General Assembly

Senate

File No. 337

January Session, 2023

Senate Bill No. 6

Senate, March 30, 2023

The Committee on Insurance and Real Estate reported through SEN. CABRERA of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

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

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

Section 1. (NEW) (*Effective October 1, 2023*) (a) As used in this section:

(1) "Evaluation" means:

(A) With respect to a health care service or course of treatment for which a participating provider does not have a prospective or concurrent review exemption, a review by a health carrier of prospective or concurrent review exemption requests submitted by such participating provider during the most recent evaluation period to determine the percentage of such requests that were approved, for a health carrier to evaluate whether to grant or deny a prospective or concurrent review exemption; or

(B) With respect to a health care service or course of treatment for which a participating provider has a prospective or concurrent review

exemption, a retrospective review by a health carrier of a random sample of payable claims submitted by such participating provider during the most recent evaluation period to determine the percentage of claims that would have been approved, based on meeting such health carrier's applicable medical necessity criteria at the time the service was provided, for such health carrier to evaluate whether to continue or rescind a prospective or concurrent review exemption; and

(2) "Evaluation period" means the six-month period preceding an evaluation. "Evaluation period" includes:

(A) For an initial determination of a prospective or concurrent review exemption grant or denial for any health care service or course of treatment, any six-month period that begins on January 1, 2024, July 1, 2024, or any subsequent six-month period that begins on any January first or July first of any subsequent year;

(B) After a denial or rescission of a prospective or concurrent review exemption for any health care service or course of treatment, the six-month period that commences on the first day following the end of the evaluation period that formed the basis of such denial or rescission of a prospective or concurrent review exemption; and

(C) For a notification of a prospective or concurrent review exemption rescission, the six-month period after the health carrier provided such notice of rescission to the participating provider or the next six-month period, provided there shall not be more than two months between the end of such evaluation period and the date such notice is received by such participating provider.

(b) For any health care contract entered into, renewed or amended on or after January 1, 2024, no health carrier that provides or performs utilization review, including prospective and concurrent review, for any health care service or course of treatment shall require that any participating provider obtain prospective or concurrent review for any health care service or course of treatment if, in the immediately preceding six-month evaluation period, such health carrier approved

not less than ninety per cent of such prospective or concurrent review requests submitted by such participating provider for such health care service or course of treatment.

(c) Except for any exemption from the prospective or concurrent review requirements that shall continue without evaluation pursuant to subsection (f) of this section, each health carrier shall conduct an evaluation once every six months to determine whether each participating provider qualifies for an exemption from the prospective or concurrent review requirements pursuant to subsection (b) of this section.

(d) No participating provider shall be required to request an exemption from such prospective or concurrent review requirements in order to qualify for such exemption.

(e) Each participating provider's exemption from the prospective or concurrent review requirements pursuant to subsection (b) of this section, shall remain in effect until:

(1) The thirtieth day after the date on which the health carrier notifies such participating provider of such health carrier's determination to rescind such exemption pursuant to the provisions of subsection (g) of this section, provided such participating provider does not appeal such health carrier's determination in accordance with the provisions of subsection (i) of this section; or

(2) If such participating provider appeals such health carrier's determination in accordance with the provisions of subsection (i) of this section and the independent review organization affirms such health carrier's determination to rescind such exemption, the fifth day after the date such independent review organization affirms such health carrier's determination to rescind such exemption.

(f) If a health carrier does not finalize any determination to rescind such exemption from the prospective or concurrent review requirements in accordance with the provisions of subsection (e) of this

section, the participating provider shall automatically satisfy the exemption from the prospective or concurrent review requirements pursuant to subsection (b) of this section.

