



General Assembly

January Session, 2021

Raised Bill No. 6586

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:

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 Section 38a-1 of the general statutes is repealed and the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

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

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

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

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

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

18 (4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

133 (I) Medically necessary covered benefits; or

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

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

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

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

147 (a) (1) (A) No insurer, health care center, fraternal benefit society,
148 hospital service corporation or medical service corporation or other
149 entity, delivering, issuing for delivery, renewing, amending or
150 continuing an individual or group health insurance policy in this state
151 providing coverage of the type specified in subdivisions (1), (2), (4), (11)
152 and (12) of section 38a-469 or utilization review company performing
153 utilization review for such insurer, center, society, corporation or entity,
154 that issues prior authorization for or precertifies, on or after January 1,
155 2012, an admission, service, procedure or extension of stay shall reverse
156 or rescind such prior authorization or precertification or refuse to pay
157 for such admission, service, procedure or extension of stay if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

243 (B) A provision that in the event of a health carrier or intermediary
244 insolvency or other cessation of operations, the participating provider's
245 obligation to deliver covered health care services to covered persons
246 without requesting payment from a covered person other than a
247 coinsurance, copayment, deductible or other out-of-pocket expense for
248 such services will continue until the earlier of (i) the termination of the
249 covered person's coverage under the network plan, including any
250 extension of coverage provided under the contract terms or applicable
251 state or federal law for covered persons who are in an active course of
252 treatment, as set forth in subdivision (2) of subsection (g) of section 38a-
253 472f, or are totally disabled, or (ii) the date the contract between the
254 health carrier and the participating provider would have terminated if
255 the health carrier or intermediary had remained in operation, including
256 any extension of coverage required under applicable state or federal law
257 for covered persons who are in an active course of treatment or are
258 totally disabled;

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

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

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

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

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

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

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

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

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

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

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

303 (A) If such contract is entered into, renewed or amended before July
304 1, 2022, timely notify a participating provider of any change to [such]
305 the provisions or other documents specified under subparagraph (A) of
306 subdivision (1) of this subsection that will result in a material change to
307 such contract; or

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

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

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

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

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

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

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

338 (5) (A) Each intermediary shall, if applicable, (i) transmit to the health
339 carrier documentation of health care services utilization and claims
340 paid, and (ii) maintain at its principal place of business in this state, for
341 a period of time prescribed by the commissioner, the books, records,
342 financial information and documentation of health care services
343 received by covered persons, in a manner that facilitates regulatory
344 review, and shall allow the commissioner access to such books, records,
345 financial information and documentation as necessary for the
346 commissioner to determine compliance with this section and section
347 38a-472f.

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

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

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

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

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

368 As used in this section and sections 38a-591b to 38a-591n, inclusive,
369 as amended by this act, and sections 6 to 9, inclusive, of this act:

370 (1) "Adverse determination" means:

371 (A) The denial, reduction, termination or failure to provide or make
372 payment, in whole or in part, for a benefit under the health carrier's
373 health benefit plan requested by a covered person or a covered person's
374 treating health care professional, based on a determination by a health
375 carrier or its designee utilization review company:

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

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

383 (B) Any prospective review, concurrent review or retrospective
384 review determination, including, but not limited to, any prior
385 authorization determination, that denies, reduces or terminates or fails
386 to provide or make payment, in whole or in part, for a benefit under the

387 health carrier's health benefit plan requested by a covered person or a
388 covered person's treating health care professional. "Adverse
389 determination" includes a rescission of coverage determination for
390 grievance purposes.

391 (2) "Authorized representative" means:

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

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

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

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

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

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

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

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

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

421 (7) "Clinical peer" means a physician or other health care professional
422 who (A) holds a nonrestricted license in a state of the United States and
423 in the same or similar specialty as typically manages the medical
424 condition, procedure or treatment under review, and (B) for a review
425 specified under subparagraph (B) or (C) of subdivision [(38)] (41) of this
426 section concerning (i) a child or adolescent substance use disorder or a
427 child or adolescent mental disorder, holds (I) a national board
428 certification in child and adolescent psychiatry, or (II) a doctoral level
429 psychology degree with training and clinical experience in the treatment
430 of child and adolescent substance use disorder or child and adolescent
431 mental disorder, as applicable, or (ii) an adult substance use disorder or
432 an adult mental disorder, holds (I) a national board certification in
433 psychiatry, or (II) a doctoral level psychology degree with training and
434 clinical experience in the treatment of adult substance use disorders or
435 adult mental disorders, as applicable.

