CHAPTER 193

INSURANCE

HOUSE BILL 03-1033

BY REPRESENTATIVE(S) Spradley, Jahn, Tochtrop, Boyd, Butcher, Coleman, Hoppe, Paccione, Stafford, Stengel, Weddig, Williams T., and Young;
also SENATOR(S) Hagedorn, Chlouber, Groff, Hanna, Jones, and Sandoval.

AN ACT

CONCERNING THE IMPLEMENTATION OF THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT" WITH REGARD TO THE ADMINISTRATION OF REQUESTS FOR HEALTH BENEFITS.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-16-113 (1), (2), (3), (4), (6), and (7), Colorado Revised Statutes, are amended to read:

10-16-113. Procedure for denial of benefits. (1) (a) A health coverage plan shall not make a determination, IN WHOLE OR IN PART, that it will deny a request for ~~reimbursement for or coverage of medical treatment or other~~ benefits for a covered individual on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

(b) FOR THE PURPOSES OF THIS SECTION, A DENIAL OF A PREAUTHORIZATION FOR A COVERED BENEFIT SHALL BE CONSIDERED A DENIAL OF A REQUEST FOR BENEFITS AND SHALL BE MADE PURSUANT TO THE PROVISIONS OF THIS SECTION.

(2) Following a denial OF A REQUEST FOR BENEFITS by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.

(3) (a) (I) All denials of requests for reimbursement for medical treatment, standing referrals, or other benefits on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient shall include:

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Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(A) An explanation of the specific medical basis for the denial; ~~and shall advise the covered person of the right to appeal such decision.~~

(B) THE SPECIFIC REASONS FOR THE ADVERSE DETERMINATION;

(C) REFERENCE TO THE SPECIFIC HEALTH COVERAGE PLAN PROVISIONS ON WHICH THE DETERMINATION IS BASED;

(D) A DESCRIPTION OF THE HEALTH COVERAGE PLAN'S REVIEW PROCEDURES AND THE TIME LIMITS APPLICABLE TO SUCH PROCEDURES AND SHALL ADVISE THE COVERED PERSON AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE OF THE RIGHT TO APPEAL SUCH DECISION; AND

(E) A DESCRIPTION OF ANY ADDITIONAL MATERIAL OR INFORMATION NECESSARY, IF ANY, FOR THE COVERED PERSON AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE TO PERFECT THE REQUEST FOR BENEFITS AND AN EXPLANATION OF WHY SUCH MATERIAL OR INFORMATION IS NECESSARY.

(II) IN THE CASE OF AN ADVERSE BENEFIT DETERMINATION BY HEALTH COVERAGE PLAN:

(A) IF AN INTERNAL RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION WAS RELIED UPON IN MAKING THE ADVERSE DETERMINATION, THE CARRIER SHALL FURNISH THE COVERED PERSON AND THE COVERED PERSON'S REPRESENTATIVE WITH EITHER THE SPECIFIC RULE, GUIDELINE, PROTOCOL, OR OTHER SIMILAR CRITERION OR A STATEMENT THAT SUCH RULE, GUIDELINE, PROTOCOL, OR OTHER CRITERION WAS RELIED UPON IN MAKING THE ADVERSE DETERMINATION AND THAT A COPY OF SUCH RULE, GUIDELINE, PROTOCOL, OR OTHER CRITERION WILL BE PROVIDED FREE OF CHARGE TO THE COVERED PERSON AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE UPON REQUEST; OR

(B) IF THE ADVERSE BENEFIT DETERMINATION IS BASED ON A MEDICAL NECESSITY OR EXPERIMENTAL TREATMENT OR SIMILAR EXCLUSION OR LIMIT, THE CARRIER SHALL FURNISH THE COVERED PERSON AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE WITH EITHER AN EXPLANATION OF THE SCIENTIFIC OR CLINICAL JUDGMENT FOR THE DETERMINATION, APPLYING THE TERMS OF THE PLAN TO THE COVERED PERSON'S MEDICAL CIRCUMSTANCES, OR A STATEMENT THAT SUCH EXPLANATION WILL BE PROVIDED FREE OF CHARGE UPON REQUEST.

