



Senate

General Assembly

File No. 283

February Session, 2012

Substitute Senate Bill No. 410

Senate, April 5, 2012

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 ADVERSE DETERMINATION REVIEWS.

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

1 Section 1. Section 38a-591d of the 2012 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective October 1, 2012*):

4 (a) (1) Each health carrier shall maintain written procedures for (A)
5 utilization review and benefit determinations, (B) expedited utilization
6 review and benefit determinations with respect to prospective urgent
7 care requests and concurrent review urgent care requests, and (C)
8 notifying covered persons or covered persons' authorized
9 representatives of such review and benefit determinations. Each health
10 carrier shall make such review and benefit determinations within the
11 specified time periods under this section.

12 (2) In determining whether a benefit request shall be considered an
13 urgent care request, an individual acting on behalf of a health carrier
14 shall apply the judgment of a prudent layperson who possesses an

15 average knowledge of health and medicine, except that any benefit
16 request determined to be an urgent care request by a health care
17 professional with knowledge of the covered person's medical
18 condition shall be deemed an urgent care request.

19 (b) With respect to a nonurgent care request:

20 (1) For a prospective or concurrent review request, a health carrier
21 shall make a determination within a reasonable period of time
22 appropriate to the covered person's medical condition, but not later
23 than fifteen calendar days after the date the health carrier receives such
24 request, and shall notify the covered person and, if applicable, the
25 covered person's authorized representative of such determination,
26 whether or not the carrier certifies the provision of the benefit.

27 (2) For a retrospective review request, a health carrier shall make a
28 determination within a reasonable period of time, but not later than
29 thirty calendar days after the date the health carrier receives such
30 request.

31 (3) The time periods specified in subdivisions (1) and (2) of this
32 subsection may be extended once by the health carrier for up to fifteen
33 calendar days, provided the health carrier:

34 (A) Determines that an extension is necessary due to circumstances
35 beyond the health carrier's control; and

36 (B) Notifies the covered person and, if applicable, the covered
37 person's authorized representative prior to the expiration of the initial
38 time period, of the circumstances requiring the extension of time and
39 the date by which the health carrier expects to make a determination.

40 (4) (A) If the extension pursuant to subdivision (3) of this subsection
41 is necessary due to the failure of the covered person or the covered
42 person's authorized representative to provide information necessary to
43 make a determination on the request, the health carrier shall:

44 (i) Specifically describe in the notice of extension the required

45 information necessary to complete the request; and

46 (ii) Provide the covered person and, if applicable, the covered
47 person's authorized representative with not less than forty-five
48 calendar days after the date of receipt of the notice to provide the
49 specified information.

50 (B) If the covered person or the covered person's authorized
51 representative fails to submit the specified information before the end
52 of the period of the extension, the health carrier may deny certification
53 of the benefit requested.

54 (c) With respect to an urgent care request:

55 (1) Unless the covered person or the covered person's authorized
56 representative has failed to provide information necessary for the
57 health carrier to make a determination, the health carrier shall make a
58 determination as soon as possible, taking into account the covered
59 person's medical condition, but not later than seventy-two hours after
60 the health carrier receives such request, provided, if the urgent care
61 request is a concurrent review request to extend a course of treatment
62 beyond the initial period of time or the number of treatments, such
63 request is made at least twenty-four hours prior to the expiration of the
64 prescribed period of time or number of treatments;

65 (2) (A) If the covered person or the covered person's authorized
66 representative has failed to provide information necessary for the
67 health carrier to make a determination, the health carrier shall notify
68 the covered person or the covered person's representative, as
69 applicable, as soon as possible, but not later than twenty-four hours
70 after the health carrier receives such request.

71 (B) The health carrier shall provide the covered person or the
72 covered person's authorized representative, as applicable, a reasonable
73 period of time to submit the specified information, taking into account
74 the covered person's medical condition, but not less than forty-eight
75 hours after notifying the covered person or the covered person's

76 authorized representative, as applicable.

77 (3) The health carrier shall notify the covered person and, if
78 applicable, the covered person's authorized representative of its
79 determination as soon as possible, but not later than forty-eight hours
80 after the earlier of (A) the date on which the covered person and the
81 covered person's authorized representative, as applicable, provides the
82 specified information to the health carrier, or (B) the date on which the
83 specified information was to have been submitted.

84 (d) (1) Whenever a health carrier receives a review request from a
85 covered person or a covered person's authorized representative that
86 fails to meet the health carrier's filing procedures, the health carrier
87 shall notify the covered person and, if applicable, the covered person's
88 authorized representative of such failure not later than five calendar
89 days after the health carrier receives such request, except that for an
90 urgent care request, the health carrier shall notify the covered person
91 and, if applicable, the covered person's authorized representative of
92 such failure not later than twenty-four hours after the health carrier
93 receives such request.

94 (2) If the health carrier provides such notice orally, the health carrier
95 shall provide confirmation in writing to the covered person and the
96 covered person's health care professional of record not later than five
97 calendar days after providing the oral notice.

98 (e) Each health carrier shall provide promptly to a covered person
99 and, if applicable, the covered person's authorized representative a
100 notice of an adverse determination.

