



General Assembly

January Session, 2023

Committee Bill No. 6

LCO No. 4966



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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:

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

2 (1) "Evaluation" means:

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

11 (B) With respect to a health care service or course of treatment for
12 which a participating provider has a prospective or concurrent review
13 exemption, a retrospective review by the health carrier of a random
14 sample of payable claims submitted by such participating provider

15 during the most recent evaluation period to determine the percentage
16 of claims that would have been approved, based on meeting such health
17 carrier's applicable medical necessity criteria at the time the service was
18 provided, for such health carrier to evaluate whether to continue or
19 rescind a prospective or concurrent review exemption; and

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

22 (A) For an initial determination of a prospective or concurrent review
23 exemption grant or denial for any health care service or course of
24 treatment, any six-month period that begins on January 1, 2024, July 1,
25 2024, or any subsequent six-month period that begins on any January
26 first or July first of any subsequent year.

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

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

38 (b) For any health care contracts entered into, renewed or amended
39 on or after January 1, 2024, no health carrier that provides or performs
40 utilization review, including prospective and concurrent review, for any
41 health care service or course of treatment shall require that any
42 participating provider obtain prospective or concurrent review for any
43 health care service or course of treatment if, in the immediately
44 preceding six-month evaluation period, such health carrier approved
45 not less than ninety per cent of such prospective or concurrent review

46 requests submitted by such participating provider for such health care
47 service or course of treatment.

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

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

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

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

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

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

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

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

82 (1) During January or July of each year;

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

92 (3) If such health carrier:

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

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

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

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

102 (h) No health carrier may deny an exemption from the prospective or
103 concurrent review requirements set forth in subsection (b) of this

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

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

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

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

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

134 (3) Each independent review organization shall complete the review

135 of any adverse determination of the participating provider's exemption
136 not later than the thirtieth calendar day after the date that such
137 participating provider files such request for such independent review
138 under subdivision (1) of this subsection.

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

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

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

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

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

164 (B) May only rescind such exemption after the end of the next

165 evaluation period, provided such health carrier complies with the
166 provisions of subsections (g) to (i), inclusive, of this section.

167 (k) After a final determination or review affirming a rescission or
168 denial of an exemption for a health care service or course of treatment,
169 any participating provider shall be eligible for reconsideration of such
170 exemption for the same health care service or course of treatment after
171 the end of the six-month evaluation period that follows such evaluation
172 period that formed the basis of the rescission or denial of such
173 exemption.

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

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

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

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

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

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

192 (3) Not later than five business days after any participating provider
193 qualifies for an exemption from the prospective or concurrent review

194 requirements under subsection (b) of this section, the health carrier shall
195 provide to such participating provider a written notice that includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

239 (3) For any utilization review for the treatment of a substance use
240 disorder, as described in section 17a-458, the clinical review criteria used
241 shall be: (A) The most recent edition of the American Society of
242 Addiction Medicine Treatment Criteria for Addictive, Substance-
243 Related, and Co-Occurring Conditions; or (B) clinical review criteria that
244 the health carrier demonstrates to the Insurance Department is
245 consistent with the most recent edition of the American Society of
246 Addiction Medicine Treatment Criteria for Addictive, Substance-
247 Related, and Co-Occurring Conditions, except that nothing in this
248 subdivision shall prohibit a health carrier from developing its own
249 clinical review criteria or purchasing or licensing additional clinical
250 review criteria from qualified vendors approved by the commissioner,
251 to address advancements in technology or types of care for the
252 treatment of a substance use disorder, that are not covered in the most
253 recent edition of the American Society of Addiction Medicine Treatment

254 Criteria for Addictive, Substance-Related, and Co-Occurring
255 Conditions. Any such clinical review criteria developed by a health
256 carrier or purchased or licensed from a qualified vendor shall conform
257 to the requirements of subparagraph (A) of subdivision (2) of this
258 subsection.

