General Assembly

Raised Bill No. 6586

January Session, 2021

LCO No. **3772**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING PRIOR AUTHORIZATIONS AND HEALTH CARE PROVIDER CONTRACTS.

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

Section 1. Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

Terms used in this title and sections 2 and 6 to 9, inclusive, of this act, unless it appears from the context to the contrary, shall have a scope and meaning as set forth in this section.

(1) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(2) "Alien insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of any jurisdiction or country without the United States.

(3) "Annuities" means all agreements to make periodical payments where the making or continuance of all or some of the series of the

payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life insurance.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control", "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the person.

(6) "Domestic insurer" means any insurer that has been chartered by, incorporated, organized or constituted within or under the laws of this state.

(7) "Domestic surplus lines insurer" means any domestic insurer that has been authorized by the commissioner to write surplus lines insurance.

(8) "Foreign country" means any jurisdiction not in any state, district or territory of the United States.

(9) "Foreign insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of another state or a territory of the United States.

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or

specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

(11) "Insurance" means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration.

(12) "Insurer" or "insurance company" includes any person or combination of persons doing any kind or form of insurance business other than a fraternal benefit society, and shall include a receiver of any insurer when the context reasonably permits.

(13) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy. The term includes policyholders, subscribers, members and beneficiaries. This definition applies only to the provisions of this title and does not define the meaning of this word as used in insurance policies or certificates.

(14) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life. The business of life insurance includes granting endowment benefits, granting additional benefits in the event of death by accident or accidental means, granting additional benefits in the event of the total and permanent disability of the insured, and providing optional methods of settlement of proceeds. Life insurance includes burial contracts to the extent provided by section 38a-464.

(15) "Mutual insurer" means any insurer without capital stock, the managing directors or officers of which are elected by its members.

(16) "Person" means an individual, a corporation, a partnership, a limited liability company, an association, a joint stock company, a business trust, an unincorporated organization or other legal entity.

(17) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

(18) "State" means any state, district, or territory of the United States.

(19) "Subsidiary" of a specified person means an affiliate controlled by the person directly, or indirectly through one or more intermediaries.

(20) "Unauthorized insurer" or "nonadmitted insurer" means an insurer that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state or an insurer transacting business not authorized by a valid certificate.

(21) "United States" means the United States of America, its territories and possessions, the Commonwealth of Puerto Rico and the District of Columbia.

Sec. 2. (NEW) (*Effective October 1, 2021*) (a) For the purposes of this section, "covered benefit", "covered person", "facility", "health benefit plan", "health care professional" and "health carrier" have the same meanings as provided in section 38a-591a of the general statutes, as amended by this act.

(b) Each contract entered into, renewed, amended or continued on or after July 1, 2022, between a health carrier and a facility or health care professional shall:

(1) Require the health carrier to reimburse the facility or health care professional for all medically necessary covered benefits that such facility or health care professional provides to covered persons participating in the health benefit plans delivered, issued for delivery, renewed, amended or continued by such health carrier;

(2) Provide that if the health carrier denies coverage for any health care services that the facility or health care professional provides to a covered person, or refuses to reimburse such facility or health care professional for such health care services, because such health carrier determines that such facility or health care professional failed to comply with such health carrier's notification and prior authorization policies, or that such health carrier has no record of issuing a prior authorization, for such health care services:

(A) Such facility or health care professional may, not later than eighteen months after such denial or refusal, submit a request to such health carrier requesting that such health carrier reconsider such determination and provide such coverage and issue such reimbursement;

(B) Such health carrier shall reverse such determination and provide such coverage and issue such reimbursement if the request submitted pursuant to subparagraph (A) of this subdivision demonstrates that:

(i) The facility or health care professional that submitted such request:

(I) Complied with such health carrier's notification and prior authorization policies for the health care services that are the subject of such request; or

(II) Did not know, or was unable to determine after making reasonable efforts, that the patient who received such health care services was a covered person but promptly submitted a claim for such health care services after such facility or health care professional determined that such patient was a covered person; or

(ii) The facility or health care professional that submitted such request demonstrates that the health care services that are the subject of such request were:

(I) Medically necessary covered benefits; or

(II) At the time that such facility or health care professional provided

such health care services, the most clinically appropriate health care services for the patient and, if applicable, approved by the American Medical Association or federal Food and Drug Administration; and

(3) Provide that the facility or health care professional may collect payment from a covered person participating in the health benefit plans delivered, issued for delivery, renewed, amended or continued by such health carrier to whom such facility or health care professional provides health care services if the health carrier determines, through such health carrier's prior authorization process, that such health care services are not medically necessary.

Sec. 3. Section 38a-472g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) (A) No insurer, health care center, fraternal benefit society, hospital service corporation or medical service corporation or other entity, delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 or utilization review company performing utilization review for such insurer, center, society, corporation or entity, that issues prior authorization for or precertifies, on or after January 1, 2012, an admission, service, procedure or extension of stay shall reverse or rescind such prior authorization or precertification or refuse to pay for such admission, service, procedure or extension of stay if:

[(A)**]** (i) Such insurer, center, society, corporation, entity or company failed to notify the insured's or enrollee's health care provider at least three business days prior to the scheduled date of such admission, service, procedure or extension of stay that such prior authorization or precertification has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage; and

[(B)**]** (ii) Such admission, service, procedure or extension of stay has taken place in reliance on such prior authorization or precertification.

[(2)**]** (B) The provisions of this **[**subsection**]** subdivision shall apply regardless of whether such prior authorization or precertification is required or is requested by an insured's or enrollee's health care provider. Unless reversed or rescinded as set forth in subparagraph **[**(A)**]** (A)(i) of this subdivision, **[**(1) of this subsection,**]** such prior authorization or precertification shall be effective for not less than sixty days from the date of issuance.

[(b)**]** (2) Nothing in subdivision (1) of this subsection **[**(a) of this section**]** shall be construed to authorize benefits or services in excess of those that are provided for in the insured's or enrollee's policy or contract.

[(c)**]** (3) Nothing in subdivision (1) of this subsection **[**(a) of this section**]** shall affect the provisions of subsection (b) of section 38a-479b.

(b) (1) On and after January 1, 2022, no health carrier, and no preferred provider network or utilization review company performing utilization review for the health carrier, shall require prior authorization for:

(A) A surgical or other invasive procedure performed during the perioperative period of another surgical or other invasive procedure for which the health carrier has issued a prior authorization; or

(B) A discharge or transfer of a covered person from a hospital to a nursing home following a hospital admission, emergency room visit or observation stay if the covered person resided in the nursing home before the hospital admission, emergency room visit or observation stay.

(2) Each health carrier, and any preferred provider network or utilization review company performing utilization review for such health carrier, shall make a decision, and notify the hospital of its decision, on a prior authorization request filed by a hospital on or after January 1, 2022, for post-stabilization and maintenance services not later than one hour after such hospital filed such prior authorization request.

Any health carrier, preferred provider network or utilization review company that fails to timely make a decision, and notify a hospital, under this subdivision shall be financially responsible for the post-stabilization and maintenance services that the hospital provides to the covered person until such time as the hospital receives notice of such decision. Payment for such post-stabilization and maintenance services shall consist of a per diem payment that is equal to the per diem usual, customary and reasonable rate for such post-stabilization and maintenance services, within the meaning of section 38a-477aa, or the per diem amount that Medicare would reimburse for such post-stabilization and maintenance services, whichever is greater.

(3) For the purposes of this subsection, "prior authorization" has the same meaning as provided in section 38a-591a, as amended by this act.

Sec. 4. Section 38a-477g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a, as amended by this act, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f.