101 (1) Such notice may be provided in writing or by electronic means
102 and shall set forth, in a manner calculated to be understood by the
103 covered person or the covered person's authorized representative:

104 [(1)] (A) Information sufficient to identify the benefit request or
105 claim involved, including the date of service, if applicable, the health
106 care professional and the claim amount;

107 [(2)] (B) The specific reason or reasons for the adverse determination
108 and a description of the health carrier's standard, if any, that was used
109 in reaching the denial;

110 [(3)] (C) Reference to the specific health benefit plan provisions on
111 which the determination is based;

112 [(4)] (D) A description of any additional material or information
113 necessary for the covered person to perfect the benefit request or claim,
114 including an explanation of why the material or information is
115 necessary to perfect the request or claim;

116 [(5)] (E) A description of the health carrier's internal grievance
117 process that includes [(A)] (i) the health carrier's expedited review
118 procedures, [(B)] (ii) any time limits applicable to such process or
119 procedures, [(C)] (iii) the contact information for the organizational
120 unit designated to coordinate the review on behalf of the health carrier,
121 and [(D)] (iv) a statement that the covered person or, if applicable, the
122 covered person's authorized representative is entitled, pursuant to the
123 requirements of the health carrier's internal grievance process, to [(i)]
124 (I) submit written comments, documents, records and other material
125 relating to the covered person's benefit request for consideration by the
126 individual or individuals conducting the review, and [(ii)] (II) receive
127 from the health carrier, free of charge, [upon request,] reasonable
128 access to and copies of all documents, records and other information
129 relevant to the covered person's benefit request;

130 [(6)] (F) If the adverse determination is based on a health carrier's
131 internal rule, guideline, protocol or other similar criterion, [(A)] the
132 specific rule, guideline, protocol or other similar criterion; [or (B) a
133 statement that a specific rule, guideline, protocol or other similar
134 criterion of the health carrier was relied upon to make the adverse
135 determination and that a copy of such rule, guideline, protocol or other
136 similar criterion will be provided to the covered person free of charge
137 upon request, and instructions for requesting such copy;]

138 [(7)] (G) If the adverse determination is based on medical necessity

139 or an experimental or investigational treatment or similar exclusion or
140 limit, the written statement of the scientific or clinical rationale for the
141 adverse determination and [(A)] an explanation of the scientific or
142 clinical rationale used to make the determination that applies the terms
143 of the health benefit plan to the covered person's medical
144 circumstances; [, or (B) a statement that an explanation will be
145 provided to the covered person free of charge upon request, and
146 instructions for requesting a copy of such explanation;] and

147 [(8)] (H) A statement explaining the right of the covered person to
148 contact the commissioner's office or the Office of the Healthcare
149 Advocate at any time for assistance or, upon completion of the health
150 carrier's internal grievance process, to file a civil suit in a court of
151 competent jurisdiction. Such statement shall include the contact
152 information for said offices.

153 (2) The health carrier shall include, free of charge, with such notice a
154 copy of all documents, communications, information, evidence and
155 rationale regarding the adverse determination, whether or not the
156 health carrier considered such documents, communications,
157 information, evidence or rationale in making the adverse
158 determination.

159 (f) If the adverse determination is a rescission, the health carrier
160 shall include with the advance notice of the application for rescission
161 required to be sent to the covered person, a written statement that
162 includes:

163 (1) Clear identification of the alleged fraudulent act, practice or
164 omission or the intentional misrepresentation of material fact;

165 (2) An explanation as to why the act, practice or omission was
166 fraudulent or was an intentional misrepresentation of a material fact;

167 (3) A disclosure that the covered person or the covered person's
168 authorized representative may file immediately, without waiting for
169 the date such advance notice of the proposed rescission ends, a

170 grievance with the health carrier to request a review of the adverse
171 determination to rescind coverage, pursuant to sections 38a-591e and
172 38a-591f, as amended by this act;

173 (4) A description of the health carrier's grievance procedures
174 established under sections 38a-591e and 38a-591f, as amended by this
175 act, including [,] any time limits applicable to those procedures; and

176 (5) The date such advance notice of the proposed rescission ends
177 and the date back to which the coverage will be retroactively
178 rescinded.

179 (g) (1) Whenever a health carrier fails to strictly adhere to the
180 requirements of this section with respect to making utilization review
181 and benefit determinations of a benefit request or claim, the covered
182 person shall be deemed to have exhausted the internal grievance
183 process of such health carrier and may file a request for an external
184 review in accordance with the provisions of section 38a-591g, as
185 amended by this act, regardless of whether the health carrier asserts it
186 substantially complied with the requirements of this section or that
187 any error it committed was de minimis.

188 (2) A covered person who has exhausted the internal grievance
189 process of a health carrier may, in addition to filing a request for an
190 external review, pursue any available remedies under state or federal
191 law on the basis that the health carrier failed to provide a reasonable
192 internal grievance process that would yield a decision on the merits of
193 the claim.

194 (h) Notwithstanding subdivision (3) of subsection (c) of section 38a-
195 591e, as amended by this act, if a covered person or the covered
196 person's authorized representative files any grievance or requests any
197 review of an adverse determination or a final adverse determination
198 pursuant to section 38a-591e, 38a-591f or 38a-591g, as amended by this
199 act, relating to the dispensation of a drug prescribed by a licensed
200 participating provider, the health carrier shall issue immediate
201 electronic authorization to the covered person's pharmacy for such

202 drug for the duration of any such grievance or review. Such
203 authorization shall include confirmation of the availability of payment
204 for such supply of such drug.

205 Sec. 2. Section 38a-591e of the 2012 supplement to the general
206 statutes is repealed and the following is substituted in lieu thereof
207 (*Effective October 1, 2012*):

208 (a) (1) Each health carrier shall establish and maintain written
209 procedures for (A) the review of grievances of adverse determinations
210 that were based, in whole or in part, on medical necessity, (B) the
211 expedited review of grievances of adverse determinations of urgent
212 care requests, including concurrent review urgent care requests
213 involving an admission, availability of care, continued stay or health
214 care service for a covered person who has received emergency services
215 but has not been discharged from a facility, and (C) notifying covered
216 persons or covered persons' authorized representatives of such
217 adverse determinations.

