

---

---

## OLR Bill Analysis

### SB 38

#### ***AN ACT REDUCING THE TIME FRAME FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS AND EXPEDITED EXTERNAL REVIEWS.***

#### **SUMMARY**

Existing law establishes a structure and timeframe for health carriers (e.g., insurers and HMOs) and independent review organizations (IROs) to conduct benefit reviews and notify the covered individual whether a specific medical service is reimbursable by his or her health insurance plan. This bill shortens, from 72 to 48 hours, the maximum time a health insurer or IRO can take, after receiving all the required health information, to notify an insured or his or her authorized representative of decisions for one of the following urgent care reviews:

1. initial utilization reviews,
2. expedited internal adverse determination reviews that are based on medical necessity, and
3. expedited external or final adverse determination reviews.

Existing law, unchanged by the bill, requires urgent initial utilization reviews to be conducted as soon as possible, urgent internal adverse determination reviews to be conducted within a reasonable period of time appropriate to the covered person's condition, and urgent expedited external reviews as quickly as the covered person's condition requires.

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, 2020

## **BACKGROUND**

### ***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.

### ***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 18 Nay 2 (03/14/2019)