



Senate

General Assembly

File No. 83

February Session, 2016

Senate Bill No. 34

Senate, March 21, 2016

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, AND 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. Subsection (b) of section 38a-591d of the 2016 supplement
2 to the general statutes is repealed and the following is substituted in
3 lieu thereof (*Effective January 1, 2017*):

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, 2017*):

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.

132 Sec. 3. Subdivision (1) of subsection (c) of section 38a-591d of the
133 2016 supplement to the general statutes is repealed and the following
134 is substituted in lieu thereof (*Effective January 1, 2017*):

135 (1) (A) Unless the covered person or the covered person's
136 authorized representative has failed to provide information necessary
137 for the health carrier to make a determination and except as specified
138 under subparagraph (B) of this subdivision, the health carrier shall

139 make a determination as soon as possible, taking into account the
140 covered person's medical condition, but not later than [seventy-two]
141 forty-eight hours after the health carrier receives such request,
142 provided, if the urgent care request is a concurrent review request to
143 extend a course of treatment beyond the initial period of time or the
144 number of treatments, such request is made at least twenty-four hours
145 prior to the expiration of the prescribed period of time or number of
146 treatments.

147 (B) Unless the covered person or the covered person's authorized
148 representative has failed to provide information necessary for the
149 health carrier to make a determination, for an urgent care request
150 specified under subparagraph (B) or (C) of subdivision (38) of section
151 38a-591a, the health carrier shall make a determination as soon as
152 possible, taking into account the covered person's medical condition,
153 but not later than twenty-four hours after the health carrier receives
154 such request, provided, if the urgent care request is a concurrent
155 review request to extend a course of treatment beyond the initial
156 period of time or the number of treatments, such request is made at
157 least twenty-four hours prior to the expiration of the prescribed period
158 of time or number of treatments.

159 Sec. 4. Subdivision (1) of subsection (d) of section 38a-591e of the
160 general statutes is repealed and the following is substituted in lieu
161 thereof (*Effective January 1, 2017*):

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

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

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

171 (C) For expedited review requests, except as specified under
172 subparagraph (D) of this subdivision, [seventy-two] forty-eight hours
173 after the health carrier receives the grievance; and

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

178 Sec. 5. Subdivision (1) of subsection (i) of section 38a-591g of the
179 general statutes is repealed and the following is substituted in lieu
180 thereof (*Effective January 1, 2017*):

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

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

189 (B) For external reviews involving a determination that the
190 recommended or requested health care service or treatment is
191 experimental or investigational, twenty calendar days after such
192 organization receives the assignment from the commissioner to
193 conduct such review;

194 (C) For expedited external reviews, except as specified under
195 subparagraph (D) of this subdivision, as expeditiously as the covered
196 person's medical condition requires, but not later than [seventy-two]
197 forty-eight hours after such organization receives the assignment from
198 the commissioner to conduct such review;

199 (D) For expedited external reviews involving a health care service or
200 course of treatment specified under subparagraph (B) or (C) of
201 subdivision (38) of section 38a-591a, as expeditiously as the covered

202 person's medical condition requires, but not later than twenty-four
 203 hours after such organization receives the assignment from the
 204 commissioner to conduct such review; and

205 (E) For expedited external reviews involving a determination that
 206 the recommended or requested health care service or treatment is
 207 experimental or investigational, as expeditiously as the covered
 208 person's medical condition requires, but not later than five calendar
 209 days after such organization receives the assignment from the
 210 commissioner to conduct such review.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2017</i>	38a-591d(b)
Sec. 2	<i>January 1, 2017</i>	38a-591e(c)
Sec. 3	<i>January 1, 2017</i>	38a-591d(c)(1)
Sec. 4	<i>January 1, 2017</i>	38a-591e(d)(1)
Sec. 5	<i>January 1, 2017</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 17 \$	FY 18 \$
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, (3) excludes circumstances where a generic substitution has taken place and the physician has not explicitly indicated "no substitution", (4) requires the approval of the prescribing physician for a temporary supply of the prescription, and (5) 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, 2017.

Lastly, decreasing the timeframe from 72 to 48 hours for certain

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

urgent care review requests is not anticipated to result in a cost to municipalities.

The Out Years

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

OLR Bill Analysis**SB 34*****AN ACT CONCERNING DISPENSATION AND COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC DISEASE DURING CERTAIN ADVERSE DETERMINATION REVIEWS, AND DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.*****SUMMARY:**

This bill reduces, from 72 to 48 hours, the maximum time health carriers (e.g., insurers and HMOs) and independent review organizations may take to conduct certain urgent care (1) initial utilization reviews, (2) internal adverse determination reviews, and (3) external or final adverse determination reviews. These reviews are how health carriers and independent review organizations determine whether a covered person's health insurance covers a specific medical service. (The bill does not apply to urgent care reviews involving substance use disorders and certain mental disorders, which must be completed within 24 hours.)

