Senate

General Assembly

File No. 370

January Session, 2021

Senate Bill No. 1045

Senate, April 8, 2021

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

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

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child, stepchild or other dependent child shall terminate **[**no**]** not earlier than the policy anniversary date **[**on or**]** after **[**whichever of the following occurs first,**]** the date on which the child, **[**: Becomes covered under a group health plan through the dependent's own employment; or**]** stepchild or other dependent child attains the age of twenty-six. Each such policy shall cover a stepchild or other dependent child on the same basis as a

biological child.

Sec. 2. Section 38a-512b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child, stepchild or other dependent child shall terminate **[**no**]** not earlier than the policy anniversary date **[**on or**]** after **[**whichever of the following occurs first,**]** the date on which the child, **[**: Becomes covered under a group health plan through the dependent's own employment; or**]** stepchild or other dependent child attains the age of twenty-six. Each such policy shall cover a stepchild or other dependent child on the same basis as a biological child.

Sec. 3. Subsection (a) of section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for:

(A) **[**any**]** Any prescribed drug for longer than sixty days; **[**,**]** or

(B) **[**a**]** A prescribed drug for **[**cancer**]** treatment of a behavioral health

condition or a chronic, disabling or life-threatening condition or disease for an insured who has been diagnosed with **[**stage IV metastatic cancer**]** such a condition or disease, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection, **[**or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection,**]** an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

Sec. 4. Subsection (a) of section 38a-544 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation,

medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for:

(A) **[**any**]** Any prescribed drug for longer than sixty days; **[**,**]** or

(B) **[**a**]** A prescribed drug for **[**cancer**]** treatment of a behavioral health condition or a chronic, disabling or life-threatening condition or disease for an insured who has been diagnosed with **[**stage IV metastatic cancer**]** such a condition or disease, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection, **[**or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection,**]** an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

Sec. 5. Subdivision (7) of section 38a-591a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(7) "Clinical peer" means a physician or other health care professional who:

(A) **[**holds**]** For a review other than as specified under subparagraph (B) or (C) of subdivision (38) of this section:

(i) Holds a nonrestricted license in a state of the United States [and] in the same [or similar] specialty as [typically manages the medical condition, procedure or treatment] the treating physician or other health care professional under review; [, and]

(ii) Holds a doctoral or medical degree; and

(iii) (I) Holds an appropriate national board certification including at the subspecialty level, where available, or (II) actively practices and typically manages the medical condition under review or provides the procedure or treatment under review; or

(B) [for] For a review specified under subparagraph (B) or (C) of subdivision (38) of this section concerning:

(i) [a] A child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable; [,] or

(ii) [an] An adult substance use disorder or an adult mental disorder, holds (I) a national board certification in psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

Sec. 6. Subsection (a) of section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) Each health carrier shall contract with (A) health care professionals to administer such health carrier's utilization review program, and (B) clinical peers to evaluate the clinical appropriateness of an adverse determination.

(2) (A) Each utilization review program shall use documented clinical

review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 38a-591b to assure such program's ongoing effectiveness.

(B) Except as provided in subdivisions (3), (4) and (5) of this subsection, a health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner, provided such clinical review criteria conform to the requirements of subparagraph (A) of this subdivision.

(C) Each health carrier shall (i) post on its Internet web site (I) any clinical review criteria it uses, and (II) links to any rule, guideline, protocol or other similar criterion a health carrier may rely upon to make an adverse determination as described in subparagraph (F) of subdivision (1) of subsection (e) of section 38a-591d, as amended by this act, and (ii) make its clinical review criteria available upon request to authorized government agencies.

(D) For each utilization review, there shall be a rebuttable presumption that each health care service under review is medically necessary if such health care service was ordered by a health care professional acting within the health care professional's scope of practice. A health carrier, or any utilization review company or designee of a health carrier that performs utilization review on behalf of the health carrier, shall have the burden of proving that a health care service is not medically necessary.