(b) (1) Each contract entered into, renewed or amended on or after January 1, 2017, between a health carrier and a participating provider shall include:

(A) A hold harmless provision that specifies protections for covered persons. Such provision shall include the following statement or a substantially similar statement: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the

health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.";

(B) A provision that in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in subdivision (2) of subsection (g) of section 38a-472f, or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled;

(C) (i) A provision that requires the participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons, and (ii) a statement that

such participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records; and

(D) **[**Definitions**]** (i) If such contract is entered into, renewed or amended before July 1, 2022, definitions of what is considered timely notice and a material change for the purposes of subparagraph (A) of subdivision (2) of subsection (c) of this section, or (ii) if such contract is entered into, renewed or amended on or after July 1, 2022, (I) a statement disclosing the ninety-day advance written notice requirement established under subparagraph (B) of subdivision (2) of subsection (c) of this section and what is considered a material change for the purposes of subdivision (2) of subsection (c) of this section, and (II) provisions affording the participating provider a right to appeal any proposed change to the provisions, other documents, provider manuals or policies disclosed pursuant to subdivision (1) of subsection (c) of this section.

(2) The contract terms set forth in subparagraphs (A) and (B) of subdivision (1) of this subsection shall (A) be construed in favor of the covered person, (B) survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health carrier, and (C) supersede any oral or written agreement between a health care provider and a covered person or a covered person's authorized representative that is contrary to or inconsistent with the requirements set forth in subdivision (1) of this subsection.

(3) No contract subject to this subsection shall include any provision that conflicts with the provisions contained in the network plan or required under this section, section 38a-472f or section 38a-477h.

(4) No health carrier or participating provider that is a party to a contract under this subsection shall assign or delegate any right or responsibility required under such contract without the prior written consent of the other party.

(c) (1) At the time a contract subject to subsection (b) of this section is

signed, the health carrier or such health carrier's intermediary shall disclose to a participating provider: **[**all**]**

(A) All provisions and other documents incorporated by reference in such contract; and

(B) If such contract is entered into, renewed or amended on or after July 1, 2022, all provider manuals and policies incorporated by reference in such contract, if any.

(2) While such contract is in force, the health carrier shall:

(A) If such contract is entered into, renewed or amended before July 1, 2022, timely notify a participating provider of any change to **[**such**]** the provisions or other documents specified under subparagraph (A) of subdivision (1) of this subsection that will result in a material change to such contract; or

(B) If such contract is entered into, renewed or amended on or after July 1, 2022, provide to a participating provider at least ninety days' advance written notice of any change to the provisions or other documents specified under subparagraph (A) of subdivision (1) of this subsection, and any change to the provider manuals and policies specified under subparagraph (B) of subdivision (1) of this subsection, that will result in a material change to such contract or the procedures that a participating provider must follow pursuant to such contract.

(d) (1) (A) Each contract between a health carrier and an intermediary entered into, renewed or amended on or after January 1, 2017, shall satisfy the requirements of this subsection.

(B) Each intermediary and participating providers with whom such intermediary contracts shall comply with the applicable requirements of this subsection.

(2) No health carrier shall assign or delegate to an intermediary such health carrier's responsibilities to monitor the offering of covered benefits to covered persons. To the extent a health carrier assigns or

delegates to an intermediary other responsibilities, such health carrier shall retain full responsibility for such intermediary's compliance with the requirements of this section.

(3) A health carrier shall have the right to approve or disapprove the participation status of a health care provider or facility in such health carrier's own or a contracted network that is subcontracted for the purpose of providing covered benefits to the health carrier's covered persons.

(4) A health carrier shall maintain at its principal place of business in this state copies of all intermediary subcontracts or ensure that such health carrier has access to all such subcontracts. Such health carrier shall have the right, upon twenty days' prior written notice, to make copies of any intermediary subcontracts to facilitate regulatory review.

(5) (A) Each intermediary shall, if applicable, (i) transmit to the health carrier documentation of health care services utilization and claims paid, and (ii) maintain at its principal place of business in this state, for a period of time prescribed by the commissioner, the books, records, financial information and documentation of health care services received by covered persons, in a manner that facilitates regulatory review, and shall allow the commissioner access to such books, records, financial information and documentation as necessary for the commissioner to determine compliance with this section and section 38a-472f.

(B) Each health carrier shall monitor the timeliness and appropriateness of payments made by its intermediary to participating providers and of health care services received by covered persons.

(6) In the event of the intermediary's insolvency, a health carrier shall have the right to require the assignment to the health carrier of the provisions of a participating provider's contract that address such participating provider's obligation to provide covered benefits. If a health carrier requires such assignment, such health carrier shall remain obligated to pay the participating provider for providing covered

benefits under the same terms and conditions as the intermediary prior to the insolvency.

(e) The commissioner shall not act to arbitrate, mediate or settle (1) disputes regarding a health carrier's decision not to include a health care provider or facility in such health carrier's network or network plan, or (2) any other dispute between a health carrier, such health carrier's intermediary or one or more participating providers, that arises under or by reason of a participating provider contract or the termination of such contract.

Sec. 5. Section 38a-591a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

As used in this section and sections 38a-591b to 38a-591n, inclusive, as amended by this act, and sections 6 to 9, inclusive, 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, including, but not limited to, any prior authorization 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, as amended by this act;

(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)**]** (41) 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)**]** (10) "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"**]** (11) "Covered benefit" or "benefit" means a health care **[**services**]** service to which a covered person is entitled under the terms of a health benefit plan.

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

[(14)**]** (13) "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)**]** (14) "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)**]** (15) "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)**]** (16) "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)**]** (17) "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)**]** (18) "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 review of a prior authorization appeal, or (B) for which the internal grievance process or prior authorization appeal process has been deemed exhausted.

[(20)**]** (19) "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)**]** (20) (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)**]** (21) "Health care center" has the same meaning as provided in section 38a-175.

[(23)**]** (22) "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)**]** (23) "Health care services" has the same meaning as provided in section 38a-478.

[(25)**]** (24) "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)**]** (25) "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.

(26) "Hospital" has the same meaning as provided in section 19a-490.

(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**]** 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.**]**

(31) "Preferred provider network" has the same meaning as provided in section 38a-479aa.

(32) "Prior authorization" means any form of prospective review or concurrent review, or other form of prior approval or precertification, that a health carrier requires for (A) an inpatient hospital admission, laboratory test, procedure, service, surgery, treatment, continued hospital stay or other health care service provided to a covered person when the covered person has received emergency services at a hospital but has not been discharged from the hospital, or (B) a hospital to discharge or transfer a covered person to a skilled nursing center following an inpatient admission to, or observation stay or provision of a covered benefit to the covered person at, the hospital.

(33) "Prior authorization appeal" means an appeal that a health care professional or hospital files with a health carrier to challenge an adverse determination that involves a prior authorization request.

[(32)**]** (34) "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)**]** (35) "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)**]** (36) "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)**]** (37) (A) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(B) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if: **[**(A) such**]**

(i) Such cancellation or discontinuance has a prospective effect only; **[**,**]** or **[**(B) such**]**

(ii) 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)**]** (38) (A) "Retrospective review" means any review of a request for a benefit that is not a prospective review or concurrent review.

(B) "Retrospective review" does not include a review of a request that is limited to the veracity of documentation or the accuracy of coding.

(39) "Skilled nursing center" means a nursing home or nursing home facility, as such terms are defined in section 19a-490.

[(37)**]** (40) "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)**]** (41) "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)**]** (42) "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 or prior authorization.

[(40)**]** (43) "Utilization review company" means an entity that

conducts utilization review.

Sec. 6. (NEW) (*Effective October 1, 2021*) (a) (1) Except as provided in subdivision (3) of this subsection, each health carrier shall, not later than June 1, 2023, and annually thereafter, submit to the commissioner, in a form and manner prescribed by the commissioner, a report disclosing the following information for each type of health insurance product that such health carrier offered in this state for the prior calendar year:

(A) The number of prior authorization requests that such health carrier received;

(B) The number and percentage of prior authorization requests that such health carrier approved;

(C) The number and percentage of prior authorization requests that such health carrier initially denied and were the subject of a prior authorization appeal;

(D) The number and percentage of prior authorization requests that such health carrier initially denied but subsequently approved following a prior authorization appeal;

(E) The average and median number of hours that elapsed between such health carrier's receipt of a prior authorization request and response thereto; and

(F) Such other information that the commissioner, in the commissioner's discretion, reasonably requires to carry out the purposes of this section.

