General Assembly

Amendment

January Session, 2023

LCO No. **8168**

Offered by:
SEN. LOONEY, 11th Dist.
SEN. CABRERA, 17th Dist.
SEN. MARX, 20th Dist.

To: Senate Bill No. **6** File No. 337 Cal. No. 197

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

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

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 Section 38a-591a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

As used in this section, **[**and**]** sections 38a-591b to 38a-591n, inclusive, and section 2 of this act:

(1) "Adverse determination" means:

(A) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's

treating health care professional, based on a determination by a health carrier or its designee utilization review company:

(i) That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or (II) is determined to be experimental or investigational;

(ii) Of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(B) Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional.

"Adverse determination" includes a rescission of coverage determination for grievance purposes.

(2) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person for the purposes of this section and sections 38a-591b to 38a-591n, inclusive;

(B) A person authorized by law to provide substituted consent for a covered person;

(C) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(D) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(E) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

(3) "Best evidence" means evidence based on (A) randomized clinical trials, (B) if randomized clinical trials are not available, cohort studies or case-control studies, (C) if such trials and studies are not available, case-series, or (D) if such trials, studies and case-series are not available, expert opinion.

(4) "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(5) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(6) "Certification" means a determination by a health carrier or its designee utilization review company that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(7) "Clinical peer" means a physician or other health care professional who (A) holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and (B) for a review specified under subparagraph (B) or (C) of subdivision (38) of this section concerning (i) a child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or (ii) an adult substance use disorder or an adult mental disorder, holds (I) a national board certification in psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or

adult mental disorders, as applicable.

(8) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

(9) "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or specific interventions.

(10) "Commissioner" means the Insurance Commissioner.

(11) "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting, including home care.

(12) "Covered benefits" or "benefits" means health care services to which a covered person is entitled under the terms of a health benefit plan.

(13) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

(14) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(15) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

(16) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on an overall systematic review of medical research when making determinations about the care of individual patients.

(17) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

(18) "Facility" means an institution providing health care services or a health care setting. "Facility" includes a hospital and other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing center, residential treatment center, diagnostic, laboratory and imaging center, and rehabilitation and other therapeutic health care setting.

(19) "Final adverse determination" means an adverse determination (A) that has been upheld by the health carrier at the completion of its internal grievance process, or (B) for which the internal grievance process has been deemed exhausted.

(20) "Grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding:

(A) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(B) Claims payment, handling or reimbursement for health care services; or

(C) Any matter pertaining to the contractual relationship between a covered person and a health carrier.

(21) (A) "Health benefit plan" means an insurance policy or contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5) to (9), inclusive, (14) and (15) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

(viii) Other insurance coverage similar to the coverages specified in subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) (I) Limited scope dental or vision benefits, (II) benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, or (III) other similar, limited benefits

specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, provided any benefits specified in subparagraphs (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided under a separate insurance policy, certificate or contract and are not otherwise an integral part of a health benefit plan; or

(x) Coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (I) they are provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor.

(22) "Health care center" has the same meaning as provided in section 38a-175.

(23) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(24) "Health care services" has the same meaning as provided in section 38a-478.

(25) "Health carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health care center, a managed care organization, a hospital service corporation, a medical service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

(26) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information

about events or relationships that relate to (A) the past, present or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family, (B) the provision of health care services to a covered person, or (C) payment for the provision of health care services to a covered person.

(27) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations. Such review entities include, but are not limited to, medical peer review organizations, independent utilization review companies, provided such organizations or companies are not related to or associated with any health carrier, and nationally recognized health experts or institutions approved by the Insurance Commissioner.

