Senate

General Assembly

File No. 329

February Session, 2018

Senate Bill No. 209

Senate, April 9, 2018

The Committee on Insurance and Real Estate reported through SEN. LARSON of the 3rd Dist. and SEN. KELLY of the 21st Dist., Chairpersons of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT REDUCING THE TIME FRAME FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.

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

Section 1. Subdivision (1) of subsection (c) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

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

prior to the expiration of the prescribed period of time or number of treatments.

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

Sec. 2. Subdivision (1) of subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

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

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

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

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

(D) For expedited review requests of a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision

(38) of section 38a-591a, twenty-four hours after the health carrier receives the grievance.

Sec. 3. Subdivision (1) of subsection (i) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

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

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

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

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

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

(E) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is

experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	38a-591d(c)(1)
Sec. 2	*January 1, 2019*	38a-591e(d)(1)
Sec. 3	*January 1, 2019*	38a-591g(i)(1)

INS *Joint Favorable*

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill is not anticipated to result in a fiscal impact to the state plan or fully insured municipalities. Due to federal law, self-insured plans are exempt from the provisions of CGS § 38a-591d. The bill decreases the timeframe from 72 to 48 hours for certain urgent care and adverse determination review requests.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

SB 209

AN ACT REDUCING THE TIME FRAME FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.

SUMMARY

This bill shortens, from 72 to 48 hours, the maximum time for certain health benefit reviews. It applies to:

1. certain urgent care initial utilization reviews,
2. internal adverse determination reviews, and
3. external or final adverse determination reviews.

These reviews are conducted by health carriers (e.g., insurers and HMOs) or, in the case of external or final reviews, independent review organizations (IROs) and are one factor used to determine if a specific medical service is reimbursable by the individual's health plan.

The bill does not apply to urgent care reviews involving substance use disorders and certain mental disorders, which by law must be completed within 24 hours.

EFFECTIVE DATE: January 1, 2019

HEALTH BENEFIT REVIEW TIMEFRAMES

Generally, reviews have up to three steps: (1) an initial review, to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is conducted when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the insurance department. External reviews, also called final adverse

determination reviews, are conducted by an IRO assigned by the insurance department.

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 of 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

By law, and at the request of the covered person, a health carrier must review an adverse determination of a utilization review. 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 that an IRO conduct an expedited external review of the adverse determination. Current law requires the IRO to complete such a review and notify the appropriate individuals as quickly as the covered person's condition requires, but within 72 hours of receiving the assignment from the commissioner. The bill reduces the maximum time to 48 hours.

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.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 20 Nay 1 (03/20/2018)