(2) Each health carrier shall disclose the information required under subdivision (1) of this subsection:

(A) In the aggregate for each type of health insurance product that such health carrier offered, with a breakdown for each type of covered benefit; and

(B) Separately for each hospital that provided a covered benefit under a health insurance product that such health carrier offered, with a breakdown for each type of covered benefit.

(3) No managed care organization that is required to include the information required under subdivision (1) of this subsection in such managed care organization's annual report to the commissioner pursuant to section 38a-478c of the general statutes, as amended by this act, shall be required to submit a report to the commissioner pursuant to this subsection.

(b) Each health carrier that submits an annual report to the commissioner pursuant to subsection (a) of this section shall make a copy of such report publicly available on such health carrier's Internet web site, and disclose the address of such Internet web site in such health carrier's enrollment materials.

Sec. 7. (NEW) (*Effective October 1, 2021*) (a) Not later than January 1, 2024, the commissioner shall convene a working group, which shall consist of the commissioner, or the commissioner's designee, and four individuals appointed by the commissioner, two of whom shall represent the interests of health carriers and two of whom shall represent the interests of hospitals. The working group shall:

(1) Review the information included in the annual reports submitted to the commissioner pursuant to subsection (a) of section 6 of this act and subdivision (7) of subsection (a) of section 38a-478c of the general statutes, as amended by this act, for the prior calendar year; and

(2) Identify the types of health care services for which health carriers required prior authorization during, and the trends in prior authorization approvals and denials for, the prior calendar year.

(b) Not later than December 31, 2024, the working group convened pursuant to subsection (a) of this section shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of

matters relating to insurance and public health. Such report shall include the working group's:

(1) Analysis of:

(A) The information described in subdivision (1) of subsection (a) of this section; and

(B) The health care services and trends described in subdivision (2) of subsection (a) of this section; and

(2) Recommendations concerning:

(A) The health care services for which prior authorization should be required;

(B) The clinical review criteria that should be applied in reviewing prior authorization requests; and

(C) Any other matters that the working group, in the working group's discretion, deems relevant for the purposes of this section.

Sec. 8. (NEW) (*Effective October 1, 2021*) (a) Not later than January 1, 2024, the commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes:

(1) Establishing standards for the commissioner to determine what constitutes an inappropriate prior authorization delay and incorporate a review of each health carrier's compliance or noncompliance with such standards in audit and enforcement processes for health carriers; and

(2) Requiring each health carrier that fails to satisfy the standards established pursuant to subdivision (1) of this subsection to submit to the commissioner, and successfully implement, a corrective action plan to ensure that such health carrier satisfies such standards.

(b) Notwithstanding any provision of the general statutes, no health carrier that fails to satisfy the standards established by the commissioner pursuant to subdivision (1) of subsection (a) of this section, or submit or

successfully implement a corrective action plan pursuant to subdivision (2) of subsection (a) of this section, shall be eligible to receive or renew any license issued by the commissioner.

Sec. 9. (NEW) (*Effective October 1, 2021*) (a) Not later than January 1, 2024, the commissioner shall develop, in consultation with hospitals and health care professionals, an annual health care provider satisfaction survey to determine hospital and health care professional satisfaction with health carrier prior authorization processes.

(b) Not later than January 1, 2024, and annually thereafter, the commissioner shall conduct the health care provider satisfaction survey developed by the commissioner pursuant to subsection (a) of this section and include the results of such survey in the consumer report card required under section 38a-478*l* of the general statutes, as amended by this act.

Sec. 10. Section 38a-591b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Sections 38a-591a to 38a-591n, inclusive, as amended by this act, shall apply to (1) any health carrier offering a health benefit plan and that provides or performs utilization review including prospective, concurrent or retrospective review benefit determinations or prior authorizations, and (2) any utilization review company or designee of a health carrier that performs utilization review on the health carrier's behalf, including prospective, concurrent or retrospective review benefit determinations or prior authorizations.

(b) Each health carrier shall be responsible for monitoring all utilization review program activities carried out by or on behalf of such health carrier. Such health carrier shall comply with the provisions of sections 38a-591a to 38a-591n, inclusive, as amended by this act, and any regulations adopted thereunder, and shall be responsible for ensuring that any utilization review company or other entity such health carrier contracts with to perform utilization review complies with said sections and regulations. Each health carrier shall ensure that appropriate

personnel have operational responsibility for the activities of the health carrier's utilization review program.

(c) (1) A health carrier that requires utilization review of a benefit request under a health benefit plan shall implement a utilization review program and develop a written document that describes all utilization review activities and procedures, whether or not delegated, for (A) the filing of benefit requests, (B) the notification to covered persons of utilization review and benefit determinations, and (C) the review of adverse determinations, **[**and**]** grievances and prior authorization appeals in accordance with sections 38a-591e, as amended by this act, and 38a-591f.

(2) Such document shall describe the following:

(A) Procedures to evaluate the medical necessity, appropriateness, health care setting, level of care or effectiveness of health care services;

(B) Data sources and clinical review criteria used in making determinations;

(C) Procedures to ensure consistent application of clinical review criteria and compatible determinations;

(D) Data collection processes and analytical methods used to assess utilization of health care services;

(E) Provisions to ensure the confidentiality of clinical, proprietary and protected health information;

(F) The health carrier's organizational mechanism, such as a utilization review committee or quality assurance or other committee, that periodically assesses the health carrier's utilization review program and reports to the health carrier's governing body; **[**and**]**

(G) The health carrier's procedures to ensure prompt consideration of prior authorization requests; and

[(G)**]** (H) The health carrier's staff position that is responsible for the day-to-day management of the utilization review program.

(d) Each health carrier shall:

(1) Include in the insurance policy, certificate of coverage or handbook provided to covered persons: **[**a clear and comprehensive description of:**]**

(A) **[**Its utilization**]** A clear and comprehensive description of:

(i) Its utilization review and benefit determination procedures;

[(B)**]** (ii) Its grievance procedures, including the grievance procedures for requesting a review of an adverse determination;

[(C) A description of the**]** (iii) The external review procedures set forth in section 38a-591g, as amended by this act, in a format prescribed by the commissioner and including a statement that discloses that:

[(i)**]** (I) A covered person may file a request for an external review of an adverse determination or a final adverse determination with the commissioner and that such review is available when the adverse determination or the final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. Such disclosure shall include the contact information of the commissioner; and

[(ii)**]** (II) When filing a request for an external review of an adverse determination or a final adverse determination, the covered person shall be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request;

(iv) What constitutes a surprise bill, as defined in section 38a-477aa; and

(v) The health carrier's prior authorization procedures; and

[(D)**]** (B) A statement of the rights and responsibilities of covered persons with respect to each of the procedures under subparagraphs **[**(A) to (C)**]** (A)(i) to (A)(iii), inclusive, of this subdivision. Such statement shall include a disclosure that a covered person has the right to contact the commissioner's office or the Office of Healthcare Advocate at any time for assistance and shall include the contact information for said offices;

[(E) A description of what constitutes a surprise bill, as defined in subsection (a) of section 38a-477aa;**]**

(2) Inform its covered persons, at the time of initial enrollment and at least annually thereafter, of its grievance procedures. This requirement may be fulfilled by including such procedures in an enrollment agreement or update to such agreement;

(3) Inform a covered person or the covered person's health care professional, as applicable, at the time the covered person or the covered person's health care professional requests a prospective or concurrent review:

(A) The network status under such covered person's health benefit plan of the health care professional who will be providing the health care service or course of treatment;

(B) **[**an**]** An estimate of the amount the health carrier will reimburse such health care professional for such service or treatment; and

(C) **[**how**]** How such amount compares to the usual, customary and reasonable charge, as determined by the Centers for Medicare and Medicaid Services, for such service or treatment;

(4) Inform a covered person and the covered person's health care professional of the health carrier's grievance procedures whenever the health carrier denies certification of a benefit requested by a covered person's health care professional;

(5) Prominently post on its Internet web site the description required

under subparagraph **[**(E)**]** (A)(iv) of subdivision (1) of this subsection;

(6) Include in materials intended for prospective covered persons a summary of its utilization review and benefit determination procedures;

(7) Print on its membership or identification cards a toll-free telephone number for utilization review and benefit determinations;

(8) Maintain records of all benefit requests, claims and notices associated with utilization review and benefit determinations made in accordance with section 38a-591d, as amended by this act, for not less than six years after such requests, claims and notices were made. Each health carrier shall make such records available for examination by the commissioner and appropriate federal oversight agencies upon request; and

(9) Maintain records in accordance with section 38a-591h, as amended by this act, of all grievances received. Each health carrier shall make such records available for examination by covered persons, to the extent such records are permitted to be disclosed by law, the commissioner and appropriate federal oversight agencies upon request.

Sec. 11. Section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

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

(2) (A) Each utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 38a-591b, as amended by this act, to assure such program's ongoing effectiveness.

(B) Except as provided in subdivisions (3), (4), **[**and**]** (5) and (6) of this subsection, a health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner, provided such clinical review criteria conform to the requirements of subparagraph (A) of this subdivision.

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

(3) For any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: (A) The most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of a substance use disorder, that are not covered in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

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

(5) For any utilization review for the treatment of an adult mental disorder, the clinical review criteria used shall be: (A) The most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare; or (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of an adult mental disorder, that are not covered in the most recent guidelines of the American Psychiatric Association or the most recent Standards

and Guidelines of the Association for Ambulatory Behavioral Healthcare. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

(6) For any utilization review involving a prior authorization request filed on or after March 1, 2022, each health carrier's clinical review criteria shall be based on the standardized clinical review criteria developed and established by the commissioner pursuant to subsection (e) of this section and implemented by such health carrier pursuant to subsection (f) of this section.

(b) Each health carrier shall:

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

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

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

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

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

review program.

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

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

(e) (1) Not later than January 1, 2022, the commissioner shall develop and establish:

(A) Technical standards for hospitals and health care professionals to electronically file prior authorization requests, and other requests for prospective or concurrent utilization reviews, with health carriers; and

(B) Standardized clinical review criteria for common services, treatments and procedures provided in hospitals in inpatient and outpatient settings.

(2) The commissioner shall develop the technical standards required under subparagraph (A) of subdivision (1) of this subsection in consultation with appropriate standard-setting organizations, hospitals, health care professionals, health carriers and health information

technology software vendors. Such technical standards shall include, but need not be limited to, standards to ensure that electronic prior authorization requests, and other electronic requests for prospective or concurrent utilization reviews, filed by hospitals and health care professionals with health carriers support attachments containing clinical information and can be integrated into existing electronic health record systems.

(3) The commissioner shall develop the standardized clinical review criteria required under subparagraph (B) of subdivision (1) of this subsection in consultation with hospitals, health care professionals and health carriers.

(f) (1) Not later than March 1, 2022, each health carrier shall establish an electronic program to provide for the secure electronic:

(A) (i) Filing of prior authorization requests, and other requests for prospective or concurrent utilization reviews, by hospitals and health care professionals with such health carrier, and (ii) submission of available clinical information in support of such requests; and

(B) Transmission of such health carrier's responses to the requests described in subparagraph (A) of this subdivision.

(2) Each electronic program established pursuant to subdivision (1) of this subsection shall comply with all standards developed and established by the commissioner pursuant to subsection (e) of this section.

(3) No facsimile, electronic form or proprietary health carrier portal that fails to comply with the technical standards developed and established by the commissioner pursuant to subsection (e) of this section shall be deemed to satisfy the provisions of this subsection.

(4) Each health carrier shall provide hospitals and health care professionals with access to such health carrier's criteria for making determinations on prior authorization requests and other requests for

prospective or concurrent utilization reviews, including, but not limited to, an itemization of any documentation such health carrier requires for such requests.

(5) Notwithstanding any provision of this subsection, no health carrier shall implement any technical or clinical standards pursuant to this subsection unless such health carrier has consulted with hospitals to facilitate seamless transmission and processing of requests for prior authorization or other requests for prospective or concurrent utilization reviews. Such consultations shall include, but need not be limited to, consultations concerning the ability of hospitals and health care professionals to submit clinical records and securely access electronic health information.

Sec. 12. Section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(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, (C) prior authorization determinations, and **[**(C)**]** (D) notifying covered persons or covered persons' authorized representatives or, in the case of prior authorization determinations, health care professionals or hospital representatives, as applicable, 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)**]** (41) 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, including, but not limited to, a prior authorization, or of a benefit request, the health carrier shall notify the covered person's health care professional or, with respect to a prior authorization, health care professional and hospital representative (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 or a covered person's health care professional and hospital representative, as applicable, of an initial adverse determination that was based, in whole or in part, on medical necessity, of a concurrent or prospective utilization review, including, but not limited to, a prior authorization, or of a benefit request, the health carrier shall offer a covered person's health care professional the opportunity to confer, at the request of the covered person's health care professional, with a clinical peer of such health carrier, provided such covered person, covered person's authorized representative or covered person's health care professional has not filed a grievance of such initial adverse determination prior to such conference. Such conference shall not be considered a grievance of such initial adverse determination.

(b) With respect to a nonurgent care request:

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

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

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

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

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

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

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

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

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

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

information.

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

(c) With respect to an urgent care request:

(1) (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than forty-eight 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 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)**]** (41) 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 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) With respect to prior authorization requests, each health carrier shall:

(A) Process prior authorization requests twenty-four hours a day, seven days a week including holidays;

(B) Designate a staff member to serve, during normal business hours, as the primary contact person for each hospital under contract with such health carrier;

(C) Respond to each prior authorization request immediately, and in no event later than one hour, following such health carrier's receipt of such prior authorization request, except such health carrier shall respond more quickly if a quicker response is required by applicable federal or state law; and

(D) Base such health carrier's response to each prior authorization request on information that (i) the health care professional or hospital submitted with such prior authorization request, and (ii) was reasonably available to such health care professional or hospital at the time that such health care professional or hospital filed such prior authorization request.

(2) No health carrier shall delay a decision on a prior authorization request by requiring a health care professional or hospital to submit additional information that was not reasonably available to the health care professional or hospital at the time that such health care professional or hospital filed the prior authorization request with such health carrier.

[(d)**]** (e) (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.

(2) If the health carrier provides such notice orally, the health carrier shall provide confirmation in writing to the covered person and the covered person's health care professional of record not later than five calendar days after providing the oral notice.

[(e)**]** (f) 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. If the adverse determination involves a prior authorization request, the health carrier shall also provide notice of such adverse determination to the covered person's health care professional or hospital representative.

(1) Such notice may be provided in writing or by electronic means, [and] except that if such notice is provided for an adverse determination that involves a prior authorization request, such notice shall also be provided to the covered person's health care professional or hospital representative in the manner in which the health care professional or hospital filed such prior authorization request, including through electronic means required under subsection (f) of section 38a-591c, as amended by this act. Such notice 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) A statement disclosing that a health care professional or hospital may appeal the health carrier's adverse determination if the adverse determination involves a prior authorization request that is subject to the provisions of section 38a-591e, as amended by this act, and that the prior authorization appeal shall not render the covered person, or the covered person's authorized representative, ineligible to pursue the health carrier's grievance procedures or any other legal remedy;

[(F)**]** (G) (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)**]** (H) 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)**]** (I) 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)**]** (J) A statement 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, as amended by this act.