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

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

443 [(10) "Commissioner" means the Insurance Commissioner.]

444 [(11)] (10) "Concurrent review" means utilization review conducted
445 during a patient's stay or course of treatment in a facility, the office of a
446 health care professional or other inpatient or outpatient health care

447 setting, including home care.

448 [(12) "Covered benefits" or "benefits"] (11) "Covered benefit" or
449 "benefit" means a health care [services] service to which a covered
450 person is entitled under the terms of a health benefit plan.

451 [(13)] (12) "Covered person" means a policyholder, subscriber,
452 enrollee or other individual participating in a health benefit plan.

453 [(14)] (13) "Emergency medical condition" means a medical condition
454 manifesting itself by acute symptoms of sufficient severity, including
455 severe pain, such that a prudent layperson with an average knowledge
456 of health and medicine, acting reasonably, would have believed that the
457 absence of immediate medical attention would result in serious
458 impairment to bodily functions or serious dysfunction of a bodily organ
459 or part, or would place the person's health or, with respect to a pregnant
460 woman, the health of the woman or her unborn child, in serious
461 jeopardy.

462 [(15)] (14) "Emergency services" means, with respect to an emergency
463 medical condition:

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

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

471 [(16)] (15) "Evidence-based standard" means the conscientious,
472 explicit and judicious use of the current best evidence based on an
473 overall systematic review of medical research when making
474 determinations about the care of individual patients.

475 [(17)] (16) "Expert opinion" means a belief or an interpretation by
476 specialists with experience in a specific area about the scientific evidence

477 pertaining to a particular service, intervention or therapy.

478 [(18)] (17) "Facility" means an institution providing health care
479 services or a health care setting. "Facility" includes a hospital and other
480 licensed inpatient center, ambulatory surgical or treatment center,
481 skilled nursing center, residential treatment center, diagnostic,
482 laboratory and imaging center, and rehabilitation and other therapeutic
483 health care setting.

484 [(19)] (18) "Final adverse determination" means an adverse
485 determination (A) that has been upheld by the health carrier at the
486 completion of its internal grievance process or review of a prior
487 authorization appeal, or (B) for which the internal grievance process or
488 prior authorization appeal process has been deemed exhausted.

489 [(20)] (19) "Grievance" means a written complaint or, if the complaint
490 involves an urgent care request, an oral complaint, submitted by or on
491 behalf of a covered person regarding:

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

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

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

499 [(21)] (20) (A) "Health benefit plan" means an insurance policy or
500 contract, certificate or agreement offered, delivered, issued for delivery,
501 renewed, amended or continued in this state to provide, deliver, arrange
502 for, pay for or reimburse any of the costs of health care services;

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

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

- 506 (ii) Coverage issued as a supplement to liability insurance;
- 507 (iii) Liability insurance, including general liability insurance and
508 automobile liability insurance;
- 509 (iv) Workers' compensation insurance;
- 510 (v) Automobile medical payment insurance;
- 511 (vi) Credit insurance;
- 512 (vii) Coverage for on-site medical clinics;
- 513 (viii) Other insurance coverage similar to the coverages specified in
514 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are
515 specified in regulations issued pursuant to the Health Insurance
516 Portability and Accountability Act of 1996, P.L. 104-191, as amended
517 from time to time, under which benefits for health care services are
518 secondary or incidental to other insurance benefits;
- 519 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
520 term care, nursing home care, home health care, community-based care
521 or any combination thereof, or (III) other similar, limited benefits
522 specified in regulations issued pursuant to the Health Insurance
523 Portability and Accountability Act of 1996, P.L. 104-191, as amended
524 from time to time, provided any benefits specified in subparagraphs
525 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided under
526 a separate insurance policy, certificate or contract and are not otherwise
527 an integral part of a health benefit plan; or
- 528 (x) Coverage of the type specified in subdivisions (3) and (13) of
529 section 38a-469 or other fixed indemnity insurance if (I) they are
530 provided under a separate insurance policy, certificate or contract, (II)
531 there is no coordination between the provision of the benefits and any
532 exclusion of benefits under any group health plan maintained by the
533 same plan sponsor, and (III) the benefits are paid with respect to an
534 event without regard to whether benefits were also provided under any
535 group health plan maintained by the same plan sponsor.

536 [(22)] (21) "Health care center" has the same meaning as provided in
537 section 38a-175.

538 [(23)] (22) "Health care professional" means a physician or other
539 health care practitioner licensed, accredited or certified to perform
540 specified health care services consistent with state law.