218 (2) Each health carrier shall file with the commissioner a copy of
219 such procedures, including all forms used to process requests, and any
220 subsequent material modifications to such procedures.

221 (3) In addition to a copy of such procedures, each health carrier shall
222 file annually with the commissioner, as part of its annual report
223 required under subsection (e) of section 38a-591b, a certificate of
224 compliance stating that the health carrier has established and
225 maintains grievance procedures for each of its health benefit plans that
226 are fully compliant with the provisions of sections 38a-591a to 38a-
227 591m, inclusive, as amended by this act.

228 (b) (1) A covered person or a covered person's authorized
229 representative may file a grievance of an adverse determination that
230 was based, in whole or in part, on medical necessity with the health
231 carrier not later than one hundred eighty calendar days after the
232 covered person or the covered person's authorized representative, as
233 applicable, receives the notice of an adverse determination.

234 (2) For prospective or concurrent urgent care requests, a covered
235 person or a covered person's authorized representative may make a
236 request for an expedited review orally or in writing.

237 (c) (1) (A) When conducting a review of an adverse determination
238 under this section, the health carrier shall ensure that such review is
239 conducted in a manner to ensure the independence and impartiality of
240 the individual or individuals involved in making the review decision.

241 (B) If the adverse determination involves utilization review, the
242 health carrier shall designate an appropriate clinical peer or peers to
243 review such adverse determination. Such clinical peer or peers shall
244 not have been involved in the initial adverse determination.

245 (C) The individual or individuals conducting a review under this
246 section shall take into consideration all comments, documents, records
247 and other information relevant to the covered person's benefit request
248 that is the subject of the adverse determination under review, that are
249 submitted by the covered person or the covered person's authorized
250 representative, regardless of whether such information was submitted
251 or considered in making the initial adverse determination.

252 (D) Prior to issuing a decision, the health carrier shall provide free
253 of charge, by facsimile, electronic means or any other expeditious
254 method available, to the covered person or the covered person's
255 authorized representative, as applicable, any new or additional
256 documents, communications, information and evidence relied upon
257 and any new or additional scientific or clinical rationale used by the
258 health carrier in connection with the grievance. Such documents,
259 communications, information, evidence and rationale shall be
260 provided sufficiently in advance of the date the health carrier is
261 required to issue a decision to permit the covered person or the
262 covered person's authorized representative, as applicable, a reasonable
263 opportunity to respond prior to such date.

264 (2) If the review under subdivision (1) of this subsection is an
265 expedited review, all necessary information, including the health

266 carrier's decision, shall be transmitted between the health carrier and
267 the covered person or the covered person's authorized representative,
268 as applicable, by telephone, facsimile, electronic means or any other
269 expeditious method available.

270 (3) If the review under subdivision (1) of this subsection is an
271 expedited review of a grievance involving an adverse determination of
272 a concurrent review urgent care request, the treatment shall be
273 continued without liability to the covered person until the covered
274 person has been notified of the review decision.

275 (d) (1) The health carrier shall notify the covered person and, if
276 applicable, the covered person's authorized representative, in writing
277 or by electronic means, of its decision within a reasonable period of
278 time appropriate to the covered person's medical condition, but not
279 later than:

280 (A) For prospective review and concurrent review requests, thirty
281 calendar days after the health carrier receives the grievance;

282 (B) For retrospective review requests, sixty calendar days after the
283 health carrier receives the grievance; and

284 (C) For expedited review requests, seventy-two hours after the
285 health carrier receives the grievance.

286 (2) The time periods set forth in subdivision (1) of this subsection
287 shall apply regardless of whether all of the information necessary to
288 make a decision accompanies the filing.

289 (e) (1) The notice required under subsection (d) of this section shall
290 set forth, in a manner calculated to be understood by the covered
291 person or the covered person's authorized representative:

292 [(1)] (A) The titles and qualifying credentials of the individual or
293 individuals participating in the review process;

294 [(2)] (B) Information sufficient to identify the claim involved with

295 respect to the grievance, including the date of service, if applicable, the
296 health care professional and the claim amount;

297 [(3)] (C) A statement of such individual's or individuals'
298 understanding of the covered person's grievance;

299 [(4)] (D) The individual's or individuals' decision in clear terms and
300 the health benefit plan contract basis or scientific or clinical rationale
301 for such decision in sufficient detail for the covered person to respond
302 further to the health carrier's position;

303 [(5)] (E) Reference to the evidence or documentation used as the
304 basis for the decision;

305 [(6)] (F) For a decision that upholds the adverse determination:

306 [(A)] (i) The specific reason or reasons for the final adverse
307 determination, including the denial code and its corresponding
308 meaning, as well as a description of the health carrier's standard, if
309 any, that was used in reaching the denial;

310 [(B)] (ii) Reference to the specific health benefit plan provisions on
311 which the decision is based;

312 [(C) A statement that the covered person may receive from the
313 health carrier, free of charge and upon request, reasonable access to
314 and copies of, all documents, records and other information relevant to
315 the adverse determination under review;]

316 [(D)] (iii) If the final adverse determination is based on a health
317 carrier's internal rule, guideline, protocol or other similar criterion, [(i)]
318 the specific rule, guideline, protocol or other similar criterion; [, or (ii) a
319 statement that a specific rule, guideline, protocol or other similar
320 criterion of the health carrier was relied upon to make the final adverse
321 determination and that a copy of such rule, guideline, protocol or other
322 similar criterion will be provided to the covered person free of charge
323 upon request and instructions for requesting such copy;]

