



General Assembly

Amendment

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LCO No. 3838

SB0018603838SD0

Offered by:

SEN. LOONEY, 11th Dist.

SEN. CRISCO, 17th Dist.

SEN. KELLY, 21st Dist.

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To: Senate Bill No. 186

File No. 58

Cal. No. 78

**"AN ACT CONCERNING DISPENSATION AND INSURANCE
COVERAGE OF A PRESCRIBED DRUG DURING REVIEW OF AN
ADVERSE DETERMINATION OR A FINAL ADVERSE
DETERMINATION."**

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 38a-591d of the 2014 supplement to the general
4 statutes is repealed and the following is substituted in lieu thereof
5 (*Effective January 1, 2015*):

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

12 carrier shall make such review and benefit determinations within the
13 specified time periods under this section.

14 (2) In determining whether a benefit request shall be considered an
15 urgent care request, an individual acting on behalf of a health carrier
16 shall apply the judgment of a prudent layperson who possesses an
17 average knowledge of health and medicine, except that any benefit
18 request (A) determined to be an urgent care request by a health care
19 professional with knowledge of the covered person's medical
20 condition, or (B) specified under subparagraph (B) or (C) of
21 subdivision (38) of section 38a-591a shall be deemed an urgent care
22 request.

23 (3) After a covered person, a covered person's authorized
24 representative or a covered person's health care professional is notified
25 of an initial adverse determination that was based, in whole or in part,
26 on medical necessity, of a concurrent or prospective utilization review
27 or of a benefit request, a health carrier may offer a covered person's
28 health care professional the opportunity to confer with a clinical peer
29 of such health carrier, provided such covered person, covered person's
30 authorized representative or covered person's health care professional
31 has not filed a grievance of such initial adverse determination prior to
32 such conference. Such conference shall not be considered a grievance
33 of such initial adverse determination.

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

35 (1) (A) For a prospective or concurrent review request, a health
36 carrier shall make a determination within a reasonable period of time
37 appropriate to the covered person's medical condition, but not later
38 than fifteen calendar days after the date the health carrier receives such
39 request, and shall notify the covered person and, if applicable, the
40 covered person's authorized representative of such determination,
41 whether or not the carrier certifies the provision of the benefit.

42 (B) If the review under subparagraph (A) of this subdivision is a

43 review of a grievance involving a concurrent review request, pursuant
44 to 45 CFR 147.136, as amended from time to time, the treatment shall
45 be continued without liability to the covered person until the covered
46 person has been notified of the review decision.

47 (C) If the review under subparagraph (A) of this subdivision is a
48 review of a grievance involving a prospective review request relating
49 to the dispensation of a drug, other than a schedule II or III controlled
50 substance, prescribed by a licensed participating provider, the health
51 carrier shall issue immediate electronic authorization to the covered
52 person's pharmacy for the dispensation of a one-time fourteen-day
53 supply of such drug. Such authorization shall include confirmation of
54 the availability of payment for such supply of such drug. The
55 provisions of this subparagraph shall not apply to a grievance or
56 review of an adverse determination under this section concerning the
57 substitution of a generic drug or another brand name drug for a
58 prescribed brand name drug unless the prescribing licensed
59 participating provider has specified that there shall be no substitution
60 for the specified brand name drug.

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

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

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

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

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

78 (i) Specifically describe in the notice of extension the required
79 information necessary to complete the request; and

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

84 (B) If the covered person or the covered person's authorized
85 representative fails to submit the specified information before the end
86 of the period of the extension, the health carrier may deny certification
87 of the benefit requested.

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

89 (1) (A) Unless the covered person or the covered person's
90 authorized representative has failed to provide information necessary
91 for the health carrier to make a determination and except as specified
92 under subparagraph (B) of this subdivision, the health carrier shall
93 make a determination as soon as possible, taking into account the
94 covered person's medical condition, but not later than seventy-two
95 hours after the health carrier receives such request, provided, if the
96 urgent care request is a concurrent review request to extend a course of
97 treatment beyond the initial period of time or the number of
98 treatments, such request is made at least twenty-four hours prior to the
99 expiration of the prescribed period of time or number of treatments.