[(f)**]** (g) 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, as amended by this act, and 38a-591f;

(4) A description of the health carrier's grievance procedures established under sections 38a-591e, as amended by this act, 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)**]** (h) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to making utilization review, including, but not limited to, prior authorization, 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, or, in the case of prior authorization, the health care professional or hospital shall be deemed to have exhausted the prior authorization appeal process of such health carrier and may file a request for an external review in accordance with the provisions of section 38a-591g, as amended by this act, 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 or a health care professional who, or hospital that, has exhausted the prior authorization appeal 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 or prior authorization appeals process that would yield a decision on the merits of the claim.

(i) If a health carrier, or a preferred provider network, utilization review company or other contractor acting on behalf of the health

carrier, determines, based on a future audit, that a prior authorization request should not have been approved, the health carrier, or the preferred provider network, utilization review company or other contractor acting on behalf of such health carrier, shall be prohibited from recouping payments made to a health care professional or hospital for any hospital admission, procedure, service, surgery or treatment that such health care professional or hospital provided pursuant to the previously approved prior authorization request until such time as such health care professional or hospital has fully exhausted all of such health care professional's or hospital's contractual and legal rights to appeal, or otherwise dispute, such recoupment.

Sec. 13. Section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) Each health carrier shall establish and maintain written procedures for (A) the review of grievances of adverse determinations that were based, in whole or in part, on medical necessity, (B) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests and expedited review of prior authorization appeals involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility, and (C) notifying covered persons or covered persons' authorized representatives or, for prior authorization requests, health care professionals or hospital representatives of such adverse determinations.

(2) Each health carrier shall file with the commissioner a copy of such procedures, including all forms used to process requests, and any subsequent material modifications to such procedures.

(3) In addition to a copy of such procedures, each health carrier shall file annually with the commissioner, in a form prescribed by the commissioner, a certificate of compliance stating that the health carrier has established and maintains grievance procedures and prior

authorization appeal procedures for each of its health benefit plans that are fully compliant with the provisions of sections 38a-591a to 38a-591n, inclusive, as amended by this act.

(b) (1) A covered person or a covered person's authorized representative may file a grievance of an adverse determination that was based, in whole or in part, on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the covered person's authorized representative, as applicable, receives the notice of an adverse determination.

(2) For prospective or concurrent urgent care requests, a covered person or a covered person's authorized representative or, for prior authorization requests, a health care professional or a hospital may make a request for an expedited review orally or in writing.

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) The clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized

representative, as applicable, or, in the case of a prior authorization appeal, to the health care professional or hospital any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, or, in the case of a prior authorization appeal, health care professional or hospital a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, or, in the case of a prior authorization appeal, health care professional or hospital by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of 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.

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative or, in the case of a prior authorization appeal, health care professional or hospital, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance or prior

authorization appeal;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance or prior authorization appeal;

(C) For expedited review requests, except as specified under subparagraph (D) of this subdivision, forty-eight hours after the health carrier receives the grievance or prior authorization appeal or seventy-two hours after such health carrier receives such grievance or prior authorization appeal if any portion of such forty-eight-hour period falls on a weekend; and

(D) For expedited review requests of a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision **[**(38)**]** (41) of section 38a-591a, as amended by this act, twenty-four hours after the health carrier receives the grievance or prior authorization appeal.

(2) The time periods set forth in subdivision (1) of this subsection shall apply regardless of whether all of the information necessary to make a decision accompanies the filing.

(e) (1) The notice required under subsection (d) of this section shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(A) The titles and qualifying credentials of the clinical peer or peers participating in the review process;

(B) Information sufficient to identify the claim involved with respect to the grievance or prior authorization appeal, including the date of service, if applicable, the health care professional and the claim amount;

(C) A statement of such clinical peer's or peers' understanding of the covered person's grievance or the prior authorization appeal;

(D) The clinical peer's or peers' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for such

decision in sufficient detail for the covered person or, in the case of a prior authorization appeal, health care professional or hospital to respond further to the health carrier's position;

(E) Reference to the evidence or documentation used as the basis for the decision;

(F) For a decision that upholds the adverse determination:

(i) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(ii) Reference to the specific health benefit plan provisions on which the decision is based;

(iii) A statement that the covered person or, in the case of a prior authorization appeal, health care professional or hospital may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, records, communications and other information and evidence not previously provided regarding the adverse determination under review;

(iv) If the final adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (I) the specific rule, guideline, protocol or other similar criterion, or (II) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the final adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person or, in the case of a prior authorization appeal, health care professional or hospital free of charge upon request and instructions for requesting such copy;

(v) If the final 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

final 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 or, in the case of a prior authorization appeal, health care professional or hospital free of charge upon request and instructions for requesting a copy of such explanation;

(vi) A statement describing the procedures for obtaining an external review of the final adverse determination;

(G) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(H) A statement disclosing the covered person's right to contact the commissioner's office or the Office of the Healthcare Advocate at any time. Such disclosure shall include the contact information for said offices.

(2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 38a-591n, as amended by this act.

(f) (1) Not later than January 1, 2022, the commissioner shall establish standardized procedures and deadlines for prior authorization appeals to enable hospitals and health care professionals to file expedited appeals of adverse determinations that involve a prior authorization request. Such standardized procedures shall, at a minimum:

(A) Require review by a health care professional who has undergone training that is the same as, or similar to, the training that the health care professional who files, or is involved in the particular procedure, service or treatment that is the subject of, the prior authorization request has undergone; and

(B) Provide an opportunity for review by a health care professional described in subparagraph (A) of this subdivision who is not affiliated with the health carrier.

(2) Each health carrier shall process prior authorization appeals in a timely manner.

(3) No prior authorization appeal shall limit the ability of a covered person, or the covered person's authorized representative, to dispute a prior authorization determination through the health carrier's grievance procedures or any other process authorized by law.

(4) Each contract between a health carrier and a health care professional or hospital that is entered into, renewed, amended or continued on or after January 1, 2022, shall include the standardized procedures and deadlines for prior authorization appeals established by the commissioner pursuant to subdivision (1) of this subsection.

[(f)**]** (g) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to receiving and resolving grievances or prior authorization appeals involving an adverse determination, the covered person or the health care professional or hospital, as applicable, shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that 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 or a health care professional or hospital, as applicable, 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. 14. Section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) A covered person or a covered person's authorized representative or, in the case of a prior authorization, a health care professional or a hospital may file a request for an external review or an expedited external review of an adverse determination or a final adverse determination in accordance with the provisions of this section. All requests for external review or expedited external review shall be made in writing to the commissioner. The commissioner may prescribe the form and content of such requests.

(2) (A) All requests for external review or expedited external review shall be accompanied by a filing fee of twenty-five dollars, except that no covered person or covered person's authorized representative shall pay more than seventy-five dollars in a calendar year for such covered person. Any filing fee paid by a covered person's authorized representative shall be deemed to have been paid by the covered person. If the commissioner finds that the covered person is indigent or unable to pay the filing fee, the commissioner shall waive such fee. Any such fees shall be deposited in the Insurance Fund established under section 38a-52a.

(B) The commissioner shall refund any paid filing fee to the covered person or the covered person's authorized representative, as applicable, or the health care professional or the hospital if the adverse determination or the final adverse determination that is the subject of the external review request or expedited external review request is reversed or revised.

(3) The health carrier that issued the adverse determination or the final adverse determination that is the subject of the external review request or the expedited external review request shall pay the independent review organization for the cost of conducting the review.

