



Senate

General Assembly

File No. 37

February Session, 2014

Senate Bill No. 197

Senate, March 18, 2014

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 bill ought to pass.

AN ACT DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.

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

1 Section 1. Subdivision (1) of subsection (c) of section 38a-591d of the
2 2014 supplement to the general statutes is repealed and the following
3 is substituted in lieu thereof (*Effective October 1, 2014*):

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

5 (1) [(A)] Unless the covered person or the covered person's
6 authorized representative has failed to provide information necessary
7 for the health carrier to make a determination, [and except as specified
8 under subparagraph (B) of this subdivision,] the health carrier shall
9 make a determination as soon as possible, taking into account the
10 covered person's medical condition, but not later than [seventy-two]
11 twenty-four hours after the health carrier receives such request,
12 provided, if the urgent care request is a concurrent review request to
13 extend a course of treatment beyond the initial period of time or the

14 number of treatments, such request is made at least twenty-four hours
15 prior to the expiration of the prescribed period of time or number of
16 treatments.

17 [(B) Unless the covered person or the covered person's authorized
18 representative has failed to provide information necessary for the
19 health carrier to make a determination, for an urgent care request
20 specified under subparagraph (B) or (C) of subdivision (38) of section
21 38a-591a, the health carrier shall make a determination as soon as
22 possible, taking into account the covered person's medical condition,
23 but not later than twenty-four hours after the health carrier receives
24 such request, provided, if the urgent care request is a concurrent
25 review request to extend a course of treatment beyond the initial
26 period of time or the number of treatments, such request is made at
27 least twenty-four hours prior to the expiration of the prescribed period
28 of time or number of treatments.]

29 Sec. 2. Subdivision (1) of subsection (d) of section 38a-591e of the
30 2014 supplement to the general statutes is repealed and the following
31 is substituted in lieu thereof (*Effective October 1, 2014*):

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

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

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

41 (C) For expedited review requests, [except as specified under
42 subparagraph (D) of this subdivision, seventy-two] twenty-four hours
43 after the health carrier receives the grievance. [; and]

44 [(D) For expedited review requests of a health care service or course

45 of treatment specified under subparagraph (B) or (C) of subdivision
46 (38) of section 38a-591a, twenty-four hours after the health carrier
47 receives the grievance.]

48 Sec. 3. Subdivision (1) of subsection (i) of section 38a-591g of the
49 2014 supplement to the general statutes is repealed and the following
50 is substituted in lieu thereof (*Effective October 1, 2014*):

51 (i) (1) The independent review organization shall notify the
52 commissioner, the health carrier, the covered person and, if applicable,
53 the covered person's authorized representative in writing of its
54 decision to uphold, reverse or revise the adverse determination or the
55 final adverse determination, not later than:

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

59 (B) For external reviews involving a determination that the
60 recommended or requested health care service or treatment is
61 experimental or investigational, twenty calendar days after such
62 organization receives the assignment from the commissioner to
63 conduct such review;

64 (C) For expedited external reviews, [except as specified under
65 subparagraph (D) of this subdivision,] as expeditiously as the covered
66 person's medical condition requires, but not later than [seventy-two]
67 twenty-four hours after such organization receives the assignment
68 from the commissioner to conduct such review; and

69 [(D) For expedited external reviews involving a health care service
70 or course of treatment specified under subparagraph (B) or (C) of
71 subdivision (38) of section 38a-591a, as expeditiously as the covered
72 person's medical condition requires, but not later than twenty-four
73 hours after such organization receives the assignment from the
74 commissioner to conduct such review; and]

75 [(E)] (D) For expedited external reviews involving a determination

76 that the recommended or requested health care service or treatment is
77 experimental or investigational, as expeditiously as the covered
78 person's medical condition requires, but not later than five calendar
79 days after such organization receives the assignment from the
80 commissioner to conduct such review.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2014</i>	38a-591d(c)(1)
Sec. 2	<i>October 1, 2014</i>	38a-591e(d)(1)
Sec. 3	<i>October 1, 2014</i>	38a-591g(i)(1)

INS *Joint Favorable*

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:

Municipalities	Effect	FY 15 \$	FY 16 \$
Various Municipalities	Cost	Potential	Potential

Explanation

There is no cost to the state employee and retiree health plan as a result of this bill as the state as a self-insured plan is considered an employer and not a carrier for the purposes of the utilization and review procedures outlined in CGS 38a-591d.

It is uncertain if the bill's provisions would increase costs to fully-insured municipal plans whose health insurers do not currently follow the dispensing procedures required by the bill. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts on or after October 1, 2014. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**SB 197*****AN ACT DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.*****SUMMARY:**

This bill generally reduces, from 72 to 24 hours, the deadline for health carriers (insurers) to:

1. make a determination in response to a request for urgent care and
2. notify an insured and, if applicable, his or her authorized representative, of its decision on an application for an expedited review of a grievance of its determination.

The bill similarly gives an independent review organization 24, rather than 72, hours after being assigned to review an adverse determination or final adverse determination to notify the insurance commissioner, the health carrier, the insured and, if applicable, the insured's authorized representative of its decision to uphold, reverse, or revise the determination.

By law, the time for responding begins when the carrier or review organization receives the request or grievance.

The 24-hour deadline already applies to:

1. urgent care requests for treatment of substance abuse or mental disorders,
2. expedited review requests of a grievance of a determination regarding such disorders, and
3. independent review organization action on expedited reviews

involving a health care service or course of treatment for the disorders.

EFFECTIVE DATE: October 1, 2014

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 12 Nay 7 (03/04/2014)