STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-85
July 1, 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

RE: Public Act No. 11-58 – Rescission and Eligibility Reviews

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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. Connecticut Public Act No. 11-58 (the "Act"), effective July 1, 2011, repealed Conn. Gen. Stat. §§ 38a-226 *et seq*, 38a-478m, 38a-478n and 38a-478p and by implication the corresponding regulations[1] and established the new statutes needed to bring the state internal and external review process into compliance with the requirements set forth in PPACA. The legislation also modifies the requirements for utilization review, grievances and internal appeals review to conform to PPACA requirements that health insurance issuers must follow. Bulletins HC-82, HC-83 and HC-84 provide guidance and implementations generally with respect to new procedures and timeframes associated with utilization review and internal and external appeals. This bulletin will deal specifically with the new categories eligible for external review - eligibility and rescissions.

Since 2007, Connecticut has had in place a prior approval law when an insurer or health care center sought to rescind a policy if the insurer or health care center had failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy. Pursuant to Conn. Gen. Stat. §38a-477b, the insurer or health care center could not rescind the policy without the prior approval of the Insurance Commissioner ("Commissioner"). Section 47 of the Act amended Conn. Gen. Stat. §38a-477b to conform to the rescission and cancellation limitations set forth in PPACA[2].

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[1] R.C.S.A. §§38a-226-1 et seq; 38a-478m-1; 38a-478n-1 et seq.

[2] (b) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner **[**may**]** shall only approve: **[**such rescission, cancellation**]**

The PPACA laws expressly include rescissions and eligibility grievances[3] in the definition of an adverse determination to be subject to the mandated internal and external appeal processes. The Act enacted the federal requirements relating to rescissions and grievances. In light of that, the Department has reviewed whether the provisions of Conn. Gen. Stat. §38a-477b, as amended, which require Commissioner approval to rescind a policy is preempted by the federal requirements as enacted in PA 11-58. The Department has determined that the provisions of Conn. Gen. Stat. §38a-477b do in fact conflict with the federal requirements as incorporated by reference in the Act and the Department considers that the process set forth in section §38a-477b is, by necessary implication, preempted in favor of the internal and external appeal processes set forth in the Act. Therefore, any rescissions or eligibility denials sought by an insurer or health care center as of July 1, 2011 and thereafter must conform to the provisions of the Act and be subject to internal and external review procedures.

Timelines and Process:

Federal regulations[4] require that a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph

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(1) Such rescission or limitation if the commissioner finds that **[**(1)**]** (A) the insured or such insured's representative submitted the written information **[**submitted**]** on or with the insurance application that was **[**false**]** fraudulent at the time such application was made**[**,**]** **[**and**]** (B) the insured or such insured's representative **[**knew or should have known of the falsity**]** intentionally misrepresented information therein **[**,**]** and such **[**submission**]** misrepresentation materially affects the risk or the hazard assumed by the insurer or health care center, or **[**(2)**]** (C) the information omitted from the insurance application was **[**knowingly**]** intentionally omitted by the insured or such insured's representative **[**, or the insured or such insured's representative should have known of such omission,**]** and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center; and

(2) Such cancellation in accordance with the provisions set forth in the Public Health Service Act, 42 USC 300gg et seq., as amended from time to time.

[3] Pursuant to 2011 Conn. Pub. Acts No. 11-58 § 54(1), "Adverse determination" means: (A) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional, based on a determination by a health carrier or its designee utilization review company: (i) That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or (II) is determined to be experimental or investigational; (ii) Of a covered person's eligibility to participate in the health carrier's health benefit plan; or (B) Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional. "Adverse determination" includes a rescission of coverage determination for grievance purposes.

[4] 45 C.F.R. § 147.128

regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. Federal regulations[5] also require that rescissions and eligibility denials be considered to be an adverse determination for purposes of internal and external claim review.

The Department of Health and Human Services ("HHS") Office of Consumer Information and Insurance Oversight ("CIIO") has advised us that rescissions and eligibility should be categorized as retrospective medically necessary adverse determinations. That means that the provisions of section 58 of the Act govern for timelines and procedures.

Pursuant to section 58 of the Act, each health carrier is required to establish and maintain written procedures for the review of grievances of adverse determinations, including the health carrier's procedures for notifying covered persons or covered persons' authorized representatives of such adverse determinations. That notice must include, among other requirements in the Act, a disclosure that the covered person or the covered person's authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, along with information detailing the health carrier's grievance procedures, including applicable time limits.

The Act does require specific timeframes be maintained. The chart below provides a quick reference overview of the timing.

Eligibility or Rescission Review	Notice Requirement	Period to File Grievance	Grievance Appeal Determination	Period to File External Review	External Review Determination
Medically Necessary Review (Retrospective)	30 calendar days	180 calendar days	60 calendar days	120 calendar days	45 calendar days

Please refer to the Health Carrier Notification Time Tables – July 2011 chart provided in Bulletin HC-83 for full details.

The external review process is detailed in section 60 of the Act and the resulting decision is binding on the health carrier and the covered person. A self-insured governmental plan is only eligible to participate in the state external review process if it agrees to accept the statutory review process, the statutory definition of what is medically necessary and the binding nature of the review decisions.

Because eligibility and rescission external reviews may have legal components in addition to medical issues, the Department has verified that the independent review organizations ("IRO") currently contracted to perform external reviews for the

[5] 45 C.F.R. § 136 for rescissions; 29 C.F.R. § 2560.503–1 for eligibility

Department do have legal resources available to assist in medical necessity external reviews. Therefore, the Department is confident that the contracted IROs have the necessary capabilities to perform all types of external reviews The current IRO contracts will expire December 31, 2011 and the Department is in the process of soliciting bids for selecting new IRO vendors who will contract for the upcoming two-year period.

Please contact the Insurance Department Consumer Services Division at externalreview@ct.gov with any questions.

Thomas B. Leonardi
Insurance Commissioner