(28) "Medical or scientific evidence" means evidence found in the following sources:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) or Elsevier Science for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the Secretary of the United States Department of Health and Human Services under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: (i) The American Hospital Formulary Service - Drug Information; (ii) Drug Facts and

Comparisons; (iii) The American Dental Association's Accepted Dental Therapeutics; and (iv) The United States Pharmacopoeia - Drug Information;

(E) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: (i) The Agency for Healthcare Research and Quality; (ii) the National Institutes of Health; (iii) the National Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers for Medicare and Medicaid Services; (vi) the Food and Drug Administration; and (vii) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(F) Any other findings, studies or research conducted by or under the auspices of a source comparable to those listed in subparagraphs (E)(i) to (E)(v), inclusive, of this subdivision.

(29) "Medical necessity" has the same meaning as provided in sections 38a-482a and 38a-513c.

(30) "Participating provider" means a health care professional who, under a contract with the health carrier, its contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment or reimbursement directly or indirectly from the health carrier, other than coinsurance, copayments or deductibles.

(31) "Person" has the same meaning as provided in section 38a-1.

(32) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment, in accordance with a health carrier's requirement that such service or treatment be approved, in whole or in part, prior to such service's or treatment's provision.

(33) "Protected health information" means health information (A) that

identifies an individual who is the subject of the information, or (B) for which there is a reasonable basis to believe that such information could be used to identify such individual.

(34) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study, with only the experimental group of patients receiving a specific intervention, and that includes study of the groups for variables and anticipated outcomes over time.

(35) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if (A) such cancellation or discontinuance has a prospective effect only, or (B) such cancellation or discontinuance is effective retroactively to the extent it is attributable to the covered person's failure to timely pay required premiums or contributions towards the cost of such coverage.

(36) "Retrospective review" means any review of a request for a benefit that is not a prospective review or concurrent review. "Retrospective review" does not include a review of a request that is limited to the veracity of documentation or the accuracy of coding.

(37) "Stabilize" means, with respect to an emergency medical condition, that (A) no material deterioration of such condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or (B) with respect to a pregnant woman, the woman has delivered, including the placenta.

(38) "Urgent care request" means a request for a health care service or course of treatment (A) for which the time period for making a non-urgent care request determination (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (ii) in the opinion of a health care professional with knowledge of the covered person's medical condition,

would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested, or (B) for a substance use disorder, as described in section 17a-458, or for a co-occurring mental disorder, or (C) for a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, as defined in section 38a-496, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

(39) "Utilization review" means the use of a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy or efficiency of, health care services, health care procedures or health care settings. Such techniques may include the monitoring of or evaluation of (A) health care services performed or provided in an outpatient setting, (B) the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility, (C) opportunities or requirements to obtain a clinical evaluation by a health care professional other than the one originally making a recommendation for a proposed health care service, (D) coordinated sets of activities conducted for individual patient management of serious, complicated, protracted or other health conditions, or (E) prospective review, concurrent review, retrospective review or certification.

(40) "Utilization review company" means an entity that conducts utilization review.

Sec. 2. (NEW) (*Effective January 1, 2024*) No health carrier shall require a prospective or concurrent review of a recurring prescription drug to treat any autoimmune disorder, multiple sclerosis or cancer after such health carrier has certified such prescription drug through utilization review. Nothing in this section shall require a health carrier to cover any prescription drug to treat any autoimmune disorder, multiple sclerosis or cancer if the terms of coverage completely exclude such prescription drug from the policy's covered benefits, or cover a brand name drug

when an equivalent generic drug is available.

Sec. 3. Section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

(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, as amended by this act, 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**]** seven calendar days 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) (A) The time **[**periods**]** period specified in **[**subdivisions (1) and (2)**]** subdivision (1) of this subsection may be extended once by the health carrier for up to **[**fifteen**]** five calendar days, and the time period specified in subdivision (2) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the health

carrier:

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

[(B)**]** (ii) 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.

(B) Notwithstanding the provisions of subparagraph (A) of subdivision (3) of this subsection, the time period specified in subdivision (1) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the covered person's health care professional notifies the health carrier that the service will not be performed for at least three months from the date such health carrier received the request.