100 (B) Unless the covered person or the covered person's authorized
101 representative has failed to provide information necessary for the
102 health carrier to make a determination, for an urgent care request
103 specified under subparagraph (B) or (C) of subdivision (38) of section
104 38a-591a, the health carrier shall make a determination as soon as

105 possible, taking into account the covered person's medical condition,
106 but not later than twenty-four hours after the health carrier receives
107 such request, provided, if the urgent care request is a concurrent
108 review request to extend a course of treatment beyond the initial
109 period of time or the number of treatments, such request is made at
110 least twenty-four hours prior to the expiration of the prescribed period
111 of time or number of treatments.

112 (2) (A) If the covered person or the covered person's authorized
113 representative has failed to provide information necessary for the
114 health carrier to make a determination, the health carrier shall notify
115 the covered person or the covered person's representative, as
116 applicable, as soon as possible, but not later than twenty-four hours
117 after the health carrier receives such request.

118 (B) The health carrier shall provide the covered person or the
119 covered person's authorized representative, as applicable, a reasonable
120 period of time to submit the specified information, taking into account
121 the covered person's medical condition, but not less than forty-eight
122 hours after notifying the covered person or the covered person's
123 authorized representative, as applicable.

124 (3) The health carrier shall notify the covered person and, if
125 applicable, the covered person's authorized representative of its
126 determination as soon as possible, but not later than forty-eight hours
127 after the earlier of (A) the date on which the covered person and the
128 covered person's authorized representative, as applicable, provides the
129 specified information to the health carrier, or (B) the date on which the
130 specified information was to have been submitted.

131 (d) (1) Whenever a health carrier receives a review request from a
132 covered person or a covered person's authorized representative that
133 fails to meet the health carrier's filing procedures, the health carrier
134 shall notify the covered person and, if applicable, the covered person's
135 authorized representative of such failure not later than five calendar
136 days after the health carrier receives such request, except that for an

137 urgent care request, the health carrier shall notify the covered person
138 and, if applicable, the covered person's authorized representative of
139 such failure not later than twenty-four hours after the health carrier
140 receives such request.

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

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

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

151 (A) Information sufficient to identify the benefit request or claim
152 involved, including the date of service, if applicable, the health care
153 professional and the claim amount;

154 (B) The specific reason or reasons for the adverse determination,
155 including, upon request, a listing of the relevant clinical review
156 criteria, including professional criteria and medical or scientific
157 evidence and a description of the health carrier's standard, if any, that
158 were used in reaching the denial;

159 (C) Reference to the specific health benefit plan provisions on which
160 the determination is based;

161 (D) A description of any additional material or information
162 necessary for the covered person to perfect the benefit request or claim,
163 including an explanation of why the material or information is
164 necessary to perfect the request or claim;

165 (E) A description of the health carrier's internal grievance process

166 that includes (i) the health carrier's expedited review procedures, (ii)
167 any time limits applicable to such process or procedures, (iii) the
168 contact information for the organizational unit designated to
169 coordinate the review on behalf of the health carrier, and (iv) a
170 statement that the covered person or, if applicable, the covered
171 person's authorized representative is entitled, pursuant to the
172 requirements of the health carrier's internal grievance process, to
173 receive from the health carrier, free of charge upon request, reasonable
174 access to and copies of all documents, records, communications and
175 other information and evidence regarding the covered person's benefit
176 request;

177 (F) If the adverse determination is based on a health carrier's
178 internal rule, guideline, protocol or other similar criterion, (i) the
179 specific rule, guideline, protocol or other similar criterion, or (ii) (I) a
180 statement that a specific rule, guideline, protocol or other similar
181 criterion of the health carrier was relied upon to make the adverse
182 determination and that a copy of such rule, guideline, protocol or other
183 similar criterion will be provided to the covered person free of charge
184 upon request, (II) instructions for requesting such copy, and (III) the
185 links to such rule, guideline, protocol or other similar criterion on such
186 health carrier's Internet web site. If the adverse determination involves
187 the treatment of a substance use disorder, as described in section 17a-
188 458, or a mental disorder, the notice of adverse determination shall
189 also include, if applicable, a link to the document created and
190 maintained by such health carrier pursuant to subdivision (3), (4) or (5)
191 of subsection (a) of section 38a-591c, as applicable, on such health
192 carrier's Internet web site;

