OLR Bill Analysis

SB 6 (File 337, as amended by Senate "A" and "B")*

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

SUMMARY

This bill makes the following changes to the insurance statutes:

1. prohibits health carriers (e.g., insurers and HMOs) from requiring a prospective or concurrent review of a recurring prescription drug used to treat an autoimmune disorder, multiple sclerosis, or cancer that they already approved through utilization review (§§ 1 & 2);

2. shortens the maximum timeframes for health carriers to notify an insured or his or her authorized representative of certain utilization reviews (§ 3);

3. extends, from 61 days to 91 days after birth, the time period within which an insured person must (a) notify the insurer, HMO, or hospital or medical service corporation about a newborn's birth and (b) pay any required premium or subscription fee to continue the newborn's coverage beyond that period (§§ 4 & 5);

4. reduces how long an insurer can require an insured to use step therapy for prescription drugs from 60 to 30 days and prohibits step therapy from January 1, 2024, to January 1, 2027, for drugs used to treat schizophrenia, major depressive disorder or bipolar disorder (§§ 6 & 7);

5. establishes a 23-member task force to study step therapy data collection, including step therapy edits, rejections, and appeals for behavioral health drugs, and the best ways to collect data (§

8);

6. requires managed care organizations (MCOs) to annually report certain prior authorization and utilization review data, actuarial analyses, and estimated premium savings to the insurance commissioner, and requires the commissioner to include some of this information in his annual consumer report card (§§ 9 & 10); and

7. requires providers participating in a health carrier's network to use a carrier's secure electronic system to process utilization reviews (§ 11).

The bill also makes numerous minor and technical changes.

*Senate Amendment "A" (1) eliminates provisions that establish conditions under which health carriers must exempt providers from certain utilization reviews based on their approval rates for health care services and treatments over the prior six months; (2) limits a prohibition on reviews of recurring prescription drugs to those drugs used to treat certain conditions; (3) shortens the underlying bill's extended time period to notify a carrier about a newborn's birth from 121 to 91 days; (4) prohibits step therapy for a three-year period for drugs used to treat schizophrenia, major depressive disorder or bipolar disorder, rather than for behavioral health conditions or disabling, chronic, or life-threatening conditions; (5) eliminates provisions requiring health carriers to implement electronic utilization review programs; (6) adds the step therapy task force, MCO reporting, consumer report card, and electronic utilization review provisions; and (7) makes numerous minor changes.

*Senate Amendment "B" delays by one year, until January 1, 2025, the effective date of the provision prohibiting certain utilization reviews of recurring prescription drugs to treat specified illnesses.

EFFECTIVE DATE: January 1, 2024, except (1) a technical section and the provisions on MCO reporting and the consumer report card are effective October 1, 2023; (2) the prohibition on utilization reviews for

certain reoccurring prescription drugs is effective January 1, 2025; and (3) the step therapy task force is effective upon passage.

§§ 1 & 2 — PROHIBITION ON REVIEWS OF RECURRING PRESCRIPTION DRUGS TO TREAT AUTOIMMUNE DISORDERS, MULTIPLE SCLEROSIS, OR CANCER

The bill prohibits health carriers from requiring a prospective or concurrent review of a recurring prescription drug used to treat any autoimmune disorder, multiple sclerosis, or cancer, after they have certified it through utilization review. The bill specifies that it does not require a health carrier to cover a (1) prescription drug to treat these conditions if the policy’s coverage terms completely exclude the drug from its covered benefits or (2) brand name drug if an equivalent generic is available.

§ 3 — UTILIZATION REVIEW REQUEST TIME FRAMES

Existing law establishes a structure and timeframe for health carriers, and any designee or utilization review company that performs utilization reviews on their behalf, 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 these entities can take, after receiving all the required 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 to 7 calendar days after the date the health carrier receives the request, but the bill allows the health carrier to extend this once for up to 15 days as long as the insured’s provider notifies the carrier that the service will not be performed for at least three months from the date the request was received;

2. a one-time extension of non-urgent prospective or concurrent review request due to circumstances beyond the carrier’s control

and following proper notice, from 15 to 5 calendar days (for retrospective reviews, the bill maintains current law's one-time extension of 15 calendar days); and

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

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

Procedural Failures

The bill also changes how a health carrier must process review requests that fail to meet the carrier's filing procedures. Under current law, a health carrier must notify an insured and his or her authorized representative, if applicable, within five calendar days of receiving the request for a non-urgent request or within 24 hours for an urgent care request. Under the bill, for non-urgent prospective and concurrent review requests, a carrier must instead acknowledge receipt of these requests as soon as practicable but within 24 hours after receiving it, unless federal law requires a faster response.