(g) Each health carrier may rescind any participating provider exemption from the prospective or concurrent review requirements under subsection (b) of this section only:

(1) During January or July of each year;

(2) If such health carrier makes a determination on the basis of a retrospective review of a random sample of not less than five and not more than twenty claims submitted by such participating provider during the most recent evaluation period, as set forth in subsection (b) of this section, that less than ninety per cent of such claims for the health care service or course of treatment met the medical necessity criteria that would have been used by such health carrier when conducting prospective or concurrent review for the health care service or course of treatment during the relevant evaluation period; and

(3) If such health carrier:

(A) Notifies such participating provider, in writing, not less than thirty days before such rescission is to take effect; and

(B) Provides with such notice pursuant to subparagraph (A) of this subdivision:

(i) The sample information used by such health carrier to make such determination pursuant to subdivision (2) of this subsection; and

(ii) A plain language description identifying the process for such participating provider to (I) submit an appeal of such rescission, and (II) seek an independent review of such determination.

(h) No health carrier may deny an exemption from the prospective or concurrent review requirements set forth in subsection (b) of this section, unless such health carrier provides the participating provider

with statistics and data for the relevant prospective or concurrent review evaluation period and information sufficient to demonstrate that such participating provider fails to meet the criteria for an exemption from the prospective or concurrent review requirements set forth in subsection (b) of this section for each health care service or course of treatment.

(i) (1) If a health carrier rescinds any participating provider's exemption from the prospective or concurrent review requirements pursuant to subsection (g) of this section, such participating provider may request an independent review of such health carrier's determination. Such independent review shall be conducted by an independent review organization. No health carrier shall require a participating provider to engage in an internal review process before requesting an independent review of an adverse determination of an exemption.

(2) Each health carrier that issues any adverse determination of a participating provider's exemption pursuant to subsection (g) of this section that is the subject of such independent review shall pay:

(A) The independent review organization for the cost of conducting such independent review requested by such participating provider pursuant to subdivision (1) of this subsection; and

(B) Reasonable fees for copies of all documents, communications, information and evidence relating to the adverse determination of such participating provider's exemption requested by such participating provider for purposes of such independent review pursuant to this subsection. The Insurance Commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement such fees that shall be paid by health carriers pursuant to this subparagraph.

(3) Each independent review organization shall complete the review of any adverse determination of the participating provider's exemption not later than the thirtieth calendar day after the date that such

participating provider files such request for such independent review under subdivision (1) of this subsection.

(4) The participating provider may request that the independent review organization consider a random sample of not less than five and not more than twenty claims submitted to the health carrier by such participating provider during the relevant evaluation period for the health care service or course of treatment that is subject to such independent review as part of such independent review organization's review. If such participating provider requests a review of such random sample, such independent review organization shall base its determination on the medical necessity of claims reviewed by such health carrier under subdivision (2) of subsection (g) of this section and by such independent review organization pursuant to this subdivision.

(j) (1) Each independent review determination shall be binding on the health carrier and the participating provider, except to the extent such health carrier or participating provider has other remedies available under federal or state law.

(2) No health carrier shall retroactively deny any health care service or course of treatment on the basis of a rescission of an exemption, even if such health carrier's determination to rescind such prospective or concurrent review exemption is affirmed by an independent review organization.

(3) If any independent review organization overturns any health carrier's determination of a prospective or concurrent review exemption, such health carrier:

(A) Shall not attempt to rescind such exemption before the end of the next evaluation period; and

(B) May only rescind such exemption after the end of the next evaluation period, provided such health carrier complies with the provisions of subsections (g) to (i), inclusive, of this section.

(k) After a final determination or review affirming a rescission or

denial of an exemption for a health care service or course of treatment, any participating provider shall be eligible for reconsideration of such exemption for the same health care service or course of treatment after the end of the six-month evaluation period that follows such evaluation period that formed the basis of the rescission or denial of such exemption.

(l) (1) No health carrier shall deny or reduce payment to a participating provider for any health care service or course of treatment for which such participating provider has qualified for an exemption from the prospective or concurrent review requirements pursuant to subsection (b) of this section based on medical necessity or appropriateness of care, unless such participating provider:

(A) Knowingly and materially misrepresented such health care service or course of treatment in a request for payment submitted to such health carrier; or

(B) Failed to substantially perform such health care service or course of treatment.