541 [(24)] (23) "Health care services" has the same meaning as provided
542 in section 38a-478.

543 [(25)] (24) "Health carrier" means an entity subject to the insurance
544 laws and regulations of this state or subject to the jurisdiction of the
545 commissioner, that contracts or offers to contract to provide, deliver,
546 arrange for, pay for or reimburse any of the costs of health care services,
547 including a sickness and accident insurance company, a health care
548 center, a managed care organization, a hospital service corporation, a
549 medical service corporation or any other entity providing a plan of
550 health insurance, health benefits or health care services.

551 [(26)] (25) "Health information" means information or data, whether
552 oral or recorded in any form or medium, and personal facts or
553 information about events or relationships that relate to (A) the past,
554 present or future physical, mental, or behavioral health or condition of
555 a covered person or a member of the covered person's family, (B) the
556 provision of health care services to a covered person, or (C) payment for
557 the provision of health care services to a covered person.

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

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

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

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

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

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

583 (D) The following standard reference compendia: (i) The American
584 Hospital Formulary Service - Drug Information; (ii) Drug Facts and
585 Comparisons; (iii) The American Dental Association's Accepted Dental
586 Therapeutics; and (iv) The United States Pharmacopoeia - Drug
587 Information;

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

597 (F) Any other findings, studies or research conducted by or under the

598 auspices of a source comparable to those listed in subparagraphs (E)(i)
599 to (E)(v), inclusive, of this subdivision.

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

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

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

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

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

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

624 [(32)] (34) "Prospective review" means utilization review conducted
625 prior to an admission or the provision of a health care service or a course
626 of treatment, in accordance with a health carrier's requirement that such
627 service or treatment be approved, in whole or in part, prior to such

628 service's or treatment's provision.

629 [(33)] (35) "Protected health information" means health information
630 (A) that identifies an individual who is the subject of the information, or
631 (B) for which there is a reasonable basis to believe that such information
632 could be used to identify such individual.

633 [(34)] (36) "Randomized clinical trial" means a controlled, prospective
634 study of patients that have been randomized into an experimental
635 group and a control group at the beginning of the study, with only the
636 experimental group of patients receiving a specific intervention, and
637 that includes study of the groups for variables and anticipated outcomes
638 over time.

639 [(35)] (37) (A) "Rescission" means a cancellation or discontinuance of
640 coverage under a health benefit plan that has a retroactive effect.

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

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

645 (ii) Such cancellation or discontinuance is effective retroactively to
646 the extent it is attributable to the covered person's failure to timely pay
647 required premiums or contributions towards the cost of such coverage.

648 [(36)] (38) (A) "Retrospective review" means any review of a request
649 for a benefit that is not a prospective review or concurrent review.

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

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

654 [(37)] (40) "Stabilize" means, with respect to an emergency medical
655 condition, that (A) no material deterioration of such condition is likely,

656 within reasonable medical probability, to result from or occur during
657 the transfer of the individual from a facility, or (B) with respect to a
658 pregnant woman, the woman has delivered, including the placenta.

659 [(38)] (41) "Urgent care request" means a request for a health care
660 service or course of treatment (A) for which the time period for making
661 a non-urgent care request determination (i) could seriously jeopardize
662 the life or health of the covered person or the ability of the covered
663 person to regain maximum function, or (ii) in the opinion of a health
664 care professional with knowledge of the covered person's medical
665 condition, would subject the covered person to severe pain that cannot
666 be adequately managed without the health care service or treatment
667 being requested, or (B) for a substance use disorder, as described in
668 section 17a-458, or for a co-occurring mental disorder, or (C) for a mental
669 disorder requiring (i) inpatient services, (ii) partial hospitalization, as
670 defined in section 38a-496, (iii) residential treatment, or (iv) intensive
671 outpatient services necessary to keep a covered person from requiring
672 an inpatient setting.

673 [(39)] (42) "Utilization review" means the use of a set of formal
674 techniques designed to monitor the use of, or evaluate the medical
675 necessity, appropriateness, efficacy or efficiency of, health care services,
676 health care procedures or health care settings. Such techniques may
677 include the monitoring of or evaluation of (A) health care services
678 performed or provided in an outpatient setting, (B) the formal process
679 for determining, prior to discharge from a facility, the coordination and
680 management of the care that a patient receives following discharge from
681 a facility, (C) opportunities or requirements to obtain a clinical
682 evaluation by a health care professional other than the one originally
683 making a recommendation for a proposed health care service, (D)
684 coordinated sets of activities conducted for individual patient
685 management of serious, complicated, protracted or other health
686 conditions, or (E) prospective review, concurrent review, retrospective
687 review, [or] certification or prior authorization.