Current law allows health carriers to notify patients orally if it provides written confirmation within five calendar days after providing the oral notice. The bill shortens this time period to three calendar days.

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 to the provider or hospital 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 91 days after the birth, 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.

Under current law, these provisions apply to individual health insurance policies that cover limited benefits and 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. The bill excludes individual and group accident only policies from these provisions. (In practice, these policies are unlikely to cover birth related services.)

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 that generally requires patients to try less expensive drugs before higher cost drugs. The bill lowers, from 60 to 30 days, the maximum amount of time an insurer can require an insured use step therapy. (However, it does not make a conforming change to a provision on requesting an authorization to override any step therapy regimen.)

For the three-year period beginning January 1, 2024, the bill prohibits step therapy for drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder, as defined in the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" most recent edition. Additionally, the bill allows a health care provider treating an insured with these conditions to deem step therapy clinically ineffective. (Presumably, this applies following the three year

prohibition). At that point, the insurer must authorize dispensation of and coverage for the drug prescribed by the provider, if it is covered under the insurance policy or contract. If the provider does not consider the step therapy regimen to be ineffective or does not request an override as the law allows, the drug regimen may be continued.

Existing law, unchanged by the bill, prohibits step therapy use for drugs used to treat stage IV metastatic cancer, as long as the drugs comply with approved federal Food and Drug Administration indications.

§ 8 — STEP THERAPY TASK FORCE

Under the bill, the task force includes the following members:

1. two health care providers with mental health expertise, one each appointed by the House speaker and the Senate president pro tempore;

2. one licensed pharmacist, appointed by the House minority leader;

3. one pharmaceutical manufacturing industry representative, appointed by the Senate minority leader;

4. the chairpersons and ranking members of the Insurance and Real Estate and Public Health committees, or their designees;

5. the Office of Health Strategy executive director, or her designee;

6. the insurance and consumer protection commissioners, or their designees;

7. two insurance industry representatives, one each appointed by the Insurance and Real Estate Committee chairpersons;

8. two pharmaceutical industry representatives, one each appointed by the Insurance and Real Estate Committee's ranking members;

9. two mental health care providers, one each appointed by the Public Health Committee's chairpersons; and

10. two mental health advocacy group representatives, who must be impacted individuals, appointed by the Public Health Committee's ranking members.

Appointing authorities must make their appointments within 30 days after the bill's passage and fill any vacancies. The House speaker and Senate president pro tempore must select the task force's chairpersons from among its members. The chairpersons must schedule the first meeting, which must be held within 60 days after the bill's passage. The Public Health Committee's administrative staff serve as the task force's staff.

The task force must report its findings and recommendations to the Insurance and Real Estate and Public Health committees by February 1, 2024. The task force terminates when it submits its report or on February 1, 2024, whichever is earlier.

§ 9 — MANAGED CARE ORGANIZATIONS REPORTS

Existing law requires managed care organizations (MCOs) to submit an annual quality assurance plan to the insurance commissioner by May 1. The bill specifies that the statistical information included in the report must be in a format the commissioner prescribes and include, in a manner that allows the commissioner to compare plans (1) a list of health care services that required prior authorization in the previous calendar year and (2) the percent of services that required prior authorization in the previous calendar year compared to the total overall number of covered services. By law, the statistical information must also include several other comparable criteria, such as the number of utilization review determinations and the percent of employers that renew their MCO contracts.

By law, the commissioner can accept these annual quality assurance plans and other MCO reports electronically. The bill allows him to revise the filing requirements to implement the statistical reporting provisions

described above.

Annually, also by May 1, the bill requires MCOs to submit to the commissioner a report that summarizes (1) the actuarial analysis used in setting standards for any procedures subject to prior authorization in the previous calendar year and (2) any estimated premium savings resulting from prior authorization and other utilization review protocols. The commissioner must prescribe the report's format.

§ 10 — CONSUMER REPORT CARD

By law, the consumer report card is an annual report issued by the insurance commissioner that contains certain comparative information on health care centers (i.e., HMOs) and the 15 largest health insurers that use provider networks in the state. The report card includes, for MCOs, which include HMOs and insurers, a report on claims denials. Under the bill, the report card must also include the actuarial analysis and estimated premium savings information described above (see § 9).

§ 11 — ELECTRONIC UTILIZATION REVIEW PROCESSING

The bill requires participating providers (i.e., health care providers who are contracted with a health carrier to provide services) to use a carrier's secure electronic program to process utilization review requests. However, a participating provider's failure to use the program must not contribute to an adverse determination (e.g., a benefit denial).

COMMITTEE ACTION

Insurance and Real Estate Committee

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

Appropriations Committee

Joint Favorable
Yea 37 Nay 16 (05/08/2023)