STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-83
MAY 20, 2011

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

SUBJECT: PROCESS AND TIMELINE REQUIREMENTS FOR REVISED INTERNAL AND EXTERNAL REVIEW PROCESSES

The Patient Protection and Affordable Care Act, Pub.L.111-48, as amended by the Health Care and Education Reconciliation Act of 2010, Pub.L.111-152 (collectively "PPACA") requires that a health insurance issuer offering group or individual health insurance coverage comply with the applicable state process that at a minimum includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC) and is binding on such plans. The Connecticut Insurance Department is seeking legislative changes to bring the state internal and external review process into compliance with the requirements set forth in PPACA. The proposed legislation also modifies the requirements for internal appeals and utilization review to conform to PPACA requirements that health insurance issuers must follow.

This bulletin provides information on the new notification requirements for health insurance carriers and other entities listed above in relation to internal benefit determinations and internal claims appeal processes under the proposed legislation. This high level information is being offered in recognition of the operational changes that will be needed to comply with the July 1, 2011 enforcement date. A chart titled "Health Carrier Notification Time Tables – July 2011" is attached detailing these timeframes.

The Department offers further guidance on the proposed changes to the External Review process including new responsibilities for health insurance carriers under this revised workflow. A chart titled "State of Connecticut – External Review – July 2011" is attached that provides details on timeframes and workflow processes.

In the event that the proposed legislation is not enacted, carriers will still be required to comply with the federal requirements for internal and external appeals processes as outlined in these charts. Both charts have been reviewed by the US Department of Health and Human Services and have been approved for content.

In addition, insurers should be aware that consistent with the NAIC Model, payment for external reviews will be the direct responsibility of the carriers effective July 1, 2011.

For guidance on form filings related to these changes, please refer to Department Bulletin HC-82 dated May 11, 2011. You may also contact the Insurance Department External Review Department at cid.ea@ct.gov with questions regarding the revised External Review processes.

Thomas B. Leonardi
Insurance Commissioner

State of Connecticut - External Review
July 2011

Eligibility Determinations

	Determination By:	Notification of Ineligibility to Covered Person By:
Filing Deadline Standard Review: 120 Days Expedited: 120 Days after any adverse determination	Health Carrier	Health Carrier
Contract Ineligible (Dental, vision, self-insured non-governmental plans, out-of-state, Worker's Compensation, Medicare/Medicaid)	Commissioner	Commissioner
• Coverage is Not In Force • Not a Covered Benefit • Has not exhausted internal grievance process • Missing information or required forms • Not a medical necessity denial *(rescissions and eligibility issues allowed)*	Health Carrier	Health Carrier

Process Workflow

Task	Completed By:	Standard Review	Expedited Review	Notification to Covered Person By:
External Review Received Send to health carrier	Commissioner	(1) Business Day	(1) Day	
Preliminary Review Individual is a covered person, health care service is a covered service, Internal Appeals have been exhausted or it is expedited, all required forms and releases have been signed.	Health Carrier	(5) Business Days + (1) Business Day to Notify of Results	(1) Day	Health Carrier Request is eligible and complete. -or- Notifies that appeal is incomplete or ineligible. If ineligible, covered person may appeal to Commissioner.
Accepted for Full Review Assign IRO & notify covered person of right to submit new information.	Commissioner	(1) Business Day	(1) Day	Commissioner
Documents to IRO Documents/Info considered in making an adverse determination sent to IRO.	Health Carrier	(5) Business Days	(1) Day	
Full Review Process	IRO	(45) Days or (20) Days *(Experimental)*	(72) Hours or (5) Days *(Experimental)*	IRO

Health Carrier Notification Time Tables – July 2011

	Initial Determination	Initial Determination Extension*	Missing Information	Failure to Meet Filing Procedures	Grievance Appeal Determination	Grievance Appeal Notices
Medical Necessity Reviews						
▶ Prospective	15 Days	15 Days* Notification prior to the end of the initial benefit determination period.	- Notification prior to the end of the initial benefit determination period. - Must allow 45 days for receipt of missing information.	5 Days	30 Days	<u>All Notices of Adverse Determination:</u> Notification of right to submit written material to be considered by health carrier during grievance. Right to receive free of charge access to documents related to request for benefits. Grievance procedures for standard and expedited grievance. Right to contact the Connecticut Insurance Department and the Office of the Healthcare Advocate. ..... Full compliance requirements provided in US DOL Technical Release 2011-01 dated 3-18-11
▶ Concurrent	15 Days	None	- Notification prior to the end of the initial benefit determination period. - Must allow 45 days for receipt of missing information.	5 Days	30 Days	
▶ Retrospective	30 Days	15 Days* Notification prior to the end of the initial benefit determination period.	- Notification prior to the end of the initial benefit determination period. - Must allow 45 days for receipt of missing information.	5 Days	60 Days	
▶ Expedited Urgent Care	72 Hours Plan years 1-1-12 and after	None	24 Hours Must allow 48 hours for receipt of missing information.	24 Hours	72 Hours	
Non-Medical Necessity Reviews	30 Days	15 Days* Notification prior to the end of the initial benefit determination period.			20 Business Days + Extension* of 10 Business Days	3 Business Days Notification of right to submit written material to be considered by health carrier.

*Extension only allowed due to circumstances beyond the health carrier's control and with prior notification.

CT Insurance Department May 20, 2011