324 [(E)] (iv) If the final adverse determination is based on medical
325 necessity or an experimental or investigational treatment or similar
326 exclusion or limit, the written statement of the scientific or clinical
327 rationale for the final adverse determination and [(i)] an explanation of
328 the scientific or clinical rationale used to make the determination that
329 applies the terms of the health benefit plan to the covered person's
330 medical circumstances, including citations to any medical journal
331 articles or scientific or clinical evidence relied upon; [or (ii) a statement
332 that an explanation will be provided to the covered person free of
333 charge upon request and instructions for requesting a copy of such
334 explanation;]

335 [(F)] (v) A statement describing the procedures for obtaining an
336 external review of the final adverse determination;

337 [(7)] (G) If applicable, the following statement: "You and your plan
338 may have other voluntary alternative dispute resolution options such
339 as mediation. One way to find out what may be available is to contact
340 your state Insurance Commissioner."; and

341 [(8)] (H) A statement disclosing the covered person's right to contact
342 the commissioner's office or the Office of the Healthcare Advocate at
343 any time. Such disclosure shall include the contact information for said
344 offices.

345 (2) For a decision that upholds the adverse determination, the health
346 carrier shall include, free of charge, with such notice copies of all
347 documents, communications, information, evidence and rationale
348 regarding the adverse determination, whether or not the individual or
349 individuals conducting a review under this section considered such
350 documents, communications, information, evidence or rationale in
351 making the final adverse determination, that were not provided to the
352 covered person or the covered person's authorized representative
353 pursuant to subdivision (2) of subsection (e) of section 38a-591d, as
354 amended by this act, or subparagraph (D) of subdivision (1) of
355 subsection (c) of this section. The health carrier shall not be required to
356 include the comments, documents, records or other information

357 submitted by the covered person or the covered person's authorized
358 representative pursuant to subparagraph (C) of subdivision (1) of
359 subsection (c) of this section.

360 (f) (1) Whenever a health carrier fails to strictly adhere to the
361 requirements of this section with respect to receiving and resolving
362 grievances involving an adverse determination, the covered person
363 shall be deemed to have exhausted the internal grievance process of
364 such health carrier and may file a request for an external review,
365 regardless of whether the health carrier asserts that it substantially
366 complied with the requirements of this section, or that any error it
367 committed was de minimis.

368 (2) A covered person who has exhausted the internal grievance
369 process of a health carrier may, in addition to filing a request for an
370 external review, pursue any available remedies under state or federal
371 law on the basis that the health carrier failed to provide a reasonable
372 internal grievance process that would yield a decision on the merits of
373 the claim.

374 Sec. 3. Section 38a-591f of the 2012 supplement to the general
375 statutes is repealed and the following is substituted in lieu thereof
376 (*Effective October 1, 2012*):

377 (a) Each health carrier shall establish and maintain written
378 procedures (1) for the review of grievances of adverse determinations
379 that were not based on medical necessity, and (2) notifying covered
380 persons or covered persons' authorized representatives of such
381 adverse determinations.

382 (b) (1) A covered person or the covered person's authorized
383 representative may file a grievance of an adverse determination that
384 was not based on medical necessity with the health carrier not later
385 than one hundred eighty calendar days after the covered person or the
386 covered person's representative, as applicable, receives the notice of an
387 adverse determination.

388 (2) The health carrier shall notify the covered person and, if
389 applicable, the covered person's authorized representative not later
390 than three business days after the health carrier receives a grievance
391 that the covered person or the covered person's authorized
392 representative, as applicable, is entitled to submit written material to
393 the health carrier to be considered when conducting a review of the
394 grievance.

395 (3) (A) Upon receipt of a grievance, a health carrier shall designate
396 an individual or individuals to conduct a review of the grievance.

397 (B) The health carrier shall not designate the same individual or
398 individuals who denied the claim or handled the matter that is the
399 subject of the grievance to conduct the review of the grievance.

400 (C) The health carrier shall provide the covered person and, if
401 applicable, the covered person's authorized representative with the
402 name, address and telephone number of the individual or the
403 organizational unit designated to coordinate the review on behalf of
404 the health carrier.

405 (c) (1) The health carrier shall notify the covered person and, if
406 applicable, the covered person's authorized representative in writing,
407 of its decision not later than twenty business days after the health
408 carrier received the grievance.

409 (2) If the health carrier is unable to comply with the time period
410 specified in subdivision (1) of this subsection due to circumstances
411 beyond the health carrier's control, the time period may be extended
412 by the health carrier for up to ten business days, provided that on or
413 before the twentieth business day after the health carrier received the
414 grievance, the health carrier provides written notice to the covered
415 person and, if applicable, the covered person's authorized
416 representative of the extension and the reasons for the delay.

417 (d) (1) The written decision issued pursuant to subsection (c) of this
418 section shall contain:

419 [(1)] (A) The titles and qualifying credentials of the individual or
420 individuals participating in the review process;

421 [(2)] (B) A statement of such individual's or individuals'
422 understanding of the covered person's grievance;

423 [(3)] (C) The individual's or individuals' decision in clear terms and
424 the health benefit plan contract basis for such decision in sufficient
425 detail for the covered person to respond further to the health carrier's
426 position; and

427 [(4)] (D) Reference to the evidence or documentation used as the
428 basis for the decision.

429 (2) For a decision that upholds the adverse determination, the health
430 carrier shall include, free of charge, with such notice copies of all
431 documents, communications, information and evidence regarding the
432 adverse determination, whether or not the individual or individuals
433 conducting a review under this section considered such documents,
434 communications, information or evidence in making the final adverse
435 determination, that were not provided to the covered person or the
436 covered person's authorized representative pursuant to subdivision (2)
437 of subsection (e) of section 38a-591d, as amended by this act.

