



General Assembly

February Session, 2016

Raised Bill No. 160

LCO No. 1455



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING INSURED'S ACCESS TO HEALTH INSURERS
FOR THE PROCESSING OF CERTAIN PRIOR AUTHORIZATION
REQUESTS.***

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

1 Section 1. Section 38a-503c of the 2016 supplement to the general
2 statutes is amended by adding subsection (e) as follows (*Effective*
3 *October 1, 2016*):

4 (NEW) (e) Each individual health insurance carrier subject to this
5 section that requires prior authorization for the interhospital transfer
6 of a mother or her newborn infant shall establish and maintain a
7 twenty-four-hour telephone number that the mother or an attending
8 health care provider may call for a decision on such prior
9 authorization, whether such transfer is for (1) the care or treatment of
10 such mother or newborn infant, (2) the mother to accompany her
11 newborn infant, or (3) the newborn infant to accompany the mother.
12 Such telephone number shall be manned by individuals authorized to
13 issue such decision.

14 Sec. 2. Section 38a-530c of the 2016 supplement to the general
15 statutes is amended by adding subsection (e) as follows (*Effective*

16 *October 1, 2016*):

17 (NEW) (e) A group health insurance carrier subject to this section
18 that requires prior authorization for the interhospital transfer of a
19 mother or her newborn infant shall establish and maintain a twenty-
20 four-hour telephone number that the mother or an attending health
21 care provider may call for a decision on such prior authorization,
22 whether such transfer is for (1) the care or treatment of such mother or
23 newborn infant, (2) the mother to accompany her newborn infant, or
24 (3) the newborn infant to accompany the mother. Such telephone
25 number shall be manned by individuals authorized to issue such
26 decision.

27 Sec. 3. Subsection (d) of section 38a-591b of the 2016 supplement to
28 the general statutes, as amended by section 10 of public act 15-146, is
29 repealed and the following is substituted in lieu thereof (*Effective*
30 *October 1, 2016*):

31 (d) Each health carrier shall:

32 (1) Include in the insurance policy, certificate of coverage or
33 handbook provided to covered persons a clear and comprehensive
34 description of:

35 (A) Its utilization review and benefit determination procedures;

36 (B) Its grievance procedures, including the grievance procedures for
37 requesting a review of an adverse determination;

38 (C) A description of the external review procedures set forth in
39 section 38a-591g, in a format prescribed by the commissioner and
40 including a statement that discloses that:

41 (i) A covered person may file a request for an external review of an
42 adverse determination or a final adverse determination with the
43 commissioner and that such review is available when the adverse
44 determination or the final adverse determination involves an issue of

45 medical necessity, appropriateness, health care setting, level of care or
46 effectiveness. Such disclosure shall include the contact information of
47 the commissioner; and

48 (ii) When filing a request for an external review of an adverse
49 determination or a final adverse determination, the covered person
50 shall be required to authorize the release of any medical records that
51 may be required to be reviewed for the purpose of making a decision
52 on such request;

53 (D) A statement of the rights and responsibilities of covered persons
54 with respect to each of the procedures under subparagraphs (A) to (C),
55 inclusive, of this subdivision. Such statement shall include a disclosure
56 that a covered person has the right to contact the commissioner's office
57 or the Office of Healthcare Advocate at any time for assistance and
58 shall include the contact information for said offices;

59 (E) A description of what constitutes a surprise bill, as defined in
60 subsection (a) of section 38a-477aa;

61 (2) Inform its covered persons, at the time of initial enrollment and
62 at least annually thereafter, of its grievance procedures. This
63 requirement may be fulfilled by including such procedures in an
64 enrollment agreement or update to such agreement;

65 (3) Inform a covered person or the covered person's health care
66 professional, as applicable, at the time the covered person or the
67 covered person's health care professional requests a prospective or
68 concurrent review: (A) The network status under such covered
69 person's health benefit plan of the health care professional who will be
70 providing the health care service or course of treatment; (B) an
71 estimate of the amount the health carrier will reimburse such health
72 care professional for such service or treatment; and (C) how such
73 amount compares to the usual, customary and reasonable charge, as
74 determined by the Centers for Medicare and Medicaid Services, for
75 such service or treatment;

76 (4) Inform a covered person and the covered person's health care
77 professional of the health carrier's grievance procedures whenever the
78 health carrier denies certification of a benefit requested by a covered
79 person's health care professional;

80 (5) Prominently post on its Internet web site the description
81 required under subparagraph (E) of subdivision (1) of this subsection;

82 (6) Include in materials intended for prospective covered persons a
83 summary of its utilization review and benefit determination
84 procedures;

85 (7) Print on its membership or identification cards a toll-free
86 telephone number for utilization review and benefit determinations
87 and, if applicable, the twenty-hour-hour telephone number required
88 pursuant to subsection (e) of section 38a-503c, as amended by this act,
89 and subsection (e) of section 38a-530c, as amended by this act, if
90 different from the toll-free number for utilization review and benefit
91 determinations;

92 (8) Maintain records of all benefit requests, claims and notices
93 associated with utilization review and benefit determinations made in
94 accordance with section 38a-591d for not less than six years after such
95 requests, claims and notices were made. Each health carrier shall make
96 such records available for examination by the commissioner and
97 appropriate federal oversight agencies upon request; and

98 (9) Maintain records in accordance with section 38a-591h of all
99 grievances received. Each health carrier shall make such records
100 available for examination by covered persons, to the extent such
101 records are permitted to be disclosed by law, the commissioner and
102 appropriate federal oversight agencies upon request.

103 Sec. 4. Subdivision (2) of subsection (a) of section 38a-591d of the
104 2016 supplement to the general statutes is repealed and the following
105 is substituted in lieu thereof (*Effective October 1, 2016*):

106 (2) In determining whether a benefit request shall be considered an
 107 urgent care request, an individual acting on behalf of a health carrier
 108 shall apply the judgment of a prudent layperson who possesses an
 109 average knowledge of health and medicine, except that any benefit
 110 request (A) determined to be an urgent care request by a health care
 111 professional with knowledge of the covered person's medical
 112 condition, [or] (B) specified under subparagraph (B) or (C) of
 113 subdivision (38) of section 38a-591a, or (C) that is an interhospital
 114 transfer of a mother or her newborn infant, or both, as described in
 115 subdivision (1), (2), or (3) of subsection (e) of section 38a-503c, as
 116 amended by this act, or subdivision (1), (2) or (3) of subsection (e) of
 117 section 38a-530c, as amended by this act, shall be deemed an urgent
 118 care request.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2016</i>	38a-503c
Sec. 2	<i>October 1, 2016</i>	38a-530c
Sec. 3	<i>October 1, 2016</i>	38a-591b(d)
Sec. 4	<i>October 1, 2016</i>	38a-591d(a)(2)

Statement of Purpose:

To require health insurers that require prior authorization for the interhospital transfer of a newborn infant or such newborn infant's mother to establish and maintain a manned, twenty-four-hour telephone number for the issuance of decisions regarding such prior authorization requests.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]