(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, as amended by this act, 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. For a nonurgent prospective or concurrent review request, each health carrier shall acknowledge receipt of each such request as soon as practicable, but not later than twenty-four hours after the health carrier receives such 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**]** three 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 January 1, 2024*):

(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**]** ninety-one days after the date of birth 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 January 1, 2024*):

(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**]** ninety-one days after the date of birth 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 January 1, 2024*):

(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) for any prescribed drug for longer than **[**sixty**]** thirty days, **[**or**]** (B) for a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications, or (C) for the period commencing January 1, 2024, and ending January 1, 2027, inclusive, for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(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) or (C) 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 January 1, 2024*):

(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) for any prescribed drug for longer than **[**sixty**]** thirty days, **[**or**]** (B) for a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications, or (C) for the period commencing January 1, 2024, and ending January 1, 2027, inclusive, for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(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) or (C) 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. (*Effective from passage*) (a) There is established a task force to study data collection efforts regarding step therapy. Such study shall include, but need not be limited to, data collection regarding step therapy edits, rejections and appeals of behavioral health drugs and the best methods to collect such data.

(b) The task force shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall be a health care provider with expertise in mental health;

(2) One appointed by the president pro tempore of the Senate, who shall be a health care provider with expertise in mental health;

(3) One appointed by the minority leader of the House of Representatives, who shall be a pharmacist licensed under chapter 400j of the general statutes;

(4) One appointed by the minority leader of the Senate, who shall be a representative of the pharmaceutical manufacturing industry;

(5) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance, or their designees;

(6) The executive director of the Office of Health Strategy, or the executive director's designee;

(7) The Insurance Commissioner, or the commissioner's designee;

(8) The Commissioner of Consumer Protection, or the commissioner's designee;

(9) One representative of the insurance industry, to be appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(10) One representative of the insurance industry, to be appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(11) One representative of the pharmaceutical industry, to be appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(12) One representative of the pharmaceutical industry, to be appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(13) One mental health care provider, to be appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(14) One mental health care provider, to be appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(15) One representative of a mental health advocacy group, who shall be an impacted individual, to be appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health; and

(16) One representative of a mental health advocacy group, who shall be an impacted individual, to be appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(c) All initial appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(f) Not later than February 1, 2024, the task force shall submit a report on its findings and recommendations concerning subsection (a) of this section to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or on February 1, 2024, whichever is earlier.

Sec. 9. Section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) On or before May first of each year, each managed care organization shall submit to the commissioner:

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a format prescribed by the commissioner and in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) a list of health care services that required prior authorization in the prior calendar year; (E) the percentage of services that required prior authorization in the prior calendar year compared to the total overall number of services covered in the prior calendar year; (F) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; **[**(E)**]** (G) the percentage of those employers or groups that renew their contracts within the previous twelve months; and **[**(F)**]** (H) notwithstanding the provisions of this subsection, on or before July first of each year, all data required by the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set. If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph **[**(F)**]** (H) of this subdivision;

(2) A model contract that contains the provisions currently in force in contracts between the managed care organization and preferred provider networks in this state, and the managed care organization and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary fee schedule information;

(3) A written statement of the types of financial arrangements or contractual provisions that the managed care organization has with hospitals, utilization review companies, physicians, preferred provider networks and any other health care providers including, but not limited to, compensation based on a fee-for-service arrangement, a risk-sharing arrangement or a capitated risk arrangement;

(4) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l*, as amended by this act. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this subsection, including any change in a plan's rates over the prior three years, its state medical loss ratio and its federal medical loss ratio, as both terms are defined in section 38a-478*l*, as amended by this act, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and specialty care provider, the percentage of primary and specialty care providers who are board certified, and how the medical protocols incorporate input as required

in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner;

(5) A summary of the procedures used by managed care organizations to credential providers; **[**and**]**