(4) An external review decision, whether such review is a standard external review or an expedited external review, shall be binding on the health carrier or a self-insured governmental plan and the covered person, except to the extent such health carrier or covered person has

other remedies available under federal or state law. A covered person or a covered person's authorized representative shall not file a subsequent request for an external review or an expedited external review that involves the same adverse determination or final adverse determination for which the covered person or the covered person's authorized representative already received an external review decision or an expedited external review decision.

(5) Each health carrier shall maintain written records of external reviews as set forth in section 38a-591h, as amended by this act.

(6) Each independent review organization shall maintain written records as set forth in subsection (e) of section 38a-591m.

(b) (1) Except as otherwise provided under subdivision (2) of this subsection or subsection (d) of this section: **[**, a**]**

(A) A covered person or a covered person's authorized representative shall not file a request for an external review or an expedited external review until the covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process; and

(B) A health care professional or a hospital shall not file a request for an external review or an expedited external review until the health care professional or hospital has exhausted the health carrier's prior authorization appeals process.

(2) A health carrier may waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external review or an expedited external review.

(c) (1) At the same time a health carrier sends to a covered person or a covered person's authorized representative or, in the case of a prior authorization, a health care professional or a hospital a written notice of an adverse determination or a final adverse determination issued by the health carrier, the health carrier shall include a written disclosure to the

covered person and, if applicable, the covered person's authorized representative or, in the case of a prior authorization, the health care professional or the hospital of the covered person's, health care professional's or hospital's right to request an external review.

(2) The written notice shall include:

(A) The following statement or a statement in substantially similar language: "We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.";

(B) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time period for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may (I) file a request for an expedited external review, or (II) file a request for an expedited external review if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; **[**and**]**

(ii) Such request for expedited external review may be filed at the same time the covered person or the covered person's authorized representative files a request for an expedited internal review of a

grievance involving an adverse determination, except that the independent review organization assigned to conduct the expedited external review shall determine whether the covered person shall be required to complete the expedited internal review of the grievance prior to conducting the expedited external review; and

(iii) In the case of an adverse determination that involves prior authorization, the health care professional or hospital may file a request for expedited external review in connection with the health carrier's adverse determination at the same time that the health care professional or hospital files a request for an expedited prior authorization appeal;

(C) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time period for completion of an external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or

(ii) If the final adverse determination concerns (I) a prior authorization or other approval for an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person, **[**or**]** the covered person's authorized representative, the health care professional or the hospital, as applicable, may file a request for an expedited external review, or (II) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may file a request for an expedited external review;

(D) (i) A copy of the description of both the standard and expedited external review procedures the health carrier is required to provide, highlighting the provisions in the external review procedures that give the covered person, **[**or**]** the covered person's authorized representative, the health care professional or the hospital, as applicable, the opportunity to submit additional information and including any forms used to process an external review or an expedited external review;

(ii) As part of any forms provided under subparagraph (D)(i) of this subdivision, an authorization form or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508, as amended from time to time, by which the covered person shall authorize the health carrier and the covered person's treating health care professional to release, transfer or otherwise divulge, in accordance with sections 38a-975 to 38a-999a, inclusive, the covered person's protected health information including medical records for purposes of conducting an external review or an expedited external review;

(E) A statement that the covered person or the covered person's authorized representative may request, free of charge, copies of all documents, communications, information and evidence regarding the adverse determination or the final adverse determination that were not previously provided to the covered person or the covered person's authorized representative.

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

(d) (1) A covered person or a covered person's authorized representative or, in the case of a prior authorization, a health care professional or a hospital may file a request for an expedited external review of an adverse determination or a final adverse determination with the commissioner, except that an expedited external review shall not be provided for a retrospective review request of an adverse

determination or a final adverse determination.

(2) Such request may be filed at the time the covered person receives:

(A) An adverse determination, if:

(i) (I) The covered person has a medical condition for which the time period for completion of an expedited internal review of the adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(II) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(ii) The covered person or the covered person's authorized representative has filed a request for an expedited internal review of the adverse determination; or

(B) A final adverse determination if:

(i) The covered person has a medical condition where the time period for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(ii) The final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility; or

(iii) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health

care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

(3) Such covered person or covered person's authorized representative shall not be required to file a request for an external review prior to, or at the same time as, the filing of a request for an expedited external review and shall not be precluded from filing a request for an external review, within the time periods set forth in subsection (e) of this section, if the request for an expedited external review is determined to be ineligible for such review.

(e) (1) Not later than one hundred twenty calendar days after a covered person or a covered person's authorized representative receives a notice of an adverse determination or a final adverse determination, the covered person or the covered person's authorized representative may file a request for an external review or an expedited external review with the commissioner in accordance with this section.

(2) Not later than one business day after the commissioner receives a request that is complete, the commissioner shall send a copy of such request to the health carrier that issued the adverse determination or the final adverse determination that is the subject of the request.

(3) Not later than five business days after the health carrier receives the copy of an external review request or one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

(A) The individual is or was a covered person under the health benefit plan at the time the health care service was requested or, in the case of an external review of a retrospective review request, was a covered person in the health benefit plan at the time the health care service was provided;

(B) The health care service that is the subject of the adverse

determination or the final adverse determination is a covered service under the covered person's health benefit plan but for the health carrier's determination that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(C) If the health care service or treatment is experimental or investigational:

(i) Is a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition;

(ii) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan;

(iii) The covered person's treating health care professional has certified that one of the following situations is applicable:

(I) Standard health care services or treatments have not been effective in improving the medical condition of the covered person;

(II) Standard health care services or treatments are not medically appropriate for the covered person; or

(III) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and

(iv) The covered person's treating health care professional:

(I) Has recommended a health care service or treatment that the health care professional certifies, in writing, is likely to be more beneficial to the covered person, in the health care professional's opinion, than any available standard health care services or treatments; or

(II) Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(D) The covered person has exhausted the health carrier's internal grievance process or the covered person or the covered person's authorized representative has filed a request for an expedited external review as provided under subsection (d) of this section; and

(E) The covered person has provided all the information and forms required to process an external review or an expedited external review, including an authorization form as set forth in subparagraph (D)(ii) of subdivision (2) of subsection (c) of this section.

(4) (A) Not later than one business day after the preliminary review of an external review request or the day the preliminary review of an expedited external review request is completed, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing whether the request for an external review or an expedited external review is complete and eligible for such review. The commissioner may specify the form for the health carrier's notice of initial determination under this subdivision and any supporting information required to be included in the notice.

(B) If the request:

(i) Is not complete, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are needed to perfect the request; or

(ii) Is not eligible for external review or expedited external review, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

(C) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the request for an external review or an expedited external review is ineligible for review may be appealed to the commissioner.

(D) Notwithstanding a health carrier's initial determination that a request for an external review or an expedited external review is ineligible for review, the commissioner may determine, pursuant to the terms of the covered person's health benefit plan, that such request is eligible for such review and assign an independent review organization to conduct such review. Any such review shall be conducted in accordance with this section.

(f) (1) Whenever the commissioner is notified pursuant to subparagraph (A) of subdivision (4) of subsection (e) of this section that a request is eligible for external review or expedited external review, the commissioner shall, not later than one business day after receiving such notice for an external review or one calendar day after receiving such notice for an expedited external review:

(A) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 38a-591*l* to conduct the review and notify the health carrier of the name of the assigned independent review organization. Such assignment shall be done on a random basis among those approved independent review organizations qualified to conduct the particular review based on the nature of the health care service that is the subject of the adverse determination or the final adverse determination and other circumstances, including conflict of interest concerns as set forth in section 38a-591m; and

(B) Notify the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the commissioner shall include in such notice (i) a statement that the covered person or the covered person's authorized representative may submit, not later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and (ii) where and how such additional information is to be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.

(2) Not later than five business days for an external review or one calendar day for an expedited external review, after the health carrier receives notice of the name of the assigned independent review organization from the commissioner, the health carrier or its designee utilization review company shall provide to the assigned independent review organization the documents and any information such health carrier or utilization review company considered in making the adverse determination or the final adverse determination.