(2) No health carrier shall conduct a retrospective review of any health care service or course of treatment subject to an exemption pursuant to subsection (b) of this section, except:

(A) To determine if a participating provider qualifies for such exemption under subsection (b) of this section; or

(B) If such health carrier has reasonable cause to believe that a basis for denial exists under subdivision (1) of this subsection.

(3) Not later than five business days after any participating provider qualifies for an exemption from the prospective or concurrent review requirements under subsection (b) of this section, the health carrier shall provide to such participating provider a written notice that includes:

(A) A statement that such participating provider qualifies for an exemption from the prospective or concurrent review requirements;

(B) A list of such participating provider's health care services or course of treatments, and health benefit plans to which such exemption applies; and

(C) A statement identifying the duration of such exemption.

(4) If a participating provider submits a prospective or concurrent review request to a health carrier for any health care service or course of treatment for which such participating provider qualifies for an exemption from the prospective or concurrent review requirements pursuant to subsection (b) of this section, such health carrier shall promptly provide written notice to such participating provider that includes:

(A) The information required under subparagraphs (A) to (C), inclusive, of subdivision (3) of this subsection; and

(B) Notification of such health carrier's payment requirements.

(m) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to carry out the provisions of this section.

Sec. 2. Section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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.

(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.

(b) Each health carrier shall:

(1) Have procedures in place to ensure that (A) the health care professionals administering such health carrier's utilization review program are applying the clinical review criteria consistently in utilization review determinations, and (B) the appropriate or required individual or individuals are being designated to conduct utilization reviews;

(2) Have data systems sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(3) Provide covered persons and participating providers with access to its utilization review staff through a toll-free telephone number or any other free calling option or by electronic means;

(4) Coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, processes for assessing member satisfaction and risk management; and

(5) Routinely assess the effectiveness and efficiency of its utilization review program.

(c) If a health carrier delegates any utilization review activities to a utilization review company, the health carrier shall maintain adequate oversight, which shall include (1) a written description of the utilization review company's activities and responsibilities, including such company's reporting requirements, (2) evidence of the health carrier's formal approval of the utilization review company program, and (3) a process by which the health carrier shall evaluate the utilization review company's performance.

(d) When conducting utilization review, the health carrier shall (1) collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination, and (2) ensure that such review is conducted in a manner to ensure the independence and impartiality of the individual or individuals involved in making the utilization review or benefit determination. No health carrier shall make decisions regarding the hiring, compensation, termination, promotion or other similar matters of such individual or individuals based on the likelihood that the individual or individuals will support the denial of benefits.

(e) Not later than January 1, 2024, each health carrier shall establish an electronic program to provide for the secure electronic:

(1) Filing of prospective and concurrent review requests, and other requests for prospective or concurrent utilization reviews, by hospital and health care professionals with such health carrier, and submission of available clinical information in support of such requests; and

(2) Transmission of such health carrier's responses to such requests described in subdivision (1) of this subsection.

Sec. 3. Section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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 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.

(b) With respect to a nonurgent care request:

(1) (A) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than **[**fifteen calendar days**]** seventy-two hours after the date the health carrier receives such request, and shall notify the covered person and, if

applicable, the covered person's authorized representative of such determination, whether or not the carrier certifies the provision of the benefit.

(B) If the review under subparagraph (A) of this subdivision is a review of a grievance involving 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.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to **[**fifteen calendar days**]** seventy-two hours, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

(i) Specifically describe in the notice of extension the required information necessary to complete the request; and

(ii) Provide the covered person and, if applicable, the covered person's authorized representative with not less than forty-five calendar days after the date of receipt of the notice to provide the specified

information.

(B) If the covered person or the covered person's authorized representative fails to submit the specified information before the end of the period of the extension, the health carrier may deny certification of the benefit requested.