438 Sec. 4. Section 38a-591g of the 2012 supplement to the general
439 statutes is repealed and the following is substituted in lieu thereof
440 (*Effective October 1, 2012*):

441 (a) (1) A covered person or a covered person's authorized
442 representative may file a request for an external review or an
443 expedited external review of an adverse determination or a final
444 adverse determination in accordance with the provisions of this
445 section. All requests for external review or expedited external review
446 shall be made in writing to the commissioner. The commissioner may
447 prescribe the form and content of such requests.

448 (2) (A) All requests for external review or expedited external review
449 shall be accompanied by a filing fee of twenty-five dollars, except that

450 no covered person or covered person's authorized representative shall
451 pay more than seventy-five dollars in a calendar year for such covered
452 person. Any filing fee paid by a covered person's authorized
453 representative shall be deemed to have been paid by the covered
454 person. If the commissioner finds that the covered person is indigent
455 or unable to pay the filing fee, the commissioner shall waive such fee.
456 Any such fees shall be deposited in the Insurance Fund established
457 under section 38a-52a.

458 (B) The commissioner shall refund any paid filing fee to the covered
459 person or the covered person's authorized representative, as
460 applicable, or the health care professional if the adverse determination
461 or the final adverse determination that is the subject of the external
462 review request or expedited external review request is reversed or
463 revised.

464 (3) The health carrier that issued the adverse determination or the
465 final adverse determination that is the subject of the external review
466 request or the expedited external review request shall pay the
467 independent review organization for the cost of conducting the review.

468 (4) An external review decision, whether such review is a standard
469 external review or an expedited external review, shall be binding on
470 the health carrier or a self-insured governmental plan and the covered
471 person, except to the extent such health carrier or covered person has
472 other remedies available under federal or state law. A covered person
473 or a covered person's authorized representative shall not file a
474 subsequent request for an external review or an expedited external
475 review that involves the same adverse determination or final adverse
476 determination for which the covered person or the covered person's
477 authorized representative already received an external review decision
478 or an expedited external review decision.

479 (5) Each health carrier shall maintain written records of external
480 reviews as set forth in section 38a-591h.

481 (6) Each independent review organization shall maintain written

482 records as set forth in subsection (e) of section 38a-591m.

483 (b) (1) Except as otherwise provided under subdivision (2) of this
484 subsection or subsection (d) of this section, a covered person or a
485 covered person's authorized representative shall not file a request for
486 an external review or an expedited external review until the covered
487 person or the covered person's authorized representative has
488 exhausted the health carrier's internal grievance process.

489 (2) A health carrier may waive its internal grievance process and the
490 requirement for a covered person to exhaust such process prior to
491 filing a request for an external review or an expedited external review.

492 (c) (1) At the same time a health carrier sends to a covered person or
493 a covered person's authorized representative a written notice of an
494 adverse determination or a final adverse determination issued by the
495 health carrier, the health carrier shall include a written disclosure to
496 the covered person and, if applicable, the covered person's authorized
497 representative of the covered person's right to request an external
498 review.

499 (2) The written notice shall include:

500 (A) The following statement or a statement in substantially similar
501 language: "We have denied your request for benefit approval for a
502 health care service or course of treatment. You may have the right to
503 have our decision reviewed by health care professionals who have no
504 association with us by submitting a request for external review to the
505 office of the Insurance Commissioner, if our decision involved making
506 a judgment as to the medical necessity, appropriateness, health care
507 setting, level of care or effectiveness of the health care service or
508 treatment you requested.";

509 (B) For a notice related to an adverse determination, a statement
510 informing the covered person that:

511 (i) If the covered person has a medical condition for which the time
512 period for completion of an expedited internal review of a grievance

513 involving an adverse determination would seriously jeopardize the life
514 or health of the covered person or would jeopardize the covered
515 person's ability to regain maximum function, the covered person or the
516 covered person's authorized representative may (I) file a request for an
517 expedited external review, or (II) file a request for an expedited
518 external review if the adverse determination involves a denial of
519 coverage based on a determination that the recommended or
520 requested health care service or treatment is experimental or
521 investigational and the covered person's treating health care
522 professional certifies in writing that such recommended or requested
523 health care service or treatment would be significantly less effective if
524 not promptly initiated; and

525 (ii) Such request for expedited external review may be filed at the
526 same time the covered person or the covered person's authorized
527 representative files a request for an expedited internal review of a
528 grievance involving an adverse determination, except that the
529 independent review organization assigned to conduct the expedited
530 external review shall determine whether the covered person shall be
531 required to complete the expedited internal review of the grievance
532 prior to conducting the expedited external review;

533 (C) For a notice related to a final adverse determination, a statement
534 informing the covered person that:

535 (i) If the covered person has a medical condition for which the time
536 period for completion of an external review would seriously
537 jeopardize the life or health of the covered person or would jeopardize
538 the covered person's ability to regain maximum function, the covered
539 person or the covered person's authorized representative may file a
540 request for an expedited external review; or

541 (ii) If the final adverse determination concerns (I) an admission,
542 availability of care, continued stay or health care service for which the
543 covered person received emergency services but has not been
544 discharged from a facility, the covered person or the covered person's
545 authorized representative may file a request for an expedited external

546 review, or (II) a denial of coverage based on a determination that the
547 recommended or requested health care service or treatment is
548 experimental or investigational and the covered person's treating
549 health care professional certifies in writing that such recommended or
550 requested health care service or treatment would be significantly less
551 effective if not promptly initiated, the covered person or the covered
552 person's authorized representative may file a request for an expedited
553 external review;

