HB 899 -- Health Care Utilization Review

Sponsor: Colona

This bill changes the laws regarding the state's health care utilization review process to comply with federal laws and regulations. In its main provisions, the bill:

(1) Requires a health carrier to maintain records for at least six years for all benefit requests and claims and for notices associated with utilization review and benefit determinations;

(2) Allows a covered person to file a request for an external review if a health carrier fails to strictly adhere to the requirements regarding making utilization review and benefit determinations of a benefit request or claim;

(3) Requires a health carrier to ensure that the utilization review is conducted in a manner to make certain the independence and impartiality of the individuals in making the utilization review or benefit determination;

(4) Prohibits a health carrier from making a decision regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits;

(5) Requires a written notification of an adverse determination to include information sufficient to identify the specific claim and the specific reason for the denial and to provide the required notice in a culturally and linguistically appropriate manner if required in accordance with federal regulations;

(6) Requires a health carrier that provides emergency service coverage to cover services to screen and stabilize a covered person without the need for prior authorization under certain situations, without the provider being in the network, and without the imposition of an administrative requirement or limitation on coverage for an out-of-network provider that is more restrictive than the requirements or limitations that apply to emergency services received from an in-network provider;

(7) Requires a health carrier to maintain a written register of all grievances received during the year, including the notices and claims associated with the grievances, and to retain the required information for six years. The health carrier must make the records available for examination to the enrollee; the Director of the Department of Insurance, Financial Institutions and Professional Registration; and appropriate federal oversight agencies upon request;

(8) Specifies that if a health carrier fails to strictly adhere to the provisions regarding receiving and resolving grievances involving an adverse determination, an enrollee must be deemed to have exhausted all efforts and can file for an external review;

(9) Requires every health carrier to establish a grievance review process. Currently, only a health carrier that offers managed care plans must establish a first- and second-level grievance review process;

(10) Requires, prior to issuing a decision, a health carrier to provide free of charge to the enrollee or his or her authorized representative any new or additional evidence in connection with a grievance or final adverse determination to a covered person within a time period that allows the covered person or the representative a reasonable opportunity to respond;

(11) Requires a health carrier that offers managed care plans to establish a second-level review process for its managed care plans;

(12) Requires the department director to resolve any grievance regarding a final adverse determination based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered service when appealed by an enrollee or health carrier or plan sponsor through a referral to an independent review organization. Currently, the department director must resolve any grievance regarding an adverse determination;

(13) Requires the department director to approve independent review organizations eligible to be assigned to conduct external reviews. Currently, the department director must establish the qualifications for the review organizations;

(14) Reduces, from 72 hours to 24 hours, the time period that a health carrier has to orally notify an enrollee after receiving a request for an expedited review of a carrier’s determination;

(15) Removes the provision which specifies that the requirements regarding health care utilization review are not applicable to health indemnity plans without a managed care component; and

(16) Prohibits a health care provider from charging a fee to a patient for the reproduction or copying of health care records or health information provided to the Division of Consumer Affairs within the department under specified conditions.