(c) With respect to an urgent care request:

(1) (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than **[**forty-eight**]** twenty-four hours after the health carrier receives such request, **[**or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend,**]** provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made **[**at least**]** not less than twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

(B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made **[**at least**]** not less than twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

(2) (A) If the covered person or the covered person's authorized

representative has failed to provide information necessary for the health carrier to make a determination, the health carrier shall notify the covered person or the covered person's representative, as applicable, as soon as possible, but not later than twenty-four hours after the health carrier receives such request.

(B) The health carrier shall provide the covered person or the covered person's authorized representative, as applicable, a reasonable period of time to submit the specified information, taking into account the covered person's medical condition, but not less than forty-eight hours after notifying the covered person or the covered person's authorized representative, as applicable.

(3) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of its determination as soon as possible, but not later than forty-eight hours after the earlier of (A) the date on which the covered person and the covered person's authorized representative, as applicable, provides the specified information to the health carrier, or (B) the date on which the specified information was to have been submitted.

(d) (1) **[**Whenever a health carrier receives a review request from a covered person or a covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than five calendar days after the health carrier receives such request, except that for an urgent care request, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than twenty-four hours after the health carrier receives such request.**]** With respect to prospective and concurrent review requests, each health carrier shall:

(A) Process prospective and concurrent review requests twenty-four hours a day, seven days a week, including holidays; and

(B) Acknowledge receipt of each nonurgent prospective and

concurrent review request as soon as practicable, but not later than twenty-four hours following such health carrier's receipt of such prospective and concurrent review request, except that such health carrier shall respond in less time if such a response is required by applicable federal law.

(2) **[**If the health carrier provides such notice orally, the health carrier shall provide confirmation in writing to the covered person and the covered person's health care professional of record not later than five calendar days after providing the oral notice**]** No health carrier shall require a health care professional or hospital to submit additional information that was not reasonably available to such health care professional or hospital at the time that such health care professional or hospital filed the prospective or concurrent review request with such health carrier.

(e) Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination.

(1) Such notice may be provided in writing or by electronic means and shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(A) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount;

(B) The specific reason or reasons for the adverse determination, including, upon request, a listing of the relevant clinical review criteria, including professional criteria and medical or scientific evidence and a description of the health carrier's standard, if any, that were used in reaching the denial;

(C) Reference to the specific health benefit plan provisions on which the determination is based;

(D) A description of any additional material or information necessary

for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

(E) A description of the health carrier's internal grievance process that includes (i) the health carrier's expedited review procedures, (ii) any time limits applicable to such process or procedures, (iii) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (iv) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the covered person's benefit request;

(F) (i) (I) A copy of the specific rule, guideline, protocol or other similar criterion the health carrier relied upon to make the adverse determination, or (II) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, with instructions for requesting such copy, and (ii) the links to such rule, guideline, protocol or other similar criterion on such health carrier's Internet web site;

(G) If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the adverse determination and (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances or (ii) a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation;

(H) A statement explaining the right of the covered person to contact

the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil action in a court of competent jurisdiction. Such statement shall include the contact information for said offices; and

(I) A statement, expressed in language approved by the Healthcare Advocate and prominently displayed on the first page or cover sheet of the notice using a call-out box and large or bold text, that if the covered person or the covered person's authorized representative chooses to file a grievance of an adverse determination, (i) such appeals are sometimes successful, (ii) such covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and (iv) such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (a) of section 38a-591n.

(f) If the adverse determination is a rescission, the health carrier shall include with the advance notice of the application for rescission required to be sent to the covered person, a written statement that includes:

(1) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) A disclosure that the covered person or the covered person's authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, pursuant to sections 38a-591e and 38a-591f;

(4) A description of the health carrier's grievance procedures established under sections 38a-591e and 38a-591f, including any time limits applicable to those procedures; and

(5) The date such advance notice of the proposed rescission ends and the date back to which the coverage will be retroactively rescinded.

