
OLR Bill Analysis

sSB 410

AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS.

SUMMARY:

This bill requires health insurance carriers to automatically provide, rather than upon request, certain information to covered persons when they make an adverse determination (e.g., deny coverage). It expands the types of the types of information they must provide both in the initial determination and reviews of this determination.

Under the bill, if a covered person or an authorized representative files a grievance or requests a review of an adverse or a final adverse determination, as authorized by existing law, relating to dispensing a drug prescribed by a licensed participating provider, the carrier must immediately issue an electronic authorization to the covered person's pharmacy for the drug for the duration of the grievance or review. The authorization must include confirmation of the availability of payment for the drug supply.

EFFECTIVE DATE: October 1, 2012

ADVERSE DETERMINATIONS

Initial Determination

By law, a health carrier must promptly provide a covered person and, if applicable, his or her authorized representative with a notice of an adverse determination. The notice can be in writing or electronic.

The bill requires the health carrier to include with the notice, free of charge, a copy of all documents, communications, information, evidence, and rationales regarding the adverse determination, whether or not the carrier considered them in making its determination.

The bill makes related changes. For example, under current law, if the carrier based its determination on an internal rule, guideline,

protocol, or similar criterion, it must provide (1) the criterion or (2) a statement that a specific criterion was relied upon to make the determination and the carrier will provide it to the covered person free of charge upon request, together with instructions for requesting a copy. The bill eliminates the option of providing the statement.

Internal Reviews

By law, carriers must review adverse determinations at the request of the covered person. In cases based in whole or part on medical necessity, before issuing a decision the carrier must provide the covered person or an authorized representative, free of charge, any new or additional (1) evidence relied upon and (2) scientific or clinical rationale the carrier used in connection with the grievance. The bill additionally requires the carrier to provide any related documents, communications, or information. It allows the carrier to provide the information required under current law and the bill by fax, electronic means, or any other expeditious method available.

By law, the health carrier must notify the covered person and, if applicable, his or her authorized representative of its decision following a review of its determination. The requirement applies whether or not the denial was based on medical necessity. The bill requires the carrier, when issuing a decision that upholds the adverse determination, to include with the notice, free of charge, copies of all documents, communications, information, evidence, and rationale regarding the adverse determination that were not previously provided to the covered person or authorized representative. The requirement applies whether or not the individuals conducting the review considered them in making the final adverse determination. In the case of denials based on medical necessity, the health carrier need not include information the covered person or his or authorized representative provided.

By law, if the final adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the notice must include a written statement of the scientific or clinical rationale for the determination. It must also an

explanation of the scientific or clinical rationale used to make the determination that shows how the terms of the health benefit plan apply to the covered person's medical circumstances. The bill additionally requires that this information include citations to any medical journal articles or scientific or clinical evidence relied upon.

External Reviews

By law, a covered person or an authorized representative may file a request for an external review of an adverse or a final adverse determination. The independent review organization must notify the insurance commissioner, the carrier, the covered person and, if applicable, the authorized representative of its decision to uphold, reverse, or revise the determination. If the decision upholds the determination, the bill requires this notice to include copies of all evidence or documentation regarding the determination, including any evidence-based standards, regarding the determination, whether or not the organization considered them in reaching its decision.

If the decision upholds a denial based on a determination that the requested service or treatment is experimental or investigational, the bill requires the notice to include copies of all medical or scientific evidence and evidence-based standards the organization considered in reaching its decision.

The organization must provide all of this information free of charge.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 12 Nay 8 (03/20/2012)