
OLR Bill Analysis

SB 1045

AN ACT CONCERNING STEP THERAPY, ADVERSE DETERMINATION AND UTILIZATION REVIEWS, AND HEALTH INSURANCE COVERAGE FOR CHILDREN, STEPCHILDREN AND OTHER DEPENDENT CHILDREN.

SUMMARY

This bill establishes a rebuttable presumption in a utilization or adverse determination review that a health care service ordered by a health professional acting within his or her scope of practice is medically necessary. For utilization reviews, the bill imposes on carriers or utilization review companies the burden of proving a health care service is not medically necessary. For adverse determination reviews, a carrier may rebut the assumption by reasonably substantiating to the clinical peers conducting the review that the service is not medically necessary. (Utilization and adverse determination reviews are steps in determining whether a specific service is covered and reimbursed, see BACKGROUND.)

The bill also expands current law's prohibition on step therapy to include prescription drugs prescribed to treat a behavioral health condition or a disabling, chronic, or life-threatening condition or disease.

The bill increases the education requirements to qualify as a clinical peer for utilization and adverse determination reviews unrelated to the urgent treatment of substance use or mental disorders, generally aligning them with the requirements for clinical peers that do treat those reviews. It also requires health carriers to authorize clinical peers to reverse initial adverse determinations.

Current law requires certain health insurance policies to cover children until age 26, or earlier if they receive coverage through their employer. The bill instead requires policies to cover them until age 26

regardless of whether they have coverage through their employer, and it extends this requirement to stepchildren and other dependent children.

EFFECTIVE DATE: January 1, 2022

§§ 3 & 4 — STEP THERAPY

Step therapy is a protocol establishing the sequence for prescribing drugs for specific medical conditions that generally requires patients to try less expensive drugs before higher cost drugs. The bill prohibits health insurers from requiring an insured to use step therapy for prescribed drugs to treat a behavioral health condition or a disabling, chronic, or life-threatening condition or disease, provided the drug is prescribed in accordance with federal Food and Drug Administration indications. Current law limits this prohibition to drugs used to treat stage IV metastatic cancer. By law, step therapy cannot be used for longer than 60 days.

§§ 1 & 2 — DEPENDENT CHILDREN COVERAGE

The bill requires certain health insurance policies to cover stepchildren and other dependent children until the policy anniversary date after they turn 26 years old. The provisions apply to fully insured individual and group coverage health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. It also applies to individual health insurance policies that cover (1) limited benefits and (2) accidents only. The bill also eliminates a provision allowing these health plans to terminate coverage for children before they reach age 26 if they become covered through their own employment.

(Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

§ 5 — REQUIREMENTS FOR CLINICAL PEERS

Under current law, clinical peers conducting utilization or adverse determination reviews unrelated to the urgent treatment of substance use or mental disorders must have a nonrestricted license in the same or similar specialty that typically manages the medical condition, procedures, or treatment under review. The bill instead requires these clinical peers to have a nonrestricted license in the same specialty. Additionally, these clinical peers must have:

1. a doctoral or medical degree; and
2. either an appropriate national board certification, including at the subspecialty level if possible, or actively practice and typically manage the condition or procedure under review.

BACKGROUND

Utilization and Adverse Determination Reviews

Generally, reviews have up to three steps: (1) an initial utilization review to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is conducted when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the insurance department. External reviews, also called final adverse determination reviews, are conducted by an independent review organization assigned by the insurance department.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 15 Nay 3 (03/22/2021)