or has pending, that raise a substantial question as to his or her physical, mental, or professional competence or moral character.

Conflict of Interest Prohibited

The bill imposes conflict of interest restrictions for review entities. A review entity cannot (1) own or control, (2) be a subsidiary of, (3) be owned or controlled by, or (4) exercise control over, a health insurer, MCO, UR company, health plan, or a trade association of insurers, MCOs, or providers.

The bill prohibits a review entity and its clinical reviewers assigned to appeals from having a “material professional, familial, or financial conflict of interest” with:

1. the insurer, MCO, or UR company that made the adverse determination being appealed or any of its officers, directors, or management employees;
2. the enrollee whose treatment is the subject of the appeal or the provider acting on his or her behalf;
3. the health care provider, medical group, or independent practice association recommending the service or treatment that is the subject of the appeal;
4. the facility or health care setting, including hospitals, licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitative or other therapeutic health settings, at which the service or treatment would be provided; or
5. the developer or manufacturer of the principal drug, device, procedure, or other therapy recommended for the enrollee whose treatment is the subject of the appeal.

When determining whether a review entity or clinical reviewer has a “material professional, familial, or financial conflict of interest,” the bill requires the commissioner to consider situations in which the review entity or clinical reviewer may have an apparent relationship or connection, but the actual relationship or connection does not constitute a disqualifying, material conflict of interest.

The bill requires a review entity to (1) be unbiased and (2) establish and maintain written procedures to ensure such impartiality.

Immunity from Liability

The bill specifies that no liability for damages accrues against a review entity or its clinical reviewer, employee, agent, or contractor, for an opinion rendered, or act or omission performed, within the scope of the review entity's or person's duties relating to an external appeal conducted in accordance with the bill, unless rendered or performed in bad faith or with gross negligence.

Open Records

The bill requires a review entity to maintain, for at least six years, written records of the requested external appeals it conducts each calendar year. The records must be available for insurers', MCOs', or UR companies' review.

Reporting Requirements

The bill requires a review entity, upon the commissioner's request, to file a report in a format he prescribes. The report must include, for each insurer, MCO, and UR company:

1. the number of requested standard and expedited external appeals;
2. the number of resolved standard and expedited external appeals;
3. the number of resolved standard and expedited external appeals by disposition (reversed, revised, affirmed);

4. the length of time to resolve each external appeal;
5. a summary of the procedure and diagnosis codes relating to requested external appeals; and
6. any other information the commissioner requires.

BACKGROUND

External Appeals – Filing and Fee

By law, an enrollee, or provider on his behalf with consent, who exhausts a health insurer's, MCO's, or UR company's internal appeal process may appeal to the insurance commissioner a claim denial based on medical necessity or a decision not to certify an admission, service, procedure, or extension of stay. He or she must file the external appeal within 60 days of receiving the company's final determination on forms the commissioner prescribes.

The appeal filing must include a general release from the enrollee for medical records and a \$25 processing fee, which the commissioner can waive for an indigent person. The company against which the appeal is filed must also pay a \$25 fee. The commissioner refunds (1) the company's fee if, after a preliminary review, the appeal is not accepted for a full review or (2) the prevailing party's fee after a full review is completed.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 0 (03/12/2009)