(III) IN THE EVENT OF AN ADVERSE BENEFIT DETERMINATION BY A HEALTH COVERAGE PLAN CONCERNING A REQUEST INVOLVING URGENT CARE, A CARRIER:

(A) SHALL PROVIDE A DESCRIPTION OF THE EXPEDITED REVIEW PROCESS APPLICABLE TO SUCH REQUESTS TO THE COVERED PERSON AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE; AND

(B) MAY COMMUNICATE THE OTHER INFORMATION REQUIRED PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (a) TO THE COVERED PERSON ORALLY WITHIN THE TIME FRAME OUTLINED IN 29 CFR 2560.503-1 (f) (2) (i) SO LONG AS A WRITTEN OR ELECTRONIC COPY OF SUCH INFORMATION IS FURNISHED TO THE COVERED PERSON NO LATER THAN THREE DAYS AFTER THE ORAL NOTIFICATION.

(b) (I) For the purposes of this paragraph (b), a "health coverage plan" does not include insurance arising out of the "Workers' Compensation Act of Colorado" or other similar law, automobile medical payment insurance, property and casualty insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance. A health coverage plan shall specify that ~~such~~ an appeal ~~will~~ FROM THE DENIAL OF A REQUEST FOR COVERED BENEFITS ON THE GROUNDS THAT SUCH BENEFITS ARE NOT MEDICALLY NECESSARY, APPROPRIATE, EFFECTIVE, OR EFFICIENT MAY include a two-level internal review of the decision ~~except as provided in subparagraph (II) of this paragraph (b),~~ followed by the right of the covered person to request an external review under section 10-16-113.5. The commissioner shall promulgate rules FOR SUCH BENEFITS DENIALS THAT REFLECT THE REQUIREMENTS IN 29 CFR 2560.530-1 (a) to (j). IN ADDITION, THE COMMISSIONER SHALL PROMULGATE RULES specifying the elements of and timelines for ~~these~~ EXTERNAL REVIEW appeals procedures, including but not limited to the review of appeals requiring expedited reviews and authorizations by the covered individual requesting an independent external review for access to medical records necessary for the conduct of the external review. The commissioner shall consult with and utilize public and private resources, including but not limited to health care providers, in the development of such rules.

(II) ~~The first-level appeal shall be a review by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer or peers shall not have been involved in the initial denial. However, a person that was previously involved with the denial may answer questions. A health coverage plan may establish an internal review process that eliminates the first-level review and whereby all appeals are sent directly to a review panel as provided for in this subparagraph (II).~~

(III) ~~The second-level appeal shall be to a review panel established by the health coverage plan. The panel shall include a minimum of three people. The panel may be composed of employees of the health coverage plan who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. However, a person who was previously involved with the grievance may be a member of the panel or appear before the panel to present information or answer questions. A health coverage plan shall ensure that a majority of the persons reviewing a grievance involving an adverse determination do not have a direct financial interest in the case or in the outcome of the review. However, such persons may be part of the health coverage plan's provider network or employees of the health coverage plan.~~

(4) All written denials OF REQUESTS FOR COVERED BENEFITS ON THE GROUNDS THAT SUCH BENEFITS ARE NOT MEDICALLY NECESSARY, APPROPRIATE, EFFECTIVE, OR EFFICIENT shall be signed by a licensed physician familiar with standards of care in Colorado.

(6) ~~A health coverage plan shall disclose, upon request by a covered person or a covered person's health care provider, its standards for denial of medical treatments or other benefits on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient.~~

(7) Nothing in this section shall preclude or deny the right of the covered individual to seek any other remedy or relief. ~~and nothing in this section shall be a condition precedent to any legal proceeding.~~

SECTION 2. Effective date - applicability. (1) This act shall take effect January 1, 2004, unless a referendum petition is filed during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution. If such a referendum petition is filed against this act or an item, section, or part of this act within such period, then the act, item, section, or part, if approved by the people, shall take effect on the date of the official declaration of the vote thereon by proclamation of the governor.

(2) The provisions of this act shall apply to health insurance policies issued or renewed on or after the applicable effective date of this act.

Approved: April 29, 2003