



Senate

General Assembly

File No. 89

January Session, 2015

Senate Bill No. 415

Senate, March 17, 2015

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 CONCERNING DISPENSATION AND COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC DISEASE DURING CERTAIN ADVERSE DETERMINATION REVIEWS.

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

1 Section 1. Subsection (b) of section 38a-591d of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective*
3 *January 1, 2016*):

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

5 (1) (A) For a prospective or concurrent review request, a health
6 carrier shall make a determination within a reasonable period of time
7 appropriate to the covered person's medical condition, but not later
8 than fifteen calendar days after the date the health carrier receives such
9 request, and shall notify the covered person and, if applicable, the
10 covered person's authorized representative of such determination,
11 whether or not the carrier certifies the provision of the benefit.

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

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

17 (C) (i) If the review under subparagraph (A) of this subdivision is a
18 review of a grievance involving a prospective review request relating
19 to the dispensing of a drug for a chronic disease, other than a schedule
20 II or III controlled substance, that is prescribed by a licensed
21 participating provider who is a specialist in such chronic disease, the
22 health carrier shall issue an electronic authorization to the covered
23 person's pharmacy for the dispensing of a temporary supply of such
24 drug sufficient for the duration of such review until the covered
25 person has been notified of the review decision. Such authorization
26 shall include confirmation of the availability of payment for such
27 supply of such drug.

28 (ii) Not later than twenty-four hours after the health carrier has
29 issued such authorization to the pharmacy and prior to the pharmacy's
30 dispensation of such drug, such health carrier shall confirm with such
31 participating provider the provider's concurrence with the dispensing
32 of such temporary supply of such drug. If such participating provider
33 does not concur, the health carrier shall cancel such authorization.

34 (iii) The provisions of this subparagraph shall not apply to a
35 grievance or review of an adverse determination under this section
36 concerning the substitution of a generic drug or another brand name
37 drug for a prescribed brand name drug unless the prescribing licensed
38 participating provider has specified that there shall be no substitution
39 for the specified brand name drug.

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

44 (3) The time periods specified in subdivisions (1) and (2) of this

45 subsection may be extended once by the health carrier for up to fifteen
46 calendar days, provided the health carrier:

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

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

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

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

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

63 (B) If the covered person or the covered person's authorized
64 representative fails to submit the specified information before the end
65 of the period of the extension, the health carrier may deny certification
66 of the benefit requested.

67 Sec. 2. Subsection (c) of section 38a-591e of the general statutes is
68 repealed and the following is substituted in lieu thereof (*Effective*
69 *January 1, 2016*):

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

74 (B) If the adverse determination involves utilization review, the
75 health carrier shall designate an appropriate clinical peer or peers to
76 review such adverse determination. Such clinical peer or peers shall
77 not have been involved in the initial adverse determination.

78 (C) The clinical peer or peers conducting a review under this section
79 shall take into consideration all comments, documents, records and
80 other information relevant to the covered person's benefit request that
81 is the subject of the adverse determination under review, that are
82 submitted by the covered person or the covered person's authorized
83 representative, regardless of whether such information was submitted
84 or considered in making the initial adverse determination.

85 (D) Prior to issuing a decision, the health carrier shall provide free
86 of charge, by facsimile, electronic means or any other expeditious
87 method available, to the covered person or the covered person's
88 authorized representative, as applicable, any new or additional
89 documents, communications, information and evidence relied upon
90 and any new or additional scientific or clinical rationale used by the
91 health carrier in connection with the grievance. Such documents,
92 communications, information, evidence and rationale shall be
93 provided sufficiently in advance of the date the health carrier is
94 required to issue a decision to permit the covered person or the
95 covered person's authorized representative, as applicable, a reasonable
96 opportunity to respond prior to such date.

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

103 (3) If the review under subdivision (1) of this subsection is an
104 expedited review of a grievance involving an adverse determination of
105 a concurrent review request, pursuant to 45 CFR 147.136, as amended
106 from time to time, the treatment shall be continued without liability to

107 the covered person until the covered person has been notified of the
 108 review decision.

109 (4) (A) If the review under subdivision (1) of this subsection is a
 110 review of a grievance involving a prospective review request relating
 111 to the dispensing of a drug for a chronic disease, other than a schedule
 112 II or III controlled substance, that is prescribed by a licensed
 113 participating provider who is a specialist in such chronic disease, the
 114 health carrier shall issue an electronic authorization to the covered
 115 person's pharmacy for the dispensing of a temporary supply of such
 116 drug sufficient for the duration of such review until the covered
 117 person has been notified of the review decision. Such authorization
 118 shall include confirmation of the availability of payment for such
 119 supply of such drug.