688 [(40)] (43) "Utilization review company" means an entity that

689 conducts utilization review.

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

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

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

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

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

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

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

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

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

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

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

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

731 Sec. 7. (NEW) (*Effective October 1, 2021*) (a) Not later than January 1,
732 2024, the commissioner shall convene a working group, which shall
733 consist of the commissioner, or the commissioner's designee, and four
734 individuals appointed by the commissioner, two of whom shall
735 represent the interests of health carriers and two of whom shall
736 represent the interests of hospitals. The working group shall:

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

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

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

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

750 (1) Analysis of:

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

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

755 (2) Recommendations concerning:

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

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

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

762 Sec. 8. (NEW) (*Effective October 1, 2021*) (a) Not later than January 1,
763 2024, the commissioner shall adopt regulations, in accordance with
764 chapter 54 of the general statutes:

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

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

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

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

779 Sec. 9. (NEW) (*Effective October 1, 2021*) (a) Not later than January 1,
780 2024, the commissioner shall develop, in consultation with hospitals and
781 health care professionals, an annual health care provider satisfaction
782 survey to determine hospital and health care professional satisfaction
783 with health carrier prior authorization processes.

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

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

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

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

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

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

819 (2) Such document shall describe the following:

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

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

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

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

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

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

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

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

838 (d) Each health carrier shall:

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

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

843 (i) Its utilization review and benefit determination procedures;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

996 (6) For any utilization review involving a prior authorization request
997 filed on or after March 1, 2022, each health carrier's clinical review
998 criteria shall be based on the standardized clinical review criteria
999 developed and established by the commissioner pursuant to subsection
1000 (e) of this section and implemented by such health carrier pursuant to
1001 subsection (f) of this section.

1002 (b) Each health carrier shall:

1003 (1) Have procedures in place to ensure that (A) the health care
1004 professionals administering such health carrier's utilization review
1005 program are applying the clinical review criteria consistently in
1006 utilization review determinations, and (B) the appropriate or required
1007 individual or individuals are being designated to conduct utilization
1008 reviews;

1009 (2) Have data systems sufficient to support utilization review
1010 program activities and to generate management reports to enable the
1011 health carrier to monitor and manage health care services effectively;

1012 (3) Provide covered persons and participating providers with access
1013 to its utilization review staff through a toll-free telephone number or
1014 any other free calling option or by electronic means;

1015 (4) Coordinate the utilization review program with other medical
1016 management activity conducted by the health carrier, such as quality
1017 assurance, credentialing, contracting with health care professionals,
1018 data reporting, grievance procedures, processes for assessing member
1019 satisfaction and risk management; and

1020 (5) Routinely assess the effectiveness and efficiency of its utilization

1021 review program.

1022 (c) If a health carrier delegates any utilization review activities to a
1023 utilization review company, the health carrier shall maintain adequate
1024 oversight, which shall include (1) a written description of the utilization
1025 review company's activities and responsibilities, including such
1026 company's reporting requirements, (2) evidence of the health carrier's
1027 formal approval of the utilization review company program, and (3) a
1028 process by which the health carrier shall evaluate the utilization review
1029 company's performance.

1030 (d) When conducting utilization review, the health carrier shall (1)
1031 collect only the information necessary, including pertinent clinical
1032 information, to make the utilization review or benefit determination,
1033 and (2) ensure that such review is conducted in a manner to ensure the
1034 independence and impartiality of the individual or individuals involved
1035 in making the utilization review or benefit determination. No health
1036 carrier shall make decisions regarding the hiring, compensation,
1037 termination, promotion or other similar matters of such individual or
1038 individuals based on the likelihood that the individual or individuals
1039 will support the denial of benefits.

1040 (e) (1) Not later than January 1, 2022, the commissioner shall develop
1041 and establish:

1042 (A) Technical standards for hospitals and health care professionals to
1043 electronically file prior authorization requests, and other requests for
1044 prospective or concurrent utilization reviews, with health carriers; and

1045 (B) Standardized clinical review criteria for common services,
1046 treatments and procedures provided in hospitals in inpatient and
1047 outpatient settings.