554 (D) (i) A copy of the description of both the standard and expedited
555 external review procedures the health carrier is required to provide,
556 highlighting the provisions in the external review procedures that give
557 the covered person or the covered person's authorized representative
558 the opportunity to submit additional information and including any
559 forms used to process an external review or an expedited external
560 review;

561 (ii) As part of any forms provided under subparagraph (D)(i) of this
562 subdivision, an authorization form or other document approved by the
563 commissioner that complies with the requirements of 45 CFR 164.508,
564 as amended from time to time, by which the covered person shall
565 authorize the health carrier and the covered person's treating health
566 care professional to release, transfer or otherwise divulge, in
567 accordance with sections 38a-975 to 38a-999a, inclusive, the covered
568 person's protected health information including medical records for
569 purposes of conducting an external review or an expedited external
570 review.

571 (d) (1) A covered person or a covered person's authorized
572 representative may file a request for an expedited external review of an
573 adverse determination or a final adverse determination with the
574 commissioner, except that an expedited external review shall not be
575 provided for a retrospective review request of an adverse
576 determination or a final adverse determination.

577 (2) Such request may be filed at the time the covered person
578 receives:

579 (A) An adverse determination, if:

580 (i) (I) The covered person has a medical condition for which the time
581 period for completion of an expedited internal review of the adverse
582 determination would seriously jeopardize the life or health of the
583 covered person or would jeopardize the covered person's ability to
584 regain maximum function; or

585 (II) The denial of coverage is based on a determination that the
586 recommended or requested health care service or treatment is
587 experimental or investigational and the covered person's treating
588 health care professional certifies in writing that such recommended or
589 requested health care service or treatment would be significantly less
590 effective if not promptly initiated; and

591 (ii) The covered person or the covered person's authorized
592 representative has filed a request for an expedited internal review of
593 the adverse determination; or

594 (B) A final adverse determination if:

595 (i) The covered person has a medical condition where the time
596 period for completion of a standard external review would seriously
597 jeopardize the life or health of the covered person or would jeopardize
598 the covered person's ability to regain maximum function;

599 (ii) The final adverse determination concerns an admission,
600 availability of care, continued stay or health care service for which the
601 covered person received emergency services but has not been
602 discharged from a facility; or

603 (iii) The denial of coverage is based on a determination that the
604 recommended or requested health care service or treatment is
605 experimental or investigational and the covered person's treating
606 health care professional certifies in writing that such recommended or
607 requested health care service or treatment would be significantly less
608 effective if not promptly initiated.

609 (3) Such covered person or covered person's authorized
610 representative shall not be required to file a request for an external
611 review prior to, or at the same time as, the filing of a request for an
612 expedited external review and shall not be precluded from filing a
613 request for an external review, within the time periods set forth in
614 subsection (e) of this section, if the request for an expedited external
615 review is determined to be ineligible for such review.

616 (e) (1) Not later than one hundred twenty calendar days after a
617 covered person or a covered person's authorized representative
618 receives a notice of an adverse determination or a final adverse
619 determination, the covered person or the covered person's authorized
620 representative may file a request for an external review or an
621 expedited external review with the commissioner in accordance with
622 this section.

623 (2) Not later than one business day after the commissioner receives
624 a request that is complete, the commissioner shall send a copy of such
625 request to the health carrier that issued the adverse determination or
626 the final adverse determination that is the subject of the request.

627 (3) Not later than [(A)] five business days after the health carrier
628 receives the copy of an external review request [,] or [(B)] one calendar
629 day after the health carrier receives the copy of an expedited external
630 review request, from the commissioner, the health carrier shall
631 complete a preliminary review of the request to determine whether:

632 (A) The individual is or was a covered person under the health
633 benefit plan at the time the health care service was requested or, in the
634 case of an external review of a retrospective review request, was a
635 covered person in the health benefit plan at the time the health care
636 service was provided;

637 (B) The health care service that is the subject of the adverse
638 determination or the final adverse determination is a covered service
639 under the covered person's health benefit plan but for the health
640 carrier's determination that the health care service is not covered

641 because it does not meet the health carrier's requirements for medical
642 necessity, appropriateness, health care setting, level of care or
643 effectiveness;

644 (C) If the health care service or treatment is experimental or
645 investigational:

646 (i) Is a covered benefit under the covered person's health benefit
647 plan but for the health carrier's determination that the service or
648 treatment is experimental or investigational for a particular medical
649 condition;

650 (ii) Is not explicitly listed as an excluded benefit under the covered
651 person's health benefit plan;

652 (iii) The covered person's treating health care professional has
653 certified that one of the following situations is applicable:

654 (I) Standard health care services or treatments have not been
655 effective in improving the medical condition of the covered person;

656 (II) Standard health care services or treatments are not medically
657 appropriate for the covered person; or

658 (III) There is no available standard health care service or treatment
659 covered by the health carrier that is more beneficial than the
660 recommended or requested health care service or treatment; and

661 (iv) The covered person's treating health care professional:

662 (I) Has recommended a health care service or treatment that the
663 health care professional certifies, in writing, is likely to be more
664 beneficial to the covered person, in the health care professional's
665 opinion, than any available standard health care services or treatments;
666 or

667 (II) Is a licensed, board certified or board eligible health care
668 professional qualified to practice in the area of medicine appropriate to
669 treat the covered person's condition and has certified in writing that

670 scientifically valid studies using accepted protocols demonstrate that
671 the health care service or treatment requested by the covered person
672 that is the subject of the adverse determination or the final adverse
673 determination is likely to be more beneficial to the covered person than
674 any available standard health care services or treatments;

675 (D) The covered person has exhausted the health carrier's internal
676 grievance process or the covered person or the covered person's
677 authorized representative has filed a request for an expedited external
678 review as provided under subsection (d) of this section; and

679 (E) The covered person has provided all the information and forms
680 required to process an external review or an expedited external review,
681 including an authorization form as set forth in subparagraph (D)(ii) of
682 subdivision (2) of subsection (c) of this section.