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

278 (5) For any utilization review for the treatment of an adult mental
279 disorder, the clinical review criteria used shall be: (A) The most recent
280 guidelines of the American Psychiatric Association or the most recent
281 Standards and Guidelines of the Association for Ambulatory Behavioral
282 Healthcare; or (B) clinical review criteria that the health carrier
283 demonstrates to the Insurance Department is consistent with the most
284 recent guidelines of the American Psychiatric Association or the most
285 recent Standards and Guidelines of the Association for Ambulatory
286 Behavioral Healthcare, except that nothing in this subdivision shall

287 prohibit a health carrier from developing its own clinical review criteria
288 or purchasing or licensing additional clinical review criteria from
289 qualified vendors approved by the commissioner, to address
290 advancements in technology or types of care for the treatment of an
291 adult mental disorder, that are not covered in the most recent guidelines
292 of the American Psychiatric Association or the most recent Standards
293 and Guidelines of the Association for Ambulatory Behavioral
294 Healthcare. Any such clinical review criteria developed by a health
295 carrier or purchased or licensed from a qualified vendor shall conform
296 to the requirements of subparagraph (A) of subdivision (2) of this
297 subsection.

298 (b) Each health carrier shall:

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

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

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

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

316 (5) Routinely assess the effectiveness and efficiency of its utilization

317 review program.

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

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

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

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

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

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

346 (a) (1) Each health carrier shall maintain written procedures for (A)

347 utilization review and benefit determinations, (B) expedited utilization
348 review and benefit determinations with respect to prospective urgent
349 care requests and concurrent review urgent care requests, and (C)
350 notifying covered persons or covered persons' authorized
351 representatives of such review and benefit determinations. Each health
352 carrier shall make such review and benefit determinations within the
353 specified time periods under this section.

354 (2) In determining whether a benefit request shall be considered an
355 urgent care request, an individual acting on behalf of a health carrier
356 shall apply the judgment of a prudent layperson who possesses an
357 average knowledge of health and medicine, except that any benefit
358 request (A) determined to be an urgent care request by a health care
359 professional with knowledge of the covered person's medical condition,
360 or (B) specified under subparagraph (B) or (C) of subdivision (38) of
361 section 38a-591a shall be deemed an urgent care request.

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

372 (B) After a health carrier notifies a covered person, a covered person's
373 authorized representative or a covered person's health care professional
374 of an initial adverse determination that was based, in whole or in part,
375 on medical necessity, of a concurrent or prospective utilization review
376 or of a benefit request, the health carrier shall offer a covered person's
377 health care professional the opportunity to confer, at the request of the
378 covered person's health care professional, with a clinical peer of such

379 health carrier, provided such covered person, covered person's
380 authorized representative or covered person's health care professional
381 has not filed a grievance of such initial adverse determination prior to
382 such conference. Such conference shall not be considered a grievance of
383 such initial adverse determination.

384 (b) With respect to a nonurgent care request:

385 (1) (A) For a prospective or concurrent review request, a health carrier
386 shall make a determination within a reasonable period of time
387 appropriate to the covered person's medical condition, but not later than
388 [fifteen calendar days] seventy-two hours after the date the health
389 carrier receives such request, and shall notify the covered person and, if
390 applicable, the covered person's authorized representative of such
391 determination, whether or not the carrier certifies the provision of the
392 benefit.

393 (B) If the review under subparagraph (A) of this subdivision is a
394 review of a grievance involving a concurrent review request, pursuant
395 to 45 CFR 147.136, as amended from time to time, the treatment shall be
396 continued without liability to the covered person until the covered
397 person has been notified of the review decision.

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

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

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

407 (B) Notifies the covered person and, if applicable, the covered
408 person's authorized representative prior to the expiration of the initial

409 time period, of the circumstances requiring the extension of time and
410 the date by which the health carrier expects to make a determination.

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

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

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

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

425 (c) With respect to an urgent care request:

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

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

451 (2) (A) If the covered person or the covered person's authorized
452 representative has failed to provide information necessary for the health
453 carrier to make a determination, the health carrier shall notify the
454 covered person or the covered person's representative, as applicable, as
455 soon as possible, but not later than twenty-four hours after the health
456 carrier receives such request.