The bill also requires health carriers to authorize pharmacies to dispense a temporary supply of medication to treat a chronic disease during a covered person's grievance of certain utilization and adverse determination reviews. The temporary supply must be sufficient for the review's duration.

EFFECTIVE DATE: January 1, 2017

HEALTH BENEFIT REVIEW TIMEFRAMES

Generally, health benefit reviews have up to three steps: (1) initial utilization reviews; (2) internal adverse determination reviews, which occur after a health carrier has denied coverage during an initial utilization review; and (3) external or final adverse determination reviews, which generally occur after a health carrier's internal review

process is exhausted and are conducted by an independent review organization.

Initial Utilization Reviews

Current law requires health carriers to make determinations on utilization reviews of urgent care requests, as long as the covered person or his or her authorized representative has provided all the necessary information, as soon as possible but within 72 hours (see BACKGROUND). Under the bill, health carriers must instead make these determinations within 48 hours.

Internal Adverse Determination Reviews

Internal adverse determinations are decisions by health carriers, following utilization reviews, to deny coverage for specific services based on medical necessity or certain other criteria. At the request of the covered person, the health carrier must review that decision. If the review involves an urgent care request the covered person may, orally or in writing, request an expedited review.

Under current law, health carriers must notify a covered person, and if applicable his or her authorized representative, of expedited review decisions of adverse determinations based on medical necessity within a reasonable period of time appropriate to the covered person's condition, but within 72 hours. The bill reduces the maximum time to 48 hours.

Expedited External or Final Adverse Determination Reviews

In certain circumstances, including when a health carrier's internal review process is exhausted, a covered person or his or her authorized representative may request an independent organization to conduct an external review of the adverse determination. Requests are made in writing to the insurance commissioner, who assigns the review to an independent review organization.

Urgent care requests may be expedited. Current law requires the independent review organization to notify the commissioner, the health carrier, the covered person, and if applicable, his or her

authorized representative, in writing of its decision in such a case as expeditiously as the covered person's condition requires, but within 72 hours of receiving the assignment from the commissioner. The bill reduces the maximum time for giving notification of the decision to 48 hours.

AUTHORIZING A TEMPORARY SUPPLY OF DRUGS TREATING CHRONIC DISEASES

Authorization Requirements

The bill requires health carriers to authorize a covered person's pharmacy to dispense a temporary supply of a drug to treat a chronic disease when the covered person, or his or her authorized representative, requests a grievance review. The grievance must involve a prospective review of chronic disease medication prescribed by a specialist in the disease. (A "prospective review" is a review required by a health carrier before a patient may receive a health care service or treatment.)

The bill does not apply to (1) prescriptions for schedule II or III controlled drugs (see BACKGROUND) or (2) reviews of adverse determinations concerning substituting a generic or other brand name drug for the prescribed brand, unless the prescriber has specified no substitutions.

Pharmacy Authorizations

Under the bill, health carriers must electronically authorize the covered person's pharmacy to dispense a temporary supply of the drug and confirm 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 grievance reviews within 30 days after receiving the grievance. However, expedited reviews must be completed within 72 hours, although the bill decreases that time to 48 hours. The law, unchanged by the bill, requires expedited reviews of treatment for certain substance abuse or

mental disorders to be completed within 24 hours.

Prescriber Concurrence

The bill requires health carriers, within 24 hours of issuing a pharmacy authorization, to contact the prescribing provider and confirm that he or she concurs with dispensing a temporary supply of the drug. If the provider does not concur, the health carrier must cancel the pharmacy authorization. However, the bill does not prohibit pharmacies from dispensing the drug after they receive the initial authorization but before the carrier contacts the prescriber.

BACKGROUND

Urgent and Non-urgent Care Reviews

By law, an initial utilization review may be determined urgent by a health care professional with knowledge of the covered person's medical condition. Other benefit requests may be determined urgent if the time period for a non-urgent care review:

1. could, in the judgment of an individual acting on behalf of the health carrier and applying the judgement of a prudent lay-person who possesses an average knowledge of health and medicine, seriously jeopardize the life or health of the covered person or his or her ability to regain maximum function or
2. would, in the opinion of a health care professional with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be otherwise adequately managed without the requested treatment or service.

By law, the time period for determining non-urgent care reviews varies based on the type of review. For example, (1) prospective or concurrent utilization review requests must be determined within 15 days, extendable once for up to 15 additional days, and (2) retrospective review requests must be determined within 30 days, extendable once for up to 15 additional days.

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 14 Nay 3 (03/03/2016)