

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 12-102—sSB 410

Insurance and Real Estate Committee

AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS

SUMMARY: This act expands the information health insurance carriers must provide to covered persons or their authorized representatives, upon request, when they make an adverse determination (e.g., deny coverage), both in the initial determination and any review of this determination. It requires carriers to provide copies of the information within one calendar or five business days of the request, depending on the circumstances of the case.

By law, health carriers must file annual reports with the insurance commissioner that include a certification that they are complying with the law's requirements regarding grievance procedures. The act extends this provision to cover the requirements it adds. It requires the commissioner to adopt regulations regarding the provision of copies.

Health carriers must comply with the act's provisions and implementing regulations and ensure that utilization review entities with which they contract also do so.

The act applies to any:

1. carrier offering a health benefit plan that provides or performs utilization review, including prospective, concurrent, or retrospective review benefit determinations and
2. utilization review company or designee of a carrier that performs utilization review on the carrier's behalf, including prospective, concurrent, or retrospective review benefit determinations.

The act does not apply to self-insured plans covered by the federal Employee Retirement Income Security Act (ERISA) or plans that provide health care services solely for workers' compensation benefits.

EFFECTIVE DATE: October 1, 2012

INITIAL DETERMINATION

By law, a carrier must promptly provide a covered person and, if applicable, his or her representative, with a notice of an adverse determination. The notice can be in writing or electronic. Under prior law, the notice had to state that the covered person or representative could receive, upon request, access to and copies of all documents, records, and other information relevant to the benefit request. The act expands this requirement to include evidence and communications, and specifies that it applies to information regarding, rather than relevant to, the request. By law, the carrier must provide this information free of charge.

The act requires that, at the request of the covered person or representative,

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the carrier provide him or her, free of charge, copies of all documents, communications, information, and evidence, including citations to any medical journals, regarding the covered person's benefit request that is the subject of the adverse determination that were (1) not submitted by the covered person or his or her representative and (2) available to the carrier or the utilization review entity that made the adverse determination when it was made.

The act requires the carrier to provide the copies by fax, electronic means, or any other expeditious method within one calendar day after it receives a request in the case of an adverse determination of an urgent care request. It requires the carrier to provide the copies within five business days after it receives a request in the case of an adverse determination of a non-urgent care request.

INTERNAL REVIEWS

Adverse Determinations Based on Medical Necessity

By law, carriers must review adverse determinations at the request of the covered person or his or her representative. In cases based in whole or in part on medical necessity, before issuing a decision the carrier must provide the covered person or 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 act additionally requires the carrier to provide any related documents, communications, or information. The carrier must provide the required information by fax, electronic means, or any other expeditious method available. By law, under expedited review, all necessary information must be transmitted by telephone or the methods listed above.

By law, the carrier must notify the covered person and, if applicable, his or her representative, of its decision following a review of its determination. Under prior law, if the decision upheld the adverse determination, the notice had to state that the covered person could receive, upon request, access to and copies of all documents, records, and other information relevant to the determination. The act expands this to require that the notice state that the covered person can obtain copies of all communications, and other information and evidence regarding the adverse determination that were not previously provided to the covered person or representative. By law, the carrier must provide these copies free of charge.

The act requires carriers, upon the request of the covered person or representative, to provide free of charge to him or her copies of all documents, communications, information, and evidence, including citations to any medical journals, if applicable, regarding the adverse determination or the final adverse determination, as applicable, that were not (1) submitted by the covered person or his or her representative and (2) previously provided by the carrier.

The carrier must provide these copies by fax, electronic means, or any other expeditious method within five business days after the carrier receives a request regarding a final adverse determination of a prospective, concurrent, or retrospective review.

But the carrier must provide these copies using these methods within one calendar day after it receives a request regarding a final adverse determination

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regarding:

1. an expedited review request, an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility;
2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that this care, service, or treatment would be significantly less effective if not promptly initiated; or
3. a medical condition for which the period for completing an expedited internal review of a grievance involving the adverse determination would seriously jeopardize the covered person's life or health or would jeopardize his or her ability to regain maximum function.

Adverse Determinations Based on Other Rationales

By law, carriers must establish procedures for reviewing grievances of adverse determinations that are not based on medical necessity, and the review decision must refer to evidence or documentation used as the basis for the decision. The act additionally requires the decision to refer to the relevant communications and information.

For decisions upholding an adverse determination, the act also requires that the decision include a statement that the covered person may receive from the carrier, free of charge and upon request, reasonable access to, and copies of, all documents, communications, information, and evidence regarding the subject of the final adverse determination.

Upon this request, the carrier must provide copies of the same information as described above with regard to determinations made on the basis of medical necessity. It must do so within five business days after it receives a request regarding a final adverse determination.

But the carrier must provide these copies using these methods within one calendar day after it receives a request regarding a final adverse determination regarding:

1. an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility or
2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that this care, service, or treatment would be significantly less effective if not promptly initiated.

EXTERNAL REVIEWS

By law, when the carrier sends a notice of an adverse determination or final adverse determination, it must disclose that the covered person or representative can seek an external review. The act requires the disclosure to state that the

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covered person or his or her representative may request, free of charge, copies of all documents, communications, information, and evidence regarding the adverse determination or the final adverse determination that were not previously provided to him or her.

Upon this request, the carrier must provide copies of the same information as described above with regard to determinations made on the basis of medical necessity. It must do so by the deadlines described above for determinations based on rationales other than medical necessity.

OLR Tracking: KM:MJ:PF:ts/ro/ts/eh