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

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

470 (d) (1) [Whenever a health carrier receives a review request from a

471 covered person or a covered person's authorized representative that
472 fails to meet the health carrier's filing procedures, the health carrier shall
473 notify the covered person and, if applicable, the covered person's
474 authorized representative of such failure not later than five calendar
475 days after the health carrier receives such request, except that for an
476 urgent care request, the health carrier shall notify the covered person
477 and, if applicable, the covered person's authorized representative of
478 such failure not later than twenty-four hours after the health carrier
479 receives such request.] With respect to prospective and concurrent
480 review requests, each health carrier shall:

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

483 (B) Acknowledge receipt of each nonurgent prospective and
484 concurrent review request as soon as practicable, but not later than
485 twenty-four hours following such health carrier's receipt of such
486 prospective and concurrent review request, except that such health
487 carrier shall respond in less time if such a response is required by
488 applicable federal law.

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

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

501 (1) Such notice may be provided in writing or by electronic means

502 and shall set forth, in a manner calculated to be understood by the
503 covered person or the covered person's authorized representative:

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

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

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

514 (D) A description of any additional material or information necessary
515 for the covered person to perfect the benefit request or claim, including
516 an explanation of why the material or information is necessary to perfect
517 the request or claim;

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

529 (F) (i) (I) A copy of the specific rule, guideline, protocol or other
530 similar criterion the health carrier relied upon to make the adverse
531 determination, or (II) a statement that a specific rule, guideline, protocol

532 or other similar criterion of the health carrier was relied upon to make
533 the adverse determination and that a copy of such rule, guideline,
534 protocol or other similar criterion will be provided to the covered person
535 free of charge upon request, with instructions for requesting such copy,
536 and (ii) the links to such rule, guideline, protocol or other similar
537 criterion on such health carrier's Internet web site;

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

547 (H) A statement explaining the right of the covered person to contact
548 the commissioner's office or the Office of the Healthcare Advocate at
549 any time for assistance or, upon completion of the health carrier's
550 internal grievance process, to file a civil action in a court of competent
551 jurisdiction. Such statement shall include the contact information for
552 said offices; and

553 (I) A statement, expressed in language approved by the Healthcare
554 Advocate and prominently displayed on the first page or cover sheet of
555 the notice using a call-out box and large or bold text, that if the covered
556 person or the covered person's authorized representative chooses to file
557 a grievance of an adverse determination, (i) such appeals are sometimes
558 successful, (ii) such covered person or covered person's authorized
559 representative may benefit from free assistance from the Office of the
560 Healthcare Advocate, which can assist such covered person or covered
561 person's authorized representative with the filing of a grievance
562 pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such
563 covered person or covered person's authorized representative is entitled

564 and encouraged to submit supporting documentation for the health
565 carrier's consideration during the review of an adverse determination,
566 including narratives from such covered person or covered person's
567 authorized representative and letters and treatment notes from such
568 covered person's health care professional, and (iv) such covered person
569 or covered person's authorized representative has the right to ask such
570 covered person's health care professional for such letters or treatment
571 notes.

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

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

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

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

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

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

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

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

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

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

610 (a) Each individual health insurance policy delivered, issued for
611 delivery, renewed, amended or continued in this state providing
612 coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11)
613 and (12) of section 38a-469 for a family member of the insured or
614 subscriber shall, as to such family member's coverage, also provide that
615 the health insurance benefits applicable for children shall be payable
616 with respect to a newly born child of the insured or subscriber from the
617 moment of birth.

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

622 (c) If payment of a specific premium or subscription fee is required to
623 provide coverage for a child, the policy or contract may require that

624 notification of birth of such newly born child and payment of the
625 required premium or fees shall be furnished to the insurer, hospital
626 service corporation, medical service corporation or health care center
627 not later than ~~[sixty-one]~~ one hundred twenty-one days after the date of
628 birth or the date of discharge from the hospital, whichever is later, in
629 order to continue coverage beyond such [sixty-one-day] period,
630 provided failure to furnish such notice or pay such premium or fees
631 shall not prejudice any claim originating within such [sixty-one-day]
632 period.

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

635 (a) Each group health insurance policy delivered, issued for delivery,
636 renewed, amended or continued in this state providing coverage of the
637 type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-
638 469 for a family member of the insured or subscriber shall, as to such
639 family member's coverage, also provide that the health insurance
640 benefits applicable for children shall be payable with respect to a newly
641 born child of the insured or subscriber from the moment of birth.

