OLR Bill Analysis

SB 6

AN ACT CONCERNING UTILIZATION REVIEW AND HEALTH CARE CONTRACTS, HEALTH INSURANCE COVERAGE FOR NEWBORNS AND STEP THERAPY.

SUMMARY

This bill makes the following changes in the insurance statutes:

1. establishes conditions under which health carriers (e.g., insurers and HMOs) must exempt providers from certain utilization review (e.g., prior authorization) based on their approval rates for health care services and treatments over the prior six months;

2. prohibits health carriers from requiring a prospective or concurrent review of a recurring health care service or prescription drug already approved through utilization review;

3. requires health carriers to implement a program to electronically receive and respond to certain utilization review requests;

4. shortens several of the maximum timeframes for health insurers or independent review organizations (IROs) to notify an insured or his or her authorized representative of utilization review decisions;

5. extends, from 61 days after birth to the later of 121 days after the birth or the hospital discharge date, the time period within which the insured person must (a) notify the insurer, HMO, or hospital or medical service corporation about the birth and (b) pay any required premium or subscription fee to continue the newborn's coverage beyond that period; and

6. expands when health carriers are prohibited from requiring that an insured use step therapy to include a prohibition against

requiring that step therapy be used for prescribed drugs to treat a behavioral health condition or a disabling, chronic, or life-threatening condition or disease.

EFFECTIVE DATE: October 1, 2023

§ 1 — PROSPECTIVE AND CONCURRENT REVIEW EXEMPTION

Exemption Threshold and Notification

Broadly, utilization review refers to a process in which health carriers determine whether a specific medical service is reimbursable under an individual's plan or insurance policy. Prospective reviews (which occur before a service is provided) and concurrent reviews (which occur while a person is undergoing treatment) are two types of utilization reviews. In practice, many prospective or concurrent reviews are "prior authorization" reviews, which require a health care provider to obtain approval before a medical service is covered.

Beginning with health care contracts entered into, renewed, or amended on or after January 1, 2024, the bill prohibits health carriers that perform utilization review from requiring that a participating provider obtain a prospective or concurrent review for a specific health care service or course of treatment (i.e., services) if the carrier approved 90% of the provider's reviews for the service in the preceding six months (i.e., "evaluation period" as described below). Under the bill, carriers generally must conduct an evaluation every six months to determine whether providers qualify for this exemption. However, no participating providers are required to request an exemption in order to qualify for one.

Within five business days after a provider qualifies for an exemption, the health carrier must provide it a written notice that (1) states that it qualifies for an exemption, (2) identifies the exemption's duration, and (3) lists the provider's exempt services and health benefit plans to which the exemption applies.

Scope of the Evaluation

Under the bill, the evaluation that carriers must conduct depends on

whether the participating provider has a prospective or concurrent review exemption for the service.

For non-exempt services, the evaluation is a review of the provider's prospective or concurrent review exemption requests during the most recent evaluation period to (1) determine the percentage of requests that were approved or (2) evaluate whether to grant or deny a prospective or concurrent review exemption.

For exempt services, the evaluation is a retrospective review of a random sample of the payable claims the provider submitted during the most recent evaluation period to (1) determine the percentage of claims that would have been approved based on the health carrier's applicable medical necessity data at the time the service was provided and (2) evaluate whether to continue or rescind the exemption.

Evaluation Period

Under the bill, the evaluation period is the six-month period before an evaluation. For initial exemptions or denials, the evaluation period is any six-month period beginning on January 1 or July 1, 2024, or any subsequent six-month period beginning January or July 1. After this initial determination, the evaluation period is the six-month period starting on the first day following the end of the evaluation period that the denial or recission was based on.

If an exemption is being rescinded (as described below), the evaluation period is the six-month period after the health carrier notifies the provider of the rescission. However, no more than two months may elapse between the end of this evaluation period and the date the provider receives the notice.

Length of Exemption

Under the bill, a participating provider's exemption remains in effect until 30 days after the health carrier notifies it of a decision to rescind the exemption unless the provider appeals. In that case, the exemption is in effect until the five days after the IRO (see below) affirms the health carrier's decision.

Under the bill, if a health carrier does not finalize a rescission determination, the provider automatically qualifies for an exemption. (The bill does not specify how a recission determination is "finalized.")

Providers Submitting Exemption Eligible Claims

Under the bill, carriers must notify providers if they submit a claim for a health service which qualifies for an exemption. Specifically, a carrier must promptly provide a written notice that (1) states that the provider qualifies for an exemption, (2) identifies the exemption's duration, (3) lists the provider's exempt services and health benefit plans to which the exemption applies, and (4) describes the carrier's payment requirements.

Rescissions

The bill allows health carriers to rescind a participating provider's exemption only during the following time periods and under the following circumstances:

1. during January or July of each year;

2. if it determines, based on a retrospective review of a random sample of between five and 20 claims submitted by the provider during the most recent evaluation period, that less than 90% of the claims for health care services or treatments met the medical necessity criteria the carrier would have used to evaluate the claims; and

3. if it notifies the provider in writing at least 30 days before the recission is effective and includes (a) the sample information it used to make the determination and (b) a plain language description of the appeal and independent review process (see below).

Exemption Denials

The bill prohibits carriers from denying exemptions unless they provide the participating provider the statistics, data, and other information sufficient to demonstrate that the provider failed to meet the exemption criteria for each health care service or treatment.

Independent Review Process

IRO Request and Timeline. The bill establishes a process for providers to appeal a carrier's decision to rescind an exemption with an IRO. It allows a provider to request that an IRO review a health carrier's decision to rescind an exemption. It additionally prohibits carriers from requiring that a provider engage in an internal review process before requesting a review of an adverse determination of an exemption. (Presumably, an adverse determination is a determination that an exemption should be rescinded.) IROs must complete the review within 30 calendar days of when the provider files the request.