(6) A report on claims denial data for lives covered in the state for the prior calendar year, in a format prescribed by the commissioner, that includes: (A) The total number of claims received; (B) the total number of claims denied; (C) the total number of denials that were appealed; (D) the total number of denials that were reversed upon appeal; (E) (i) the reasons for the denials, including, but not limited to, "not a covered benefit", "not medically necessary" and "not an eligible enrollee", (ii) the total number of times each reason was used, and (iii) the percentage of the total number of denials each reason was used; and (F) other information the commissioner deems necessary; and

(7) A report, in a format prescribed by the commissioner, that contains a summary of (A) the actuarial analysis utilized in setting the standards for any procedures subject to prior authorization in the prior calendar year, and (B) any estimated premium savings that resulted from prior authorization and other utilization review protocols used in the prior calendar year.

(b) The information required pursuant to subsection (a) of this section shall be consistent with the data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS).

(c) The commissioner may accept electronic filing for any of the requirements under this section and may revise such filing

requirements to facilitate implementation of the provisions of subdivision (1) of subsection (a) of this section.

(d) No managed care organization shall be liable for a claim arising out of the submission of any information concerning complaints concerning providers, provided the managed care organization submitted the information in good faith.

(e) The information required under subdivision (6) of subsection (a) of this section shall be posted on the Insurance Department's Internet web site.

Sec. 10. Section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Not later than October fifteenth of each year, the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall develop and distribute a consumer report card on all managed care organizations. The commissioner shall develop the consumer report card in a manner permitting consumer comparison across organizations.

(b) (1) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include (A) all health care centers licensed pursuant to chapter 698a, (B) the fifteen largest licensed health insurers that use provider networks and that are not included in subparagraph (A) of this subdivision, (C) the state medical loss ratio of each such health care center or licensed health insurer, (D) the federal medical loss ratio of each such health care center or licensed health insurer, (E) the information required under **[**subdivision**]** subdivisions (6) and (7) of subsection (a) of section 38a-478c, as amended by this act, and (F) information concerning mental health services, as specified in subsection (c) of this section. The insurers selected pursuant to subparagraph (B) of this subdivision shall be selected on the basis of Connecticut direct written health premiums from such network plans.

(2) For the purposes of this section and sections 38a-477c, 38a-478c, as amended by this act, and 38a-478g:

(A) "State medical loss ratio" means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features;

(B) "Federal medical loss ratio" has the same meaning as provided in, and shall be calculated in accordance with, the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(c) With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay. Such data shall be collected in a manner consistent with the National Committee for Quality Assurance Health Plan Employer Data and Information Set measures.

(d) The commissioner shall test market a draft of the consumer report card prior to its publication and distribution. As a result of such test marketing, the commissioner may make any necessary modification to its form or substance. The Insurance Department shall prominently display a link to the consumer report card on the department's Internet web site.

(e) The commissioner shall analyze annually the data submitted under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of this section for the accuracy of, trends in and statistically significant differences in such data among the health care centers and licensed health insurers included in the consumer report card. The commissioner may investigate any such differences to determine whether further action by the commissioner is warranted.

Sec. 11. Section 38a-591c of the general statutes is amended by adding subsection (e) as follows (*Effective January 1, 2024*):

(NEW) (e) Each participating provider shall utilize a health carrier's electronic program that securely accommodates the processing of utilization review requests, provided such participating provider's failure to utilize such health carrier's electronic program shall not contribute to an adverse determination."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2023*	38a-591a
Sec. 2	*January 1, 2024*	New section
Sec. 3	*January 1, 2024*	38a-591d
Sec. 4	*January 1, 2024*	38a-490
Sec. 5	*January 1, 2024*	38a-516
Sec. 6	*January 1, 2024*	38a-510(a)
Sec. 7	*January 1, 2024*	38a-544(a)
Sec. 8	*from passage*	New section
Sec. 9	*October 1, 2023*	38a-478c
Sec. 10	*October 1, 2023*	38a-478*l*
Sec. 11	*January 1, 2024*	38a-591c(e)