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

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

656 Sec. 6. Subsection (a) of section 38a-510 of the general statutes is
657 repealed and the following is substituted in lieu thereof (*Effective October*
658 *1, 2023*):

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

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

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

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

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

677 (3) At the expiration of the time period specified in subparagraph (A)
678 of subdivision (2) of this subsection, [or for a prescribed drug described
679 in subparagraph (B) of subdivision (2) of this subsection,] an insured's
680 treating health care provider may deem such step therapy drug regimen
681 clinically ineffective for the insured, at which time the insurance
682 company, hospital service corporation, medical service corporation,
683 health care center or other entity shall authorize dispensation of and
684 coverage for the drug prescribed by the insured's treating health care
685 provider, provided such drug is a covered drug under such policy or

686 contract. If such provider does not deem such step therapy drug
687 regimen clinically ineffective or has not requested an override pursuant
688 to subdivision (1) of subsection (b) of this section, such drug regimen
689 may be continued. For purposes of this section, "step therapy" means a
690 protocol or program that establishes the specific sequence in which
691 prescription drugs for a specified medical condition are to be prescribed.

692 Sec. 7. Subsection (a) of section 38a-544 of the general statutes is
693 repealed and the following is substituted in lieu thereof (*Effective October*
694 *1, 2023*):

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

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

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

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

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

713 (3) At the expiration of the time period specified in subparagraph (A)
714 of subdivision (2) of this subsection, [or for a prescribed drug described
715 in subparagraph (B) of subdivision (2) of this subsection,] an insured's

716 treating health care provider may deem such step therapy drug regimen
 717 clinically ineffective for the insured, at which time the insurance
 718 company, hospital service corporation, medical service corporation,
 719 health care center or other entity shall authorize dispensation of and
 720 coverage for the drug prescribed by the insured's treating health care
 721 provider, provided such drug is a covered drug under such policy or
 722 contract. If such provider does not deem such step therapy drug
 723 regimen clinically ineffective or has not requested an override pursuant
 724 to subdivision (1) of subsection (b) of this section, such drug regimen
 725 may be continued. For purposes of this section, "step therapy" means a
 726 protocol or program that establishes the specific sequence in which
 727 prescription drugs for a specified medical condition are to be prescribed.

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2023</i>	New section
Sec. 2	<i>October 1, 2023</i>	38a-591c
Sec. 3	<i>October 1, 2023</i>	38a-591d
Sec. 4	<i>October 1, 2023</i>	38a-490
Sec. 5	<i>October 1, 2023</i>	38a-516
Sec. 6	<i>October 1, 2023</i>	38a-510(a)
Sec. 7	<i>October 1, 2023</i>	38a-544(a)
Sec. 8	<i>October 1, 2023</i>	New section

Statement of Purpose:

To: (1) Establish a utilization review exemption standard for certain participating providers; (2) require that each health carrier process

utilization review requests more efficiently; (3) require that each health carrier develop an electronic prior authorization process; (4) extend the time period within which an insured shall provide notice of the birth of a newborn and pay any required premium or subscription fee to continue the newborn's coverage beyond such period; (5) prohibit health carriers from requiring the use of step therapy for drugs prescribed to treat behavioral health conditions or chronic, disabling or life-threatening conditions or diseases; and (6) to prohibit health carriers from requiring utilization review of a health care service or prescription drug after it has been certified through utilization review.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. DUFF, 25th Dist.
SEN. ANWAR, 3rd Dist.; SEN. CABRERA, 17th Dist.
SEN. COHEN, 12th Dist.; SEN. FLEXER, 29th Dist.
SEN. FONFARA, 1st Dist.; SEN. GASTON, 23rd Dist.
SEN. HOCHADEL, 13th Dist.; SEN. KUSHNER, 24th Dist.
SEN. LESSER, 9th Dist.; SEN. LOPES, 6th Dist.
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SEN. WINFIELD, 10th Dist.; REP. NOLAN, 39th Dist.
REP. ELLIOTT, 88th Dist.

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