



General Assembly

**Amendment**

February Session, 2022

LCO No. 4730



Offered by:  
SEN. LOONEY, 11<sup>th</sup> Dist.

To: Senate Bill No. 364

File No. 315

Cal. No. 234

**"AN ACT CONCERNING HEALTH INSURANCE."**

1 Strike everything after the enacting clause and substitute the  
2 following in lieu thereof:

3 "Section 1. Subsection (a) of section 38a-510 of the general statutes is  
4 repealed and the following is substituted in lieu thereof (*Effective January*  
5 *1, 2023*):

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

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

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

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

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

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

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

39 Sec. 2. Subsection (a) of section 38a-544 of the general statutes is  
40 repealed and the following is substituted in lieu thereof (*Effective January*  
41 *1, 2023*):

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

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

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

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

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

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

75 Sec. 3. Subdivision (7) of section 38a-591a of the general statutes is  
76 repealed and the following is substituted in lieu thereof (*Effective January*  
77 *1, 2023*):

78 (7) "Clinical peer" means a physician or other health care professional  
79 who;

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

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

86 (ii) Holds a doctoral or medical degree; and

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

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

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

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

104 Sec. 4. Subsection (a) of section 38a-591c of the general statutes is  
105 repealed and the following is substituted in lieu thereof (*Effective January*  
106 *1, 2023*):

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

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

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

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

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

137 (3) For any utilization review for the treatment of a substance use  
138 disorder, as described in section 17a-458, the clinical review criteria used

139 shall be: (A) The most recent edition of the American Society of  
140 Addiction Medicine Treatment Criteria for Addictive, Substance-  
141 Related, and Co-Occurring Conditions; or (B) clinical review criteria that  
142 the health carrier demonstrates to the Insurance Department is  
143 consistent with the most recent edition of the American Society of  
144 Addiction Medicine Treatment Criteria for Addictive, Substance-  
145 Related, and Co-Occurring Conditions, except that nothing in this  
146 subdivision shall prohibit a health carrier from developing its own  
147 clinical review criteria or purchasing or licensing additional clinical  
148 review criteria from qualified vendors approved by the commissioner,  
149 to address advancements in technology or types of care for the  
150 treatment of a substance use disorder, that are not covered in the most  
151 recent edition of the American Society of Addiction Medicine Treatment  
152 Criteria for Addictive, Substance-Related, and Co-Occurring  
153 Conditions. Any such clinical review criteria developed by a health  
154 carrier or purchased or licensed from a qualified vendor shall conform  
155 to the requirements of subparagraph (A) of subdivision (2) of this  
156 subsection.

157 (4) For any utilization review for the treatment of a child or  
158 adolescent mental disorder, the clinical review criteria used shall be: (A)  
159 The most recent guidelines of the American Academy of Child and  
160 Adolescent Psychiatry's Child and Adolescent Service Intensity  
161 Instrument; or (B) clinical review criteria that the health carrier  
162 demonstrates to the Insurance Department is consistent with the most  
163 recent guidelines of the American Academy of Child and Adolescent  
164 Psychiatry's Child and Adolescent Service Intensity Instrument, except  
165 that nothing in this subdivision shall prohibit a health carrier from  
166 developing its own clinical review criteria or purchasing or licensing  
167 additional clinical review criteria from qualified vendors approved by  
168 the commissioner, to address advancements in technology or types of  
169 care for the treatment of a child or adolescent mental disorder, that are  
170 not covered in the most recent guidelines of the American Academy of  
171 Child and Adolescent Psychiatry's Child and Adolescent Service  
172 Intensity Instrument. Any such clinical review criteria developed by a

173 health carrier or purchased or licensed from a qualified vendor shall  
174 conform to the requirements of subparagraph (A) of subdivision (2) of  
175 this subsection.

176 (5) For any utilization review for the treatment of an adult mental  
177 disorder, the clinical review criteria used shall be: (A) The most recent  
178 guidelines of the American Psychiatric Association or the most recent  
179 Standards and Guidelines of the Association for Ambulatory Behavioral  
180 Healthcare; or (B) clinical review criteria that the health carrier  
181 demonstrates to the Insurance Department is consistent with the most  
182 recent guidelines of the American Psychiatric Association or the most  
183 recent Standards and Guidelines of the Association for Ambulatory  
184 Behavioral Healthcare, except that nothing in this subdivision shall  
185 prohibit a health carrier from developing its own clinical review criteria  
186 or purchasing or licensing additional clinical review criteria from  
187 qualified vendors approved by the commissioner, to address  
188 advancements in technology or types of care for the treatment of an  
189 adult mental disorder, that are not covered in the most recent guidelines  
190 of the American Psychiatric Association or the most recent Standards  
191 and Guidelines of the Association for Ambulatory Behavioral  
192 Healthcare. Any such clinical review criteria developed by a health  
193 carrier or purchased or licensed from a qualified vendor shall conform  
194 to the requirements of subparagraph (A) of subdivision (2) of this  
195 subsection.

196 Sec. 5. Subsection (a) of section 38a-591d of the general statutes is  
197 repealed and the following is substituted in lieu thereof (*Effective January*  
198 *1, 2023*):

199 (a) (1) Each health carrier shall maintain written procedures for (A)  
200 utilization review and benefit determinations, (B) expedited utilization  
201 review and benefit determinations with respect to prospective urgent  
202 care requests and concurrent review urgent care requests, and (C)  
203 notifying covered persons or covered persons' authorized  
204 representatives of such review and benefit determinations. Each health  
205 carrier shall make such review and benefit determinations within the

206 specified time periods under this section.

207 (2) In determining whether a benefit request shall be considered an  
208 urgent care request, an individual acting on behalf of a health carrier  
209 shall apply the judgment of a prudent layperson who possesses an  
210 average knowledge of health and medicine, except that any benefit  
211 request (A) determined to be an urgent care request by a health care  
212 professional with knowledge of the covered person's medical condition,  
213 or (B) specified under subparagraph (B) or (C) of subdivision (38) of  
214 section 38a-591a shall be deemed an urgent care request.

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

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



238 Sec. 6. Subsection (c) of section 38a-591e of the general statutes is  
239 repealed and the following is substituted in lieu thereof (*Effective January*  
240 *1, 2023*):

241 (c) (1) (A) When conducting a review of an adverse determination  
242 under this section, the health carrier shall ensure that such review is  
243 conducted in a manner to ensure the independence and impartiality of  
244 the clinical peer or peers involved in making the review decision.

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

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

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

264 (D) Prior to issuing a decision, the health carrier shall provide free of  
265 charge, by facsimile, electronic means or any other expeditious method  
266 available, to the covered person or the covered person's authorized  
267 representative, as applicable, any new or additional documents,  
268 communications, information and evidence relied upon and any new or  
269 additional scientific or clinical rationale used by the health carrier in

270 connection with the grievance. Such documents, communications,  
 271 information, evidence and rationale shall be provided sufficiently in  
 272 advance of the date the health carrier is required to issue a decision to  
 273 permit the covered person or the covered person's authorized  
 274 representative, as applicable, a reasonable opportunity to respond prior  
 275 to such date.

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

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

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>January 1, 2023</i>	38a-510(a)
Sec. 2	<i>January 1, 2023</i>	38a-544(a)
Sec. 3	<i>January 1, 2023</i>	38a-591a(7)
Sec. 4	<i>January 1, 2023</i>	38a-591c(a)
Sec. 5	<i>January 1, 2023</i>	38a-591d(a)
Sec. 6	<i>January 1, 2023</i>	38a-591e(c)