193 (G) If the adverse determination is based on medical necessity or an
194 experimental or investigational treatment or similar exclusion or limit,
195 the written statement of the scientific or clinical rationale for the
196 adverse determination and (i) an explanation of the scientific or clinical
197 rationale used to make the determination that applies the terms of the
198 health benefit plan to the covered person's medical circumstances or

199 (ii) a statement that an explanation will be provided to the covered
200 person free of charge upon request, and instructions for requesting a
201 copy of such explanation;

202 (H) A statement explaining the right of the covered person to
203 contact the commissioner's office or the Office of the Healthcare
204 Advocate at any time for assistance or, upon completion of the health
205 carrier's internal grievance process, to file a civil suit in a court of
206 competent jurisdiction. Such statement shall include the contact
207 information for said offices; and

208 (I) A statement that if the covered person or the covered person's
209 authorized representative chooses to file a grievance of an adverse
210 determination, (i) such appeals are sometimes successful, (ii) such
211 covered person or covered person's authorized representative may
212 benefit from free assistance from the Office of the Healthcare
213 Advocate, which can assist such covered person or covered person's
214 authorized representative with the filing of a grievance pursuant to 42
215 USC 300gg-93, as amended from time to time, or from the Division of
216 Consumer Affairs within the Insurance Department, (iii) such covered
217 person or covered person's authorized representative is entitled and
218 encouraged to submit supporting documentation for the health
219 carrier's consideration during the review of an adverse determination,
220 including narratives from such covered person or covered person's
221 authorized representative and letters and treatment notes from such
222 covered person's health care professional, and (iv) such covered person
223 or covered person's authorized representative has the right to ask such
224 covered person's health care professional for such letters or treatment
225 notes.

226 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
227 this subsection, the health carrier shall provide such copies in
228 accordance with subsection (a) of section 38a-591n.

229 (f) If the adverse determination is a rescission, the health carrier
230 shall include with the advance notice of the application for rescission

231 required to be sent to the covered person, a written statement that
232 includes:

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

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

237 (3) A disclosure that the covered person or the covered person's
238 authorized representative may file immediately, without waiting for
239 the date such advance notice of the proposed rescission ends, a
240 grievance with the health carrier to request a review of the adverse
241 determination to rescind coverage, pursuant to sections 38a-591e, as
242 amended by this act, and 38a-591f;

243 (4) A description of the health carrier's grievance procedures
244 established under sections 38a-591e, as amended by this act, and 38a-
245 591f, including any time limits applicable to those procedures; and

246 (5) The date such advance notice of the proposed rescission ends
247 and the date back to which the coverage will be retroactively
248 rescinded.

249 (g) (1) Whenever a health carrier fails to strictly adhere to the
250 requirements of this section with respect to making utilization review
251 and benefit determinations of a benefit request or claim, the covered
252 person shall be deemed to have exhausted the internal grievance
253 process of such health carrier and may file a request for an external
254 review in accordance with the provisions of section 38a-591g,
255 regardless of whether the health carrier asserts it substantially
256 complied with the requirements of this section or that any error it
257 committed was de minimis.

258 (2) A covered person who has exhausted the internal grievance
259 process of a health carrier may, in addition to filing a request for an
260 external review, pursue any available remedies under state or federal

261 law on the basis that the health carrier failed to provide a reasonable
262 internal grievance process that would yield a decision on the merits of
263 the claim.

