CHAPTER 222

INSURANCE

SENATE BILL 05-037

BY SENATOR(S) Gordon, Shaffer, Tapia, and Tochtrop;
also REPRESENTATIVE(S) Hefley, Berens, Boyd, Carroll M., Coleman, Madden, Marshall, McGihon, Merrifield, Paccione, Riesberg, and Todd.

AN ACT

CONCERNING THE APPEALS PROCESS FOR THE DENIAL OF HEALTH BENEFITS.

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

SECTION 1. 10-16-113 (1), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-113. Procedure for denial of benefits - rules. (1) (c) IF A HEALTH COVERAGE PLAN DENIES A BENEFIT BECAUSE THE TREATMENT IS AN EXCLUDED BENEFIT AND THE CLAIMANT PRESENTS EVIDENCE FROM A MEDICAL PROFESSIONAL LICENSED PURSUANT TO THE "COLORADO MEDICAL PRACTICE ACT", ARTICLE 36 OF TITLE 12, C.R.S., OR, FOR DENTAL PLANS ONLY, A DENTIST LICENSED PURSUANT TO THE "DENTAL PRACTICE LAW OF COLORADO", ARTICLE 35 OF TITLE 12, C.R.S., ACTING WITHIN HIS OR HER SCOPE OF PRACTICE, THAT THERE IS A REASONABLE MEDICAL BASIS THAT THE CONTRACTUAL EXCLUSION DOES NOT APPLY TO THE DENIED BENEFIT, SUCH EVIDENCE ESTABLISHES THAT THE BENEFIT DENIAL IS SUBJECT TO THE APPEALS PROCESS. THE DENIAL OF SUCH BENEFIT SHALL BE SUBJECT TO THE APPEALS PROVISIONS OF THIS SECTION AND SECTION 10-16-113.5.

SECTION 2. 10-16-113 (3) (b) (I), Colorado Revised Statutes, is amended, and the said 10-16-113 (3) (b) is further amended BY THE ADDITION OF THE FOLLOWING NEW SUBPARAGRAPHS, to read:

10-16-113. Procedure for denial of benefits - rules. (3) (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, OR property and casualty insurance. ~~or insurance under which benefits are payable with or without regard to fault and that is required by law~~

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

~~to be contained in any liability insurance policy or equivalent self-insurance.~~ A health coverage plan shall specify that an appeal from the denial of a request for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient ~~may~~ SHALL include a two-level internal review of the decision, followed by the right of the covered person to request an external review under section 10-16-113.5. THE COVERED PERSON SHALL HAVE THE OPTION OF CHOOSING WHETHER TO UTILIZE THE VOLUNTARY SECOND-LEVEL INTERNAL APPEAL PROCESS. The commissioner shall promulgate rules for such benefits denials that reflect the requirements in 29 CFR 2560.503-1 (a) to (j). In addition, the commissioner shall promulgate rules specifying the elements of and timelines for 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.

(IV) THE CARRIER SHALL NOTIFY THE COVERED PERSON OF HIS OR HER RIGHT TO APPEAL A DENIAL OF BENEFITS THROUGH A TWO-LEVEL INTERNAL REVIEW PROCESS AND THAT THE SECOND LEVEL OF INTERNAL REVIEW MAY BE UTILIZED AT THE OPTION OF THE COVERED PERSON.

(V) THE FIRST-LEVEL APPEAL SHALL BE EVALUATED BY A PHYSICIAN WHO SHALL CONSULT WITH AN APPROPRIATE CLINICAL PEER OR PEERS, UNLESS THE REVIEWING PHYSICIAN IS A CLINICAL PEER. THE PHYSICIAN AND CLINICAL PEERS SHALL NOT HAVE BEEN INVOLVED IN THE INITIAL ADVERSE DETERMINATION. A PERSON WHO WAS PREVIOUSLY INVOLVED WITH THE DENIAL MAY ANSWER QUESTIONS.