(3) The failure of the health carrier or its designee utilization review company to provide the documents and information within the time specified in subdivision (2) of this subsection shall not delay the conducting of the review.

(4) (A) If the health carrier or its designee utilization review company fails to provide the documents and information within the time period specified in subdivision (2) of this subsection, the independent review organization may terminate the review and make a decision to reverse the adverse determination or the final adverse determination.

(B) Not later than one business day after terminating the review and making the decision to reverse the adverse determination or the final adverse determination, the independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of such decision.

(g) (1) The assigned independent review organization shall review all the information and documents received pursuant to subsection (f) of this section. In reaching a decision, the independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process.

(2) Not later than one business day after receiving any information submitted by the covered person or the covered person's authorized representative pursuant to subparagraph (B) of subdivision (1) of subsection (f) of this section, the independent review organization shall forward such information to the health carrier.

(3) (A) Upon the receipt of any information forwarded pursuant to subdivision (2) of this subsection, the health carrier may reconsider its adverse determination or the final adverse determination that is the subject of the review. Such reconsideration shall not delay or terminate the review.

(B) The independent review organization shall terminate the review if the health carrier decides, upon completion of its reconsideration and notice to such organization as provided in subparagraph (C) of this subdivision, to reverse its adverse determination or its final adverse determination and provide coverage or payment for the health care service or treatment that is the subject of the adverse determination or the final adverse determination.

(C) Not later than one business day after making the decision to reverse its adverse determination or its final adverse determination, the health carrier shall notify the commissioner, the assigned independent review organization, the covered person and, if applicable, the covered

person's authorized representative in writing of such decision.

(h) In addition to the documents and information received pursuant to subsection (f) of this section, the independent review organization shall consider, to the extent the documents or information are available and the independent review organization considers them appropriate, the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative or the covered person's treating health care professional;

(4) The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of coverage under such health benefit plan;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, medical boards or medical associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review company; and

(7) The opinion or opinions of the independent review organization's clinical peer or peers who conducted the review after considering subdivisions (1) to (6), inclusive, of this subsection.

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, except as specified under subparagraph (D) of this subdivision, as expeditiously as the covered person's medical condition requires, but not later than forty-eight hours after such organization receives the assignment from the commissioner to conduct such review or seventy-two hours after such organization receives such assignment if any portion of such forty-eight-hour period falls on a weekend;

(D) For expedited external reviews involving a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision **[**(38)**]** (41) of section 38a-591a, as amended by this act, as expeditiously as the covered person's medical condition requires, but not later than twenty-four hours after such organization receives the assignment from the commissioner to conduct such review; and

(E) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

(2) Such notice shall include:

(A) A general description of the reason for the request for the review;

(B) The date the independent review organization received the

assignment from the commissioner to conduct the review;

(C) The date the review was conducted;

(D) The date the organization made its decision;

(E) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were used as a basis for its decision;

(F) The rationale for the organization's decision;

(G) Reference to the evidence or documentation, including any evidence-based standards, considered by the organization in reaching its decision; and

(H) For a review involving a determination that the recommended or requested health care service or treatment is experimental or investigational:

(i) A description of the covered person's medical condition;

(ii) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that (I) the recommended or requested health care service or treatment is likely to be more beneficial to the covered person than any available standard health care services or treatments, and (II) the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(iii) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) A description and analysis of any evidence-based standard; and

(v) Information on whether the clinical peer's rationale for the opinion is based on the documents and information set forth in subsection (f) of this section.

(3) Upon the receipt of a notice of the independent review organization's decision to reverse or revise an adverse determination or a final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or the final adverse determination.

Sec. 15. Section 38a-591h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) Each health carrier shall maintain written records to document all grievances and prior authorization appeals of adverse determinations it receives, including the notices and claims associated with such grievances or prior authorization appeals, during a calendar year.

(2) (A) Each health carrier shall maintain such records for not less than six years after the notice of an adverse determination that is the subject of a grievance or a prior authorization appeal was provided to a covered person or the covered person's authorized representative, as applicable, under section 38a-591d, as amended by this act.

(B) The health carrier shall make such records available for examination by covered persons, to the extent such records are permitted to be disclosed by law, the commissioner and appropriate federal oversight agencies upon request. Such records shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

(b) For each grievance and each prior authorization appeal the record shall contain, at a minimum, the following information: (1) A general description of the reason for the grievance or prior authorization appeal; (2) the date the health carrier received the grievance or prior authorization appeal; (3) the date of each review or, if applicable, review meeting of the grievance; (4) the resolution at each level of the grievance or prior authorization appeal, if applicable; (5) the date of resolution at each such level, if applicable; and (6) the name of the covered person for whom the grievance or prior authorization appeal was filed.

(c) (1) Each health carrier shall maintain written records of all requests for external reviews, whether such requests are for standard or expedited external reviews, that such health carrier receives notice of from the commissioner in a calendar year. The health carrier shall maintain such records in the aggregate by state where the covered person requesting such review resides and by each type of health benefit plan offered by the health carrier, and shall submit a report to the commissioner upon request, in a format prescribed by the commissioner.

(2) Such report shall include, in the aggregate by state where the covered person requesting such review resides and by each type of health benefit plan:

(A) The total number of requests for an external review, whether such requests were for a standard or expedited external review;

(B) From the total number of such requests reported under subparagraph (A) of this subdivision, the number of requests determined eligible for a full external review, whether such requests were for a standard or expedited external review; and

(C) Any other information the commissioner may request or require.

(3) The health carrier shall retain the written records required pursuant to subdivision (1) of this subsection for not less than six years after the request for an external review or an expedited external review was received.

Sec. 16. Section 38a-591j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) No utilization review company shall conduct utilization review in this state for a health benefit plan under the jurisdiction of the commissioner unless it is licensed by the commissioner. All licenses shall be renewed on an annual basis.

(b) The annual license fee shall be three thousand dollars and shall be

dedicated to the regulation of utilization review, except that the commissioner shall be authorized to use such funds as is necessary to (1) implement the provisions of sections 38a-91aa to 38a-91tt, inclusive, and (2) contract with The University of Connecticut School of Medicine to provide any medical consultations necessary to carry out the commissioner's responsibilities under this title with respect to consumer and market conduct matters.

(c) The request for licensure or renewal shall include the name, address, telephone number and normal business hours of the utilization review company, and the name and telephone number of a person for the commissioner to contact. Any material changes in the information filed in accordance with this subsection shall be filed with the commissioner not later than thirty calendar days after the change.

(d) The commissioner shall receive and investigate all grievances filed against utilization review companies by a covered person, facility or health care professional. The commissioner shall code, track and review all grievances. The commissioner may impose such penalties as authorized, in accordance with section 38a-591k.

(e) In the absence of any contractual agreement to the contrary, the covered person or the covered person's authorized representative shall be responsible for requesting certification and for authorizing the covered person's treating health care professional to release, in a timely manner, all information necessary to conduct the review. A utilization review company shall permit the covered person, the covered person's authorized representative or the covered person's treating health care professional to assist in fulfilling that responsibility.

Sec. 17. Subdivision (1) of subsection (a) of section 38a-591n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) Upon request pursuant to subparagraph (E) of subdivision (1) of subsection **[**(e)**]** (f) of section 38a-591d, as amended by this act, the health carrier shall provide free of charge to a covered person or a

covered person's authorized representative, as applicable, copies of all documents, communications, information and evidence, including citations to any medical journals, regarding the covered person's benefit request that is the subject of the adverse determination that were not submitted by the covered person or the covered person's authorized representative and were available to the health carrier or the utilization review entity that made the adverse determination at the time such adverse determination was made.

