Senate

General Assembly

File No. 359

January Session, 2019

Senate Bill No. 38

Senate, April 3, 2019

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson 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 AND EXPEDITED EXTERNAL REVIEWS.

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 Subdivision (1) of subsection (c) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(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 Subdivision (1) of subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(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**]** <u>forty-eight</u> 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, 2020*):

(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, 2020*	38a-591d(c)(1)
Sec. 2	*January 1, 2020*	38a-591e(d)(1)
Sec. 3	*January 1, 2020*	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: 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 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)