General Assembly

Committee Bill No. 37

January Session, 2019

LCO No. **5682**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING ADVERSE DETERMINATION REVIEWS AND EXTERNAL REVIEW PROCESSES.

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

Section 1. Subsection (b) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(b) With respect to a nonurgent care request:

(1) (A) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than fifteen calendar days after the date the health carrier receives such request, and shall notify the covered person and, if applicable, the covered person's authorized representative of such determination, whether or not the carrier certifies the provision of the benefit.

(B) If the review under subparagraph (A) of this subdivision is a review of a grievance involving a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall

be continued without liability to the covered person until the covered person has been notified of the review decision.

(C) (i) Notwithstanding subparagraph (B) of this subdivision, if a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to dispense a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(ii) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(iii) The provisions of this subparagraph shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to fifteen

calendar days, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

(i) Specifically describe in the notice of extension the required information necessary to complete the request; and

(ii) Provide the covered person and, if applicable, the covered person's authorized representative with not less than forty-five calendar days after the date of receipt of the notice to provide the specified information.

(B) If the covered person or the covered person's authorized representative fails to submit the specified information before the end of the period of the extension, the health carrier may deny certification of the benefit requested.

Sec. 2. Subsection (c) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) The clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review request, pursuant to 45 CFR 147.136, as amended

from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(4) (A) Notwithstanding subdivision (3) of this subsection, if a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to dispense a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

Sec. 3. Subsection (b) of section 38a-591f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(b) (1) A covered person or the covered person's authorized representative may file a grievance of an adverse determination that

was not based on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the covered person's representative, as applicable, receives the notice of an adverse determination.

(2) (A) If a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy to prescribe a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

[(2)**]** (3) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative not later than three business days after the health carrier receives a grievance the covered person or the covered person's authorized representative, as applicable, is entitled to submit written material to the health carrier

to be considered when conducting a review of the grievance.

[(3)**]** (4) (A) Upon receipt of a grievance, a health carrier shall designate an individual or individuals to conduct a review of the grievance.

(B) The health carrier shall not designate the same individual or individuals who denied the claim or handled the matter that is the subject of the grievance to conduct the review of the grievance.

(C) The health carrier shall provide the covered person and, if applicable, the covered person's authorized representative with the name, address and telephone number of the individual or the organizational unit designated to coordinate the review on behalf of the health carrier.

Sec. 4. Subsection (b) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(b) (1) Except as otherwise provided under subdivision (2) of this subsection or subsection (d) of this section, a covered person or a covered person's authorized representative shall not file a request for an external review or an expedited external review until the covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process.

(2) A health carrier may waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external review or an expedited external review.

(3) (A) If a covered person or the covered person's authorized representative files any grievance or requests any review of an adverse determination pursuant to this section relating to the dispensation of a drug, other than a schedule II or III controlled substance, prescribed by a licensed participating provider, the health carrier shall issue immediate electronic authorization to the covered person's pharmacy

to dispense a temporary supply of the drug sufficient for the duration of the grievance or review. The authorization shall include confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with the licensed participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such licensed participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2020*	38a-591d(b)
Sec. 2	*January 1, 2020*	38a-591e(c)
Sec. 3	*January 1, 2020*	38a-591f(b)
Sec. 4	*January 1, 2020*	38a-591g(b)

Statement of Purpose:

To require health insurance coverage of prescribed drugs during adverse determination reviews and external review processes.

[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.]

Co-Sponsors: SEN. LOONEY, 11th Dist.

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