Sec. 18. Section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(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 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) 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) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) 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) 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) For each year beginning on or after January 1, 2022, a report on prior authorizations for such year, in a format prescribed by the commissioner, that includes the following information for all managed care plans that the managed care organization delivered, issued for delivery, renewed, amended or continued in this state for such year: (A)

The number of prior authorization requests that such managed care organization received; (B) the number and percentage of prior authorization requests that such managed care organization approved; (C) the number and percentage of prior authorization requests that such managed care organization initially denied and were the subject of a prior authorization appeal; (D) the number and percentage of prior authorization requests that such managed care organization initially denied but subsequently overturned following a prior authorization appeal; (E) the average and median number of hours that elapsed between such managed care organization's receipt of a prior authorization request and response thereto; and (F) such other information that the commissioner, in the commissioner's discretion, deems necessary. The managed care organization shall disclose the information required under this subdivision, with a breakdown for each type of covered benefit, in the aggregate for such managed care plans and separately for each hospital that provided a covered benefit under any such managed care plan. For the purposes of this subdivision, "covered benefit", "prior authorization" and "prior authorization appeal" have the same meanings as provided in section 38a-591a, as amended by this act, and "hospital" has the same meaning as provided in section 19a-490.

(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.

(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) (1) The information required under subdivision (6) of subsection

(a) of this section shall be posted on the Insurance Department's Internet web site.

(2) Each managed care organization shall make the information required under subdivision (7) of subsection (a) of this section publicly available on the managed care organization's Internet web site, and disclose the address of such Internet web site in such managed care organization's enrollment materials.

Sec. 19. Section 38a-478a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

On March first annually, the **[**Insurance Commissioner**]** commissioner shall submit a report to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance, concerning the commissioner's responsibilities under the provisions of sections 38a-478 to 38a-478u, inclusive, 38a-479aa, 38a-591a to 38a-591h, inclusive, **[**and**]** as amended by this act, 38a-993 and section 6 of this act. The report shall include: (1) A summary of the quality assurance plans submitted by managed care organizations pursuant to section 38a-478c, as amended by this act, along with suggested changes to improve such plans; (2) suggested modifications to the consumer report card developed under the provisions of section 38a-478*l*, as amended by this act; (3) a summary of the commissioner's procedures and activities in conducting market conduct examinations of utilization review companies and preferred provider networks, including, but not limited to: (A) The number of desk and field audits completed during the previous calendar year; (B) a summary of findings of the desk and field audits, including any recommendations made for improvements or modifications; (C) a description of complaints concerning managed care companies, and any preferred provider network that provides services to enrollees on behalf of the managed care organization, including a summary and analysis of any trends or similarities found in the managed care complaints filed by enrollees; (4) a summary of the complaints concerning managed care organizations received by the Insurance Department's Consumer

Affairs Division and the commissioner under section 38a-591g, as amended by this act, including a summary and analysis of any trends or similarities found in the complaints received; (5) a summary of any violations the commissioner has found against any managed care organization or any preferred provider network that provides services to enrollees on behalf of the managed care organization; **[**and**]** (6) a summary of the issues discussed related to health care or managed care organizations at the Insurance Department's quarterly forums throughout the state; and (7) the information submitted to the commissioner pursuant to section 6 of this act and subdivision (7) of subsection (a) of section 38a-478c, as amended by this act.

Sec. 20. Section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

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

(1) "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; and

(2) "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;

[(a)**]** (b) 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)**]** (c) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include: **[**(A) all**]**

(1) All health care centers licensed pursuant to chapter 698a;

[, (B) the**]** (2) The fifteen largest licensed health insurers, measured on the basis of Connecticut direct written health premiums, that use provider networks and that are not included in **[**subparagraph (A) of this**]** subdivision (1) of this subsection;

[, (C) the**]** (3) The state medical loss ratio of each **[**such**]** health care center or licensed health insurer described in subdivision (1) or (2) of this subsection;

[, (D) the**]** (4) The federal medical loss ratio of each **[**such**]** health care center or licensed health insurer described in subdivision (1) or (2) of this subsection;

[, (E) the**]** (5) The information required under subdivision (6) of subsection (a) of section 38a-478c, as amended by this act

[and (F) information**]** (6) Information concerning mental health services, as specified in subsection **[**(c)**]** (d) of this section; and **[**. 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 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**]**

(7) The results of the most recent health care provider satisfaction survey conducted by the commissioner pursuant to section 9 of this act.

[(c)**]** (d) 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)**]** (e) 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)**]** (f) The commissioner shall analyze annually the data submitted under **[**subparagraphs (E) and (F) of subdivision (1)**]** subdivisions (5) and (6) of subsection **[**(b)**]** (c) 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.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	38a-1
Sec. 2	*October 1, 2021*	New section
Sec. 3	*January 1, 2022*	38a-472g

Sec. 4	*October 1, 2021*	38a-477g
Sec. 5	*October 1, 2021*	38a-591a
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*October 1, 2021*	New section
Sec. 10	*October 1, 2021*	38a-591b
Sec. 11	*October 1, 2021*	38a-591c
Sec. 12	*October 1, 2021*	38a-591d
Sec. 13	*October 1, 2021*	38a-591e
Sec. 14	*October 1, 2021*	38a-591g
Sec. 15	*October 1, 2021*	38a-591h
Sec. 16	*October 1, 2021*	38a-591j
Sec. 17	*October 1, 2021*	38a-591n(a)(1)
Sec. 18	*October 1, 2021*	38a-478c
Sec. 19	*October 1, 2021*	38a-478a
Sec. 20	*October 1, 2021*	38a-478*l*

Statement of Purpose:

To: (1) Require each contract between a health carrier and a health care professional or facility to (A) require the health carrier to reimburse the health care professional or facility for medically necessary covered benefits, (B) include a mechanism for the health care professional or facility to request that the health carrier reconsider a denial of coverage or refusal to reimburse, and (C) permit the health care professional or facility to collect payment for health care services that are not medically necessary; (2) provide that a health carrier shall (A) not require prior authorization for certain health care services, (B) promptly respond to prior authorization requests for post-stabilization and maintenance services, and (C) be financially responsible for post-stabilization and maintenance services if the health carrier fails to promptly respond to a prior authorization request for such services; (3) require each health carrier that enters into a participating provider contract to afford to the participating provider (A) at least ninety days' advance written notice of any proposed change to the provisions, other documents, provider manuals or policies incorporated by reference in such contract, and (B) a right to appeal any such proposed change; (4) redefine "adverse determination" and "final adverse determination", and define "hospital", "preferred provider network", "prior authorization", "prior authorization appeal" and "skilled nursing center", for the purposes of adverse determination and utilization review; (5) require certain health

carriers to submit an annual prior authorization report to the Insurance Commissioner and make such report publicly available; (6) require the Insurance Commissioner to convene a prior authorization working group and require such working group to submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health; (7) require (A) the Insurance Commissioner to establish prior authorization standards and incorporate such standards into existing health carrier audit and enforcement procedures, (B) any health carrier that fails to satisfy such standards to submit to the commissioner, and successfully implement, a corrective action plan, and (C) the commissioner to refrain from issuing or renewing a license to any health carrier that fails to satisfy such standards or, if applicable, submit and successfully implement such corrective action plan; (8) the Insurance Commissioner to develop and conduct an annual health care provider satisfaction survey and include the results of such survey in the consumer report card; (9) impose various duties on health carriers with respect to prior authorizations; (10) incorporate health carriers' duties with respect to prior authorizations into various provisions concerning adverse determination and utilization review; (11) require the Insurance Commissioner to develop and establish technical standards and clinical review criteria for prior authorizations; (12) require (A) the Insurance Commissioner to establish standardized prior authorization appeal deadlines and standards, and (B) each health carrier to include such standardized deadlines and standards in any contract with a health care professional or hospital; (13) require managed care organizations to submit a prior authorization report to the Insurance Commissioner; and (14) require the Insurance Commissioner to incorporate information concerning prior authorizations into the commissioner's annual report to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health.

[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.]