120 (B) Not later than twenty-four hours after the health carrier has
 121 issued such authorization to the pharmacy and prior to the pharmacy's
 122 dispensation of such drug, such health carrier shall confirm with such
 123 participating provider the provider's concurrence with the dispensing
 124 of such temporary supply of such drug. If such participating provider
 125 does not concur, the health carrier shall cancel such authorization.

126 (C) The provisions of this subdivision shall not apply to a grievance
 127 or review of an adverse determination under this section concerning
 128 the substitution of a generic drug or another brand name drug for a
 129 prescribed brand name drug unless the prescribing licensed
 130 participating provider has specified that there shall be no substitution
 131 for the specified brand name drug.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2016	38a-591d(b)
Sec. 2	January 1, 2016	38a-591e(c)

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 16 \$	FY 17 \$
Various Municipalities	Potential Cost	Potential	Potential

Explanation

The bill does not result in a fiscal impact to the state employee and retiree health plan as the state as a self-insured plan is not governed by the utilization and review procedures outlined in CGS 38a-591d.

It is uncertain if the bill's provisions will increase costs to fully-insured municipal plans whose health insurers do not currently follow the coverage requirements of the bill while the utilization review is being conducted. The potential cost to municipalities is limited based on the following provisions of the bill: (1) coverage limited to drugs prescribed by a specialist for chronic conditions, (2) excludes schedule II and III controlled substances, (2) excludes circumstances where a generic substitution has taken place and the physician has not explicitly indicated "no substitution", (3) requires the approval of the prescribing physician for a temporary supply of the prescription, and (4) only applies to internal, prospective reviews¹ not involving questions of medical necessity. Any additional cost to the municipality will be reflected in premiums effective on or after January 1, 2016.

The Out Years

¹ Internal, prospective reviews are reviews which are undertaken by the carrier directly for a prescription newly prescribed to an insured.

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

OLR Bill Analysis**SB 415*****AN ACT CONCERNING DISPENSATION AND COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC DISEASE DURING CERTAIN ADVERSE DETERMINATION REVIEWS.*****SUMMARY:**

This bill requires health carriers (e.g., insurers and HMOs) to authorize a covered person's pharmacy to dispense a temporary supply of a drug to treat a chronic disease when:

1. the covered person, or his or her authorized representative, requests a review of an adverse determination (e.g., benefit denial) and
2. the prescriber is a licensed participating provider specializing in the chronic disease.

The adverse determination (see BACKGROUND) must be (1) of a prospective review and (2) based on medical necessity. A "prospective review" is an initial approval review that a health carrier requires before a patient may receive a health care service or course of treatment.

The requirement does not apply to (1) a prescription for a schedule II or III drug (see BACKGROUND) or (2) a review of an adverse determination concerning the substitution of a generic or other brand name drug, unless the prescriber has specified no substitutions.

EFFECTIVE DATE: January 1, 2016

PHARMACY AUTHORIZATION

Under the bill, health carriers must electronically authorize the covered person's pharmacy to dispense a temporary supply of the

drug and include confirmation that payment is available. The temporary supply must be sufficient for the review's duration, including the time required for the health carrier to notify the covered person of its decision.

By law, health carriers generally must complete reviews of adverse determinations within 30 days after receiving the grievance. However, expedited reviews must be completed within 72 hours, and expedited reviews of treatment for certain substance abuse or mental disorders must be completed within 24 hours.

PRESCRIBER CONCURRENCE

The bill requires carriers to contact a prescriber to confirm that he or she concurs with dispensing a temporary drug supply within 24 hours after authorizing the pharmacy to dispense. However, the bill does not prohibit pharmacies from dispensing the drug after they receive authorization but before the carrier contacts the prescriber.

BACKGROUND

Adverse Determination

An adverse determination is a denial of coverage for a specific service. By law, a health carrier must provide a covered person or his or her authorized representative with reasonable notice of an adverse determination. At the request of the covered person, the health carrier must review an adverse determination and notify the covered person or authorized representative of its final decision. The covered person or his or her authorized representative may request an external review of an adverse or a final adverse determination.

Drug Schedules

Federal law categorizes drugs into one of five schedules based on the (1) potential and risks of abuse and (2) safety, importance, and range of accepted medical treatments. The schedules range from I (high potential for abuse and little to no medical value) to V (low potential for abuse and accepted medical uses). For example, opioid painkillers (e.g. Vicodin) are generally categorized as Schedule II or III,

depending on their potential risks.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 19 Nay 0 (03/03/2015)