683 (4) (A) Not later than (i) one business day after the preliminary
684 review of an external review request, or (ii) the day the preliminary
685 review of an expedited external review request is completed, the
686 health carrier shall notify the commissioner, the covered person and, if
687 applicable, the covered person's authorized representative in writing
688 whether the request for an external review or an expedited external
689 review is complete and eligible for such review. The commissioner
690 may specify the form for the health carrier's notice of initial
691 determination under this subdivision and any supporting information
692 required to be included in the notice.

693 (B) If the request:

694 (i) Is not complete, the health carrier shall notify the commissioner
695 and the covered person and, if applicable, the covered person's
696 authorized representative in writing and include in the notice what
697 information or materials are needed to perfect the request; or

698 (ii) Is not eligible for external review or expedited external review,
699 the health carrier shall notify the commissioner, the covered person
700 and, if applicable, the covered person's authorized representative in

701 writing and include in the notice the reasons for its ineligibility.

702 (C) The notice of initial determination shall include a statement
703 informing the covered person and, if applicable, the covered person's
704 authorized representative that a health carrier's initial determination
705 that the request for an external review or an expedited external review
706 is ineligible for review may be appealed to the commissioner.

707 (D) Notwithstanding a health carrier's initial determination that a
708 request for an external review or an expedited external review is
709 ineligible for review, the commissioner may determine, pursuant to
710 the terms of the covered person's health benefit plan, that such request
711 is eligible for such review and assign an independent review
712 organization to conduct such review. Any such review shall be
713 conducted in accordance with this section.

714 (f) (1) Whenever the commissioner is notified pursuant to
715 subparagraph (A) of subdivision (4) of subsection (e) of this section
716 that a request is eligible for external review or expedited external
717 review, the commissioner shall, not later than [(A)] one business day
718 after receiving such notice for an external review [,] or [(B)] one
719 calendar day after receiving such notice for an expedited external
720 review:

721 [(i)] (A) Assign an independent review organization from the list of
722 approved independent review organizations compiled and maintained
723 by the commissioner pursuant to section 38a-591l to conduct the
724 review and notify the health carrier of the name of the assigned
725 independent review organization. Such assignment shall be done on a
726 random basis among those approved independent review
727 organizations qualified to conduct the particular review based on the
728 nature of the health care service that is the subject of the adverse
729 determination or the final adverse determination and other
730 circumstances, including conflict of interest concerns as set forth in
731 section 38a-591m; and

732 [(ii)] (B) Notify the covered person and, if applicable, the covered

733 person's authorized representative in writing of the request's eligibility
734 and acceptance for external review or expedited external review. For
735 an external review, the commissioner shall include in such notice [(I)]
736 (i) a statement that the covered person or the covered person's
737 authorized representative may submit, not later than five business
738 days after the covered person or the covered person's authorized
739 representative, as applicable, received such notice, additional
740 information in writing to the assigned independent review
741 organization that such organization shall consider when conducting
742 the external review, and [(II)] (ii) where and how such additional
743 information is to be submitted. If additional information is submitted
744 later than five business days after the covered person or the covered
745 person's authorized representative, as applicable, received such notice,
746 the independent review organization may, but shall not be required to,
747 accept and consider such additional information.

748 (2) Not later than [(A)] five business days for an external review []
749 or [(B)] one calendar day for an expedited external review, after the
750 health carrier receives notice of the name of the assigned independent
751 review organization from the commissioner, the health carrier or its
752 designee utilization review company shall provide to the assigned
753 independent review organization the documents and any information
754 such health carrier or utilization review company considered in
755 making the adverse determination or the final adverse determination.

756 (3) The failure of the health carrier or its designee utilization review
757 company to provide the documents and information within the time
758 specified in subdivision (2) of this subsection shall not delay the
759 conducting of the review.

760 (4) [(i)] (A) If the health carrier or its designee utilization review
761 company fails to provide the documents and information within the
762 time period specified in subdivision (2) of this subsection, the
763 independent review organization may terminate the review and make
764 a decision to reverse the adverse determination or the final adverse
765 determination.

766 [(ii)] (B) Not later than one business day after terminating the
767 review and making the decision to reverse the adverse determination
768 or the final adverse determination, the independent review
769 organization shall notify the commissioner, the health carrier, the
770 covered person and, if applicable, the covered person's authorized
771 representative in writing of such decision.

772 (g) (1) The assigned independent review organization shall review
773 all the information and documents received pursuant to subsection (f)
774 of this section. In reaching a decision, the independent review
775 organization shall not be bound by any decisions or conclusions
776 reached during the health carrier's utilization review process.

777 (2) Not later than one business day after receiving any information
778 submitted by the covered person or the covered person's authorized
779 representative pursuant to subparagraph (B) of subdivision (1) of
780 subsection (f) of this section, the independent review organization
781 shall forward such information to the health carrier.

782 (3) (A) Upon the receipt of any information forwarded pursuant to
783 subdivision (2) of this subsection, the health carrier may reconsider its
784 adverse determination or the final adverse determination that is the
785 subject of the review. Such reconsideration shall not delay or terminate
786 the review.