The participating provider may request that the IRO consider a random sample of between five and 20 claims it submitted to the health carrier for the specified health service or treatment during the evaluation period that led to the recission. If the provider requests this, the IRO must base its determination on the medical necessity of the same claims that the insurer used in rescinding the exemption.

IRO determinations are binding on the carrier and the provider, except to the extent to which either party has other remedies available under state or federal law.

Fees. The bill requires health carriers issuing adverse determinations of a provider's exemption (presumably a recission) must pay (1) the IRO for the cost of conducting the review and (2) reasonable fees for copies of all documents, communication, information, and evidence relating to the adverse determination. The bill requires the insurance commissioner to adopt regulations to implement these fees.

Overturned Determinations. If an IRO overturns a health carrier's determination of an exemption, the carrier (1) cannot attempt to rescind the exemption before the end of the next evaluation period and (2) may only rescind the exemption if it complies with the bill's notification and other recission requirements described above.

Reconsideration

Under the bill, a provider who has had an exemption denied or

rescinded is eligible for reconsideration at the end of the six-month evaluation period that follows the one that formed the basis for the recission or denial.

Patient and Provider Protections

The bill prohibits health carriers from retroactively denying services because a provider's exemption was rescinded, even if the rescission was affirmed by an IRO. It also prohibits carriers from denying or reducing a payment to a provider for a service for which it qualified for an exemption based on medical necessity or appropriateness of care except in certain cases of fraud (i.e., the provider knowingly and materially misrepresented the service in a claim submitted to the health carrier or failed to substantially perform it).

Additionally, the bill prohibits health carriers from retrospectively reviewing a service (presumably for a particular health care provider) that is subject to an exemption except (1) to determine if a provider qualifies for an exemption or (2) if they have reasonable cause to believe that the provider knowingly and materially misrepresented the service or failed to substantially perform it.

Regulations

The bill requires the insurance commissioner to adopt regulations implementing the exemption provisions.

§ 2 — ELECTRONIC PRIOR AUTHORIZATIONS

By January 1, 2024, the bill requires health carriers to establish a secure system to electronically receive and respond to prospective and concurrent review requests and other requests for prospective or concurrent utilization reviews, including supporting clinical information, submitted by hospitals and health care professionals.

§ 3 — UTILIZATION REVIEW REQUEST TIME FRAMES

Existing law establishes a structure and timeframe for health carriers and IROs to conduct benefit reviews and notify a covered individual whether a specific medical service is reimbursable by his or her health insurance plan.

The bill shortens several of the maximum timeframes a health insurer or IRO can take, after receiving all the required health information, to notify an insured or the insured's authorized representative of decisions. Specifically, the bill shortens the maximum response time for decisions about the following requests:

1. a non-urgent prospective or concurrent review request, from 15 calendar days to 72 hours;

2. a one-time extension of non-urgent prospective or concurrent review requests due to circumstances beyond the carrier's control and following proper notice, from 15 calendar days to 72 hours;

3. urgent care requests, from 48 hours (or 72 hours if the request or response time falls on a weekend) to 24 hours.

By law, urgent review requests must be done as soon as possible, taking into account the insured's medical condition.

Notification and Processing

The bill also changes how a health carrier must process incomplete review requests. Under current law, a health carrier must notify an insured and the insured's authorized representative within five calendar days of a request that does not meet the carrier's filing requirements (or within 24 hours for an urgent care request). Under the bill for prospective and concurrent review requests, a carrier must instead (1) process requests 24 hours a day, seven days a week, including holidays and (2) acknowledge receipt of these requests as soon as practicable and within 24 hours unless federal law requires a faster response.

Current law allows health carriers to notify patients orally, so long as a written notice follows. The bill repeals this explicit authorization.

Additionally, the bill prohibits health carriers from requiring that health care professionals or hospitals submit additional information with a prospective or concurrent review that is not reasonably available at the time the request is submitted.

§§ 4 & 5 — NEWBORN HEALTH INSURANCE COVERAGE

By law, certain health insurance policies that cover family members must cover newborns from birth. The coverage must include injury and sickness benefits, including the care and treatment of congenital defects and birth abnormalities.

The bill extends, from 61 days after birth to the later of 121 days after the birth or the hospital discharge date, the time period within which the insured person must (1) notify the insurer, HMO, or hospital or medical service corporation about the birth and (2) pay any required premium or subscription fee to continue the newborn's coverage beyond that period. As under current law, if notification and payment is not provided within the specified period, claims originating during that period are not prejudiced.

The bill applies to individual and group 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; (4) accidents; or (5) hospital or medical services, including those provided under an HMO plan. It also applies to individual health insurance policies that cover limited benefits. Because of the federal Employee Retirement Income Security Act, state insurance benefit mandates do not apply to self-insured benefit plans.

§§ 6 & 7 — STEP THERAPY PROHIBITIONS

Step therapy is a protocol for establishing the sequence for prescribing drugs for specific medical conditions; it generally requires patients to try less expensive drugs before higher cost drugs. The bill prohibits individual and group 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.

§ 8 — PROHIBITION ON REVIEWS OF RECURRING HEALTH CARE SERVICES AND PRESCRIPTION DRUGS

The bill prohibits health carriers from requiring a prospective or concurrent review of a recurring health care service or prescription drug after they have certified the service or drug through utilization review. The bill specifies that it does not require a health carrier to cover a health care service or prescription drug that a policy's coverage conditions completely exclude for a specific health condition.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 7 Nay 5 (03/14/2023)