1048 (2) The commissioner shall develop the technical standards required
1049 under subparagraph (A) of subdivision (1) of this subsection in
1050 consultation with appropriate standard-setting organizations, hospitals,
1051 health care professionals, health carriers and health information

1052 technology software vendors. Such technical standards shall include,
1053 but need not be limited to, standards to ensure that electronic prior
1054 authorization requests, and other electronic requests for prospective or
1055 concurrent utilization reviews, filed by hospitals and health care
1056 professionals with health carriers support attachments containing
1057 clinical information and can be integrated into existing electronic health
1058 record systems.

1059 (3) The commissioner shall develop the standardized clinical review
1060 criteria required under subparagraph (B) of subdivision (1) of this
1061 subsection in consultation with hospitals, health care professionals and
1062 health carriers.

1063 (f) (1) Not later than March 1, 2022, each health carrier shall establish
1064 an electronic program to provide for the secure electronic:

1065 (A) (i) Filing of prior authorization requests, and other requests for
1066 prospective or concurrent utilization reviews, by hospitals and health
1067 care professionals with such health carrier, and (ii) submission of
1068 available clinical information in support of such requests; and

1069 (B) Transmission of such health carrier's responses to the requests
1070 described in subparagraph (A) of this subdivision.

1071 (2) Each electronic program established pursuant to subdivision (1)
1072 of this subsection shall comply with all standards developed and
1073 established by the commissioner pursuant to subsection (e) of this
1074 section.

1075 (3) No facsimile, electronic form or proprietary health carrier portal
1076 that fails to comply with the technical standards developed and
1077 established by the commissioner pursuant to subsection (e) of this
1078 section shall be deemed to satisfy the provisions of this subsection.

1079 (4) Each health carrier shall provide hospitals and health care
1080 professionals with access to such health carrier's criteria for making
1081 determinations on prior authorization requests and other requests for

1082 prospective or concurrent utilization reviews, including, but not limited
1083 to, an itemization of any documentation such health carrier requires for
1084 such requests.

1085 (5) Notwithstanding any provision of this subsection, no health
1086 carrier shall implement any technical or clinical standards pursuant to
1087 this subsection unless such health carrier has consulted with hospitals
1088 to facilitate seamless transmission and processing of requests for prior
1089 authorization or other requests for prospective or concurrent utilization
1090 reviews. Such consultations shall include, but need not be limited to,
1091 consultations concerning the ability of hospitals and health care
1092 professionals to submit clinical records and securely access electronic
1093 health information.

1094 Sec. 12. Section 38a-591d of the general statutes is repealed and the
1095 following is substituted in lieu thereof (*Effective October 1, 2021*):

1096 (a) (1) Each health carrier shall maintain written procedures for (A)
1097 utilization review and benefit determinations, (B) expedited utilization
1098 review and benefit determinations with respect to prospective urgent
1099 care requests and concurrent review urgent care requests, (C) prior
1100 authorization determinations, and ~~[(C)]~~ (D) notifying covered persons
1101 or covered persons' authorized representatives or, in the case of prior
1102 authorization determinations, health care professionals or hospital
1103 representatives, as applicable, of such review and benefit
1104 determinations. Each health carrier shall make such review and benefit
1105 determinations within the specified time periods under this section.

1106 (2) In determining whether a benefit request shall be considered an
1107 urgent care request, an individual acting on behalf of a health carrier
1108 shall apply the judgment of a prudent layperson who possesses an
1109 average knowledge of health and medicine, except that any benefit
1110 request (A) determined to be an urgent care request by a health care
1111 professional with knowledge of the covered person's medical condition,
1112 or (B) specified under subparagraph (B) or (C) of subdivision ~~[(38)]~~ (41)
1113 of section 38a-591a, as amended by this act, shall be deemed an urgent

1114 care request.

1115 (3) (A) At the time a health carrier notifies a covered person, a covered
1116 person's authorized representative or a covered person's health care
1117 professional of an initial adverse determination that was based, in whole
1118 or in part, on medical necessity, of a concurrent or prospective
1119 utilization review, including, but not limited to, a prior authorization,
1120 or of a benefit request, the health carrier shall notify the covered person's
1121 health care professional or, with respect to a prior authorization, health
1122 care professional and hospital representative (i) of the opportunity for a
1123 conference as provided in subparagraph (B) of this subdivision, and (ii)
1124 that such conference shall not be considered a grievance of such initial
1125 adverse determination as long as a grievance has not been filed as set
1126 forth in subparagraph (B) of this subdivision.