264 Sec. 2. Section 38a-591e of the 2014 supplement to the general
265 statutes is repealed and the following is substituted in lieu thereof
266 (*Effective January 1, 2015*):

267 (a) (1) Each health carrier shall establish and maintain written
268 procedures for (A) the review of grievances of adverse determinations
269 that were based, in whole or in part, on medical necessity, (B) the
270 expedited review of grievances of adverse determinations of urgent
271 care requests, including concurrent review urgent care requests
272 involving an admission, availability of care, continued stay or health
273 care service for a covered person who has received emergency services
274 but has not been discharged from a facility, and (C) notifying covered
275 persons or covered persons' authorized representatives of such
276 adverse determinations.

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

280 (3) In addition to a copy of such procedures, each health carrier shall
281 file annually with the commissioner, as part of its annual report
282 required under subsection (e) of section 38a-591b, a certificate of
283 compliance stating that the health carrier has established and
284 maintains grievance procedures for each of its health benefit plans that
285 are fully compliant with the provisions of sections 38a-591a to 38a-
286 591n, inclusive.

287 (b) (1) A covered person or a covered person's authorized
288 representative may file a grievance of an adverse determination that
289 was based, in whole or in part, on medical necessity with the health
290 carrier not later than one hundred eighty calendar days after the
291 covered person or the covered person's authorized representative, as

292 applicable, receives the notice of an adverse determination.

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

296 (c) (1) (A) When conducting a review of an adverse determination
297 under this section, the health carrier shall ensure that such review is
298 conducted in a manner to ensure the independence and impartiality of
299 the clinical peer or peers involved in making the review decision.

300 (B) If the adverse determination involves utilization review, the
301 health carrier shall designate an appropriate clinical peer or peers to
302 review such adverse determination. Such clinical peer or peers shall
303 not have been involved in the initial adverse determination.

304 (C) The clinical peer or peers conducting a review under this section
305 shall take into consideration all comments, documents, records and
306 other information relevant to the covered person's benefit request that
307 is the subject of the adverse determination under review, that are
308 submitted by the covered person or the covered person's authorized
309 representative, regardless of whether such information was submitted
310 or considered in making the initial adverse determination.

311 (D) Prior to issuing a decision, the health carrier shall provide free
312 of charge, by facsimile, electronic means or any other expeditious
313 method available, to the covered person or the covered person's
314 authorized representative, as applicable, any new or additional
315 documents, communications, information and evidence relied upon
316 and any new or additional scientific or clinical rationale used by the
317 health carrier in connection with the grievance. Such documents,
318 communications, information, evidence and rationale shall be
319 provided sufficiently in advance of the date the health carrier is
320 required to issue a decision to permit the covered person or the
321 covered person's authorized representative, as applicable, a reasonable
322 opportunity to respond prior to such date.

323 (2) If the review under subdivision (1) of this subsection is an
324 expedited review, all necessary information, including the health
325 carrier's decision, shall be transmitted between the health carrier and
326 the covered person or the covered person's authorized representative,
327 as applicable, by telephone, facsimile, electronic means or any other
328 expeditious method available.

329 (3) If the review under subdivision (1) of this subsection is an
330 expedited review of a grievance involving an adverse determination of
331 a concurrent review request, pursuant to 45 CFR 147.136, as amended
332 from time to time, the treatment shall be continued without liability to
333 the covered person until the covered person has been notified of the
334 review decision.

335 (4) If the review under subdivision (1) of this subsection is a review
336 of a grievance involving an adverse determination of a prospective
337 review request relating to the dispensation of a drug, other than a
338 schedule II or III controlled substance, prescribed by a licensed
339 participating provider, the health carrier shall issue immediate
340 electronic authorization to the covered person's pharmacy for the
341 dispensation of a one-time fourteen-day supply of such drug. Such
342 authorization shall include confirmation of the availability of payment
343 for such supply of such drug. The provisions of this subdivision shall
344 not apply to a grievance or review of an adverse determination under
345 this section concerning the substitution of a generic drug or another
346 brand name drug for a prescribed brand name drug unless the
347 prescribing licensed participating provider has specified that there
348 shall be no substitution for the specified brand name drug.