(VI) (A) THE SECOND-LEVEL INTERNAL REVIEW OF AN APPEAL FROM THE DENIAL OF A REQUEST FOR COVERED BENEFITS SHALL BE REVIEWED BY A HEALTH CARE PROFESSIONAL WHO HAS APPROPRIATE EXPERTISE, WHO WAS NOT PREVIOUSLY INVOLVED IN THE APPEAL, AND WHO DOES NOT HAVE A DIRECT FINANCIAL INTEREST IN THE APPEAL OR OUTCOME OF THE REVIEW.

(B) THE HEALTH COVERAGE PLAN SHALL ALLOW THE COVERED PERSON TO BE PRESENT FOR THE SECOND-LEVEL INTERNAL REVIEW, EITHER IN PERSON OR BY TELEPHONE CONFERENCE. THE COVERED PERSON SHALL HAVE THE OPPORTUNITY TO BRING COUNSEL, ADVOCATES, AND HEALTH CARE PROFESSIONALS TO THE REVIEW, TO PREPARE IN ADVANCE FOR THE REVIEW, AND TO PRESENT MATERIALS TO THE HEALTH CARE PROFESSIONAL PRIOR TO THE REVIEW AND AT THE TIME OF THE REVIEW. THE HEALTH COVERAGE PLAN AND THE COVERED PERSON SHALL, UPON REQUEST, PROVIDE A COPY OF THE MATERIALS IT PRESENTS AT THE REVIEW TO THE OTHER PARTY AT LEAST FIVE DAYS PRIOR TO THE REVIEW. IF NEW INFORMATION IS DEVELOPED AFTER THE FIVE-DAY DEADLINE, SUCH MATERIAL MAY BE PRESENTED WHEN PRACTICABLE. THE HEALTH COVERAGE PLAN SHALL NOTIFY THE COVERED PERSON THAT THE PLAN SHALL MAKE AN AUDIO OR VIDEO RECORDING OF THE REVIEW UNLESS NEITHER THE COVERED PERSON NOR THE HEALTH COVERAGE PLAN WANTS THE RECORDING MADE. THE HEALTH COVERAGE PLAN SHALL MAKE SUCH RECORDING AVAILABLE TO THE COVERED PERSON. IF THERE IS AN EXTERNAL REVIEW, THE AUDIO OR VIDEO RECORDING SHALL, AT THE REQUEST OF EITHER PARTY, BE INCLUDED IN THE MATERIAL PROVIDED BY THE CARRIER TO THE REVIEWING ENTITY.

SECTION 3. 10-16-113.5 (2) (a) (I) (A), Colorado Revised Statutes, is amended to read:

10-16-113.5. Independent external review of benefit denials - legislative declaration - definitions. (2) As used in this section, unless the context otherwise requires:

(a) (I) "Covered individual requesting an independent external review" means a covered person who:

(A) Has gone through ~~each~~ AT LEAST ONE of the internal appeals review levels offered by a health coverage plan and established pursuant to section 10-16-113 (3) and who has requested an independent external review of a health coverage plan's decision to deny reimbursement for or coverage of medical treatment that is a covered benefit on the grounds that such treatment is not medically necessary, medically appropriate, medically effective, or medically efficient; or

SECTION 4. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-113.7. Reporting the denial of benefits to the division - rule. EACH CARRIER SHALL REPORT THE NUMBER AND OUTCOME OF SECOND-LEVEL INTERNAL APPEALS PURSUANT TO SECTION 10-16-113 TO THE DIVISION BY FEBRUARY 1 OF EACH YEAR. ON AT LEAST AN ANNUAL BASIS, THE DIVISION SHALL COMPILE THE INFORMATION REPORTED BY EACH CARRIER ALONG WITH THE NUMBER AND OUTCOME OF THIRD-LEVEL EXTERNAL APPEALS OF EACH HEALTH COVERAGE PLAN AND MAKE SUCH INFORMATION AVAILABLE ON THE DIVISION WEBSITE AND FOR PUBLIC INSPECTION. THE COMMISSIONER MAY SPECIFY THE FORMAT IN WHICH THE INFORMATION SHALL BE SUBMITTED BY A CARRIER.

SECTION 5. Effective date - applicability. This act shall take effect January 1, 2006, and shall apply to the appeals procedure for benefits denied on or after said date.

SECTION 6. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 1, 2005