(3) For any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: (A) The most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-

Related, and Co-Occurring Conditions, except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of a substance use disorder, that are not covered in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

(4) For any utilization review for the treatment of a child or adolescent mental disorder, the clinical review criteria used shall be: (A) The most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument, except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of a child or adolescent mental disorder, that are not covered in the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

(5) For any utilization review for the treatment of an adult mental disorder, the clinical review criteria used shall be: (A) The most recent guidelines of the American Psychiatric Association or the most recent

Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of an adult mental disorder, that are not covered in the most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

Sec. 7. Subsection (a) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) Each health carrier shall maintain written procedures for (A) utilization review and benefit determinations, (B) expedited utilization review and benefit determinations with respect to prospective urgent care requests and concurrent review urgent care requests, and (C) notifying covered persons or covered persons' authorized representatives of such review and benefit determinations. Each health carrier shall make such review and benefit determinations within the specified time periods under this section.

(2) In determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request (A) determined to be an urgent care request by a health care

professional with knowledge of the covered person's medical condition, or (B) specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as amended by this act, shall be deemed an urgent care request.

(3) (A) At the time a health carrier notifies a covered person, a covered person's authorized representative or a covered person's health care professional of an initial adverse determination that was based, in whole or in part, on medical necessity, of a concurrent or prospective utilization review or of a benefit request, the health carrier shall notify the covered person's health care professional (i) of the opportunity for a conference as provided in subparagraph (B) of this subdivision, and (ii) that such conference shall not be considered a grievance of such initial adverse determination as long as a grievance has not been filed as set forth in subparagraph (B) of this subdivision.

(B) After a health carrier notifies a covered person, a covered person's authorized representative or a covered person's health care professional of an initial adverse determination that was based, in whole or in part, on medical necessity, of a concurrent or prospective utilization review or of a benefit request, the health carrier shall offer a covered person's health care professional the opportunity to confer, at the request of the covered person's health care professional, with a clinical peer of such health carrier, provided such covered person, covered person's authorized representative or covered person's health care professional has not filed a grievance of such initial adverse determination prior to such conference. Such conference shall not be considered a grievance of such initial adverse determination. Such health carrier shall grant such clinical peer authority to reverse such initial adverse determination.

Sec. 8. Subsection (c) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of

the clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) (i) For each review of an adverse determination under this section, there shall be a rebuttable presumption that each health care service under review is medically necessary if such health care service was ordered by a health care professional acting within the scope of the health care professional's practice. The health carrier may rebut such presumption by reasonably substantiating to the clinical peer or peers conducting the review under this section that such health care service is not medically necessary.

[(C)**]** (ii) The clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2022*	38a-497
Sec. 2	*January 1, 2022*	38a-512b
Sec. 3	*January 1, 2022*	38a-510(a)
Sec. 4	*January 1, 2022*	38a-544(a)
Sec. 5	*January 1, 2022*	38a-591a(7)
Sec. 6	*January 1, 2022*	38a-591c(a)
Sec. 7	*January 1, 2022*	38a-591d(a)
Sec. 8	*January 1, 2022*	38a-591e(c)

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
State – ACA Mandate	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill does not result in a fiscal impact to the state employee and retiree health plan or municipalities that participate in the Partnership Plan as step therapy is not required by the plans.

The bill will increase costs to certain fully insured municipal plans which currently require step therapy for conditions specified in the bill. The coverage requirements will result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2022. In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA). It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

Pursuant to federal law, self-insured health plans are exempt from state health insurance mandates.

To the extent that step therapy is required by the drug formulary for plans under the Exchange, there is a cost to the state to defray costs. The cost to the state will vary based on the impact to plan premiums, based on current and projected utilization of step therapy for the treatments outlined in the bill.

While states are allowed to mandate benefits in excess of the essential health benefit (EHB), federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.

The Out Years

The fiscal impact in the outyears will vary based on an increase in premiums.

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)