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

354 (A) For prospective review and concurrent review requests, thirty

355 calendar days after the health carrier receives the grievance;

356 (B) For retrospective review requests, sixty calendar days after the
357 health carrier receives the grievance;

358 (C) For expedited review requests, except as specified under
359 subparagraph (D) of this subdivision, seventy-two hours after the
360 health carrier receives the grievance; and

361 (D) For expedited review requests of a health care service or course
362 of treatment specified under subparagraph (B) or (C) of subdivision
363 (38) of section 38a-591a, twenty-four hours after the health carrier
364 receives the grievance.

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

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

371 (A) The titles and qualifying credentials of the clinical peer or peers
372 participating in the review process;

373 (B) Information sufficient to identify the claim involved with respect
374 to the grievance, including the date of service, if applicable, the health
375 care professional and the claim amount;

376 (C) A statement of such clinical peer's or peers' understanding of the
377 covered person's grievance;

378 (D) The clinical peer's or peers' decision in clear terms and the
379 health benefit plan contract basis or scientific or clinical rationale for
380 such decision in sufficient detail for the covered person to respond
381 further to the health carrier's position;

382 (E) Reference to the evidence or documentation used as the basis for

383 the decision;

384 (F) For a decision that upholds the adverse determination:

385 (i) The specific reason or reasons for the final adverse
386 determination, including the denial code and its corresponding
387 meaning, as well as a description of the health carrier's standard, if
388 any, that was used in reaching the denial;

389 (ii) Reference to the specific health benefit plan provisions on which
390 the decision is based;

391 (iii) A statement that the covered person may receive from the
392 health carrier, free of charge and upon request, reasonable access to
393 and copies of, all documents, records, communications and other
394 information and evidence not previously provided regarding the
395 adverse determination under review;

396 (iv) If the final adverse determination is based on a health carrier's
397 internal rule, guideline, protocol or other similar criterion, (I) the
398 specific rule, guideline, protocol or other similar criterion, or (II) a
399 statement that a specific rule, guideline, protocol or other similar
400 criterion of the health carrier was relied upon to make the final adverse
401 determination and that a copy of such rule, guideline, protocol or other
402 similar criterion will be provided to the covered person free of charge
403 upon request and instructions for requesting such copy;

404 (v) If the final adverse determination is based on medical necessity
405 or an experimental or investigational treatment or similar exclusion or
406 limit, the written statement of the scientific or clinical rationale for the
407 final adverse determination and (I) an explanation of the scientific or
408 clinical rationale used to make the determination that applies the terms
409 of the health benefit plan to the covered person's medical
410 circumstances, or (II) a statement that an explanation will be provided
411 to the covered person free of charge upon request and instructions for
412 requesting a copy of such explanation;

413 (vi) A statement describing the procedures for obtaining an external
414 review of the final adverse determination;

415 (G) If applicable, the following statement: "You and your plan may
416 have other voluntary alternative dispute resolution options such as
417 mediation. One way to find out what may be available is to contact
418 your state Insurance Commissioner."; and

419 (H) A statement disclosing the covered person's right to contact the
420 commissioner's office or the Office of the Healthcare Advocate at any
421 time. Such disclosure shall include the contact information for said
422 offices.

423 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)
424 of this subsection, the health carrier shall provide such copies in
425 accordance with subsection (b) of section 38a-591n.

426 (f) (1) Whenever a health carrier fails to strictly adhere to the
427 requirements of this section with respect to receiving and resolving
428 grievances involving an adverse determination, the covered person
429 shall be deemed to have exhausted the internal grievance process of
430 such health carrier and may file a request for an external review,
431 regardless of whether the health carrier asserts that it substantially
432 complied with the requirements of this section, or that any error it
433 committed was de minimis.

434 (2) A covered person who has exhausted the internal grievance
435 process of a health carrier may, in addition to filing a request for an
436 external review, pursue any available remedies under state or federal
437 law on the basis that the health carrier failed to provide a reasonable
438 internal grievance process that would yield a decision on the merits of
439 the claim. "

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2015	38a-591d

Sec. 2	<i>January 1, 2015</i>	38a-591e
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