787 (B) The independent review organization shall terminate the review
788 if the health carrier decides, upon completion of its reconsideration
789 and notice to such organization as provided in subparagraph (C) of
790 this subdivision, to reverse its adverse determination or its final
791 adverse determination and provide coverage or payment for the health
792 care service or treatment that is the subject of the adverse
793 determination or the final adverse determination.

794 (C) Not later than one business day after making the decision to
795 reverse its adverse determination or its final adverse determination,
796 the health carrier shall notify the commissioner, the assigned
797 independent review organization, the covered person and, if

798 applicable, the covered person's authorized representative in writing
799 of such decision.

800 (h) In addition to the documents and information received pursuant
801 to subsection (f) of this section, the independent review organization
802 shall consider, to the extent the documents or information are available
803 and the independent review organization considers them appropriate,
804 the following in reaching a decision:

805 (1) The covered person's medical records;

806 (2) The attending health care professional's recommendation;

807 (3) Consulting reports from appropriate health care professionals
808 and other documents submitted by the health carrier, the covered
809 person, the covered person's authorized representative or the covered
810 person's treating health care professional;

811 (4) The terms of coverage under the covered person's health benefit
812 plan to ensure that the independent review organization's decision is
813 not contrary to the terms of coverage under such health benefit plan;

814 (5) The most appropriate practice guidelines, which shall include
815 applicable evidence-based standards and may include any other
816 practice guidelines developed by the federal government, national or
817 professional medical societies, medical boards or medical associations;

818 (6) Any applicable clinical review criteria developed and used by
819 the health carrier or its designee utilization review company; and

820 (7) The opinion or opinions of the independent review
821 organization's clinical peer or peers who conducted the review after
822 considering subdivisions (1) to (6), inclusive, of this subsection.

823 (i) (1) The independent review organization shall notify the
824 commissioner, the health carrier, the covered person and, if applicable,
825 the covered person's authorized representative in writing of its
826 decision to uphold, reverse or revise the adverse determination or the

827 final adverse determination, not later than:

828 (A) For external reviews, forty-five calendar days after such
829 organization receives the assignment from the commissioner to
830 conduct such review;

831 (B) For external reviews involving a determination that the
832 recommended or requested health care service or treatment is
833 experimental or investigational, twenty calendar days after such
834 organization receives the assignment from the commissioner to
835 conduct such review;

836 (C) For expedited external reviews, as expeditiously as the covered
837 person's medical condition requires, but not later than seventy-two
838 hours after such organization receives the assignment from the
839 commissioner to conduct such review; and

840 (D) For expedited external reviews involving a determination that
841 the recommended or requested health care service or treatment is
842 experimental or investigational, as expeditiously as the covered
843 person's medical condition requires, but not later than five calendar
844 days after such organization receives the assignment from the
845 commissioner to conduct such review.

846 (2) Such notice shall include:

847 (A) A general description of the reason for the request for the
848 review;

849 (B) The date the independent review organization received the
850 assignment from the commissioner to conduct the review;

851 (C) The date the review was conducted;

852 (D) The date the organization made its decision;

853 (E) The principal reason or reasons for its decision, including what
854 applicable evidence-based standards, if any, were used as a basis for its
855 decision;

856 (F) The rationale for the organization's decision;

857 (G) (i) Reference to the evidence or documentation, including any
858 evidence-based standards, considered by the organization in reaching
859 its decision, and (ii) for a decision that upholds the adverse
860 determination or the final adverse determination, copies of all
861 evidence or documentation, free of charge, including any evidence-
862 based standards, regarding the adverse determination or the final
863 adverse determination, whether or not the organization considered
864 such evidence or documentation in reaching its decision; and

865 (H) For a review involving a determination that the recommended
866 or requested health care service or treatment is experimental or
867 investigational:

868 (i) A description of the covered person's medical condition;

869 (ii) A description of the indicators relevant to determining whether
870 there is sufficient evidence to demonstrate that (I) the recommended or
871 requested health care service or treatment is likely to be more
872 beneficial to the covered person than any available standard health
873 care services or treatments, and (II) the adverse risks of the
874 recommended or requested health care service or treatment would not
875 be substantially increased over those of available standard health care
876 services or treatments;

877 (iii) (I) A description and analysis of any medical or scientific
878 evidence considered in reaching the opinion, and (II) for a decision
879 that upholds the adverse determination or the final adverse
880 determination, copies of all medical or scientific evidence, free of
881 charge, the organization considered in reaching its decision;

882 (iv) (I) A description and analysis of any evidence-based standard,
883 and (II) for a decision that upholds the adverse determination or the
884 final adverse determination, copies of all evidence-based standards,
885 free of charge, the organization considered in reaching its decision; and

886 (v) Information on whether the clinical peer's rationale for the

887 opinion is based on the documents and information set forth in
888 subsection (f) of this section.

889 (3) Upon the receipt of a notice of the independent review
890 organization's decision to reverse or revise an adverse determination
891 or a final adverse determination, the health carrier shall immediately
892 approve the coverage that was the subject of the adverse determination
893 or the final adverse determination.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2012	38a-591d
Sec. 2	October 1, 2012	38a-591e
Sec. 3	October 1, 2012	38a-591f
Sec. 4	October 1, 2012	38a-591g

Statement of Legislative Commissioners:

In section 4(f)(4), "(4)(i)" and "(4)(ii)" were changed to "(4)[(i)](A)" and "(4)[(ii)](B)", respectively, for accuracy.

INS *Joint Favorable Subst.-LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note***State Impact:*** None***Municipal Impact:*** None***Explanation***

The bill requires health insurers to automatically provide individuals with certain information when denying coverage. There is no state or municipal impact.

The Out Years***State Impact:*** None***Municipal Impact:*** None

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)