(g) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review in accordance with the provisions of section 38a-591g, regardless of whether the health carrier asserts it substantially complied with the requirements of this section or that any error it committed was de minimis.

(2) A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

Sec. 4. Section 38a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing

coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) Coverage for such newly born child shall consist of coverage for injury and sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities within the limits of the policy.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center not later than **[**sixty-one**]** one hundred twenty-one days after the date of birth or the date of discharge from the hospital, whichever is later, in order to continue coverage beyond such **[**sixty-one-day**]** period, provided failure to furnish such notice or pay such premium or fees shall not prejudice any claim originating within such **[**sixty-one-day**]** period.

Sec. 5. Section 38a-516 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(b) Coverage for such newly born child shall consist of coverage for injury and sickness including necessary care and treatment of medically

diagnosed congenital defects and birth abnormalities within the limits of the policy.

(c) If payment of a specific premium fee is required to provide coverage for a child, the policy may require that notification of birth of such newly born child and payment of the required premium or fees shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center not later than **[**sixty-one**]** one hundred twenty-one days after the date of birth or the date of discharge from the hospital, whichever is later, in order to continue coverage beyond such **[**sixty-one-day**]** period, provided failure to furnish such notice or pay such premium shall not prejudice any claim originating within such **[**sixty-one-day**]** period.

Sec. 6. Subsection (a) of section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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. 7. Subsection (a) of section 38a-544 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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. 8. (NEW) (*Effective October 1, 2023*) No health carrier shall require a prospective or concurrent review of a recurring health care service or prescription drug after such health carrier has certified such health care service or prescription drug through utilization review. Nothing in this section shall require a health carrier to cover any health care service or prescription drug for a health condition of which the terms of coverage completely exclude such health care service or prescription drug from the policy's covered benefits.

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

Section 1	*October 1, 2023*	New section
Sec. 2	*October 1, 2023*	38a-591c
Sec. 3	*October 1, 2023*	38a-591d
Sec. 4	*October 1, 2023*	38a-490
Sec. 5	*October 1, 2023*	38a-516
Sec. 6	*October 1, 2023*	38a-510(a)
Sec. 7	*October 1, 2023*	38a-544(a)
Sec. 8	*October 1, 2023*	New section

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 24 $	FY 25 $
State Comptroller - Fringe Benefits	GF - Potential Cost	See Below	See Below
UConn Health Ctr.	GF - Potential Cost	At Least 100,000	At Least 100,000

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 24 $	FY 25 $
Various Municipalities	Potential Cost	See Below	See Below

Explanation

Sections 1 and 3 pertain to: (1) exemptions, under certain circumstances, for health care providers from certain utilization review processes used by health insurers and HMOs (also known as "gold-carding") and (2) shortening several of the maximum timeframes for insurers or independent review organizations (IRO) to notify insureds of their utilization review decisions.

These sections do not result in a fiscal impact to the Insurance Department because: (1) the agency has the capacity and expertise to develop the regulations required by the bill and enforce its provisions, and (2) the bill specifies that the fees for IROs to conduct reviews of adverse determinations for such exemptions must be paid by the health insurer or HMO.

Section 2 could result in a potential cost to the UConn Health Center

beginning in FY 24, associated with establishing a secure system to electronically receive and respond to prospective and concurrent review requests. It is anticipated that the potential costs would exceed $100,000 annually.

Sections 4 and 5 extend the timeframe insurers must provide for notice of the birth of a newborn. This may result in a fiscal impact to the state and municipal plans to the extent that the number of claims increases.

Sections 6 and 7 eliminate step therapy for certain behavioral health, or chronic, disabling, or life-threatening conditions or diseases resulting in no fiscal impact to the state employee and retiree health plan because step therapy is not frequently used within the plans. This may impact certain municipal plans that require step therapy.

Section 8 of the bill prohibits the repeated use of utilization review for recurring health care services or prescription drugs. This decreases health carriers' ability to lower costs and in turn may impact state and municipal health plans through increased premiums.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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)