1127 (B) After a health carrier notifies a covered person, a covered person's
1128 authorized representative, [or] a covered person's health care
1129 professional or a covered person's health care professional and hospital
1130 representative, as applicable, of an initial adverse determination that
1131 was based, in whole or in part, on medical necessity, of a concurrent or
1132 prospective utilization review, including, but not limited to, a prior
1133 authorization, or of a benefit request, the health carrier shall offer a
1134 covered person's health care professional the opportunity to confer, at
1135 the request of the covered person's health care professional, with a
1136 clinical peer of such health carrier, provided such covered person,
1137 covered person's authorized representative or covered person's health
1138 care professional has not filed a grievance of such initial adverse
1139 determination prior to such conference. Such conference shall not be
1140 considered a grievance of such initial adverse determination.

1141 (b) With respect to a nonurgent care request:

1142 (1) (A) For a prospective or concurrent review request, a health carrier
1143 shall make a determination within a reasonable period of time
1144 appropriate to the covered person's medical condition, but not later than
1145 fifteen calendar days after the date the health carrier receives such

1146 request, and shall notify the covered person and, if applicable, the
1147 covered person's authorized representative of such determination,
1148 whether or not the carrier certifies the provision of the benefit.

1149 (B) If the review under subparagraph (A) of this subdivision is a
1150 review of a grievance involving a concurrent review request, pursuant
1151 to 45 CFR 147.136, as amended from time to time, the treatment shall be
1152 continued without liability to the covered person until the covered
1153 person has been notified of the review decision.

1154 (2) For a retrospective review request, a health carrier shall make a
1155 determination within a reasonable period of time, but not later than
1156 thirty calendar days after the date the health carrier receives such
1157 request.

1158 (3) The time periods specified in subdivisions (1) and (2) of this
1159 subsection may be extended once by the health carrier for up to fifteen
1160 calendar days, provided the health carrier:

1161 (A) Determines that an extension is necessary due to circumstances
1162 beyond the health carrier's control; and

1163 (B) Notifies the covered person and, if applicable, the covered
1164 person's authorized representative prior to the expiration of the initial
1165 time period, of the circumstances requiring the extension of time and
1166 the date by which the health carrier expects to make a determination.

1167 (4) (A) If the extension pursuant to subdivision (3) of this subsection
1168 is necessary due to the failure of the covered person or the covered
1169 person's authorized representative to provide information necessary to
1170 make a determination on the request, the health carrier shall:

1171 (i) Specifically describe in the notice of extension the required
1172 information necessary to complete the request; and

1173 (ii) Provide the covered person and, if applicable, the covered
1174 person's authorized representative with not less than forty-five calendar
1175 days after the date of receipt of the notice to provide the specified

1176 information.

1177 (B) If the covered person or the covered person's authorized
1178 representative fails to submit the specified information before the end
1179 of the period of the extension, the health carrier may deny certification
1180 of the benefit requested.

1181 (c) With respect to an urgent care request:

1182 (1) (A) Unless the covered person or the covered person's authorized
1183 representative has failed to provide information necessary for the health
1184 carrier to make a determination and except as specified under
1185 subparagraph (B) of this subdivision, the health carrier shall make a
1186 determination as soon as possible, taking into account the covered
1187 person's medical condition, but not later than forty-eight hours after the
1188 health carrier receives such request or seventy-two hours after such
1189 health carrier receives such request if any portion of such forty-eight-
1190 hour period falls on a weekend, provided, if the urgent care request is a
1191 concurrent review request to extend a course of treatment beyond the
1192 initial period of time or the number of treatments, such request is made
1193 at least twenty-four hours prior to the expiration of the prescribed
1194 period of time or number of treatments.

1195 (B) Unless the covered person or the covered person's authorized
1196 representative has failed to provide information necessary for the health
1197 carrier to make a determination, for an urgent care request specified
1198 under subparagraph (B) or (C) of subdivision [(38)] (41) of section 38a-
1199 591a, as amended by this act, the health carrier shall make a
1200 determination as soon as possible, taking into account the covered
1201 person's medical condition, but not later than twenty-four hours after
1202 the health carrier receives such request, provided, if the urgent care
1203 request is a concurrent review request to extend a course of treatment
1204 beyond the initial period of time or the number of treatments, such
1205 request is made at least twenty-four hours prior to the expiration of the
1206 prescribed period of time or number of treatments.

1207 (2) (A) If the covered person or the covered person's authorized

1208 representative has failed to provide information necessary for the health
1209 carrier to make a determination, the health carrier shall notify the
1210 covered person or the covered person's representative, as applicable, as
1211 soon as possible, but not later than twenty-four hours after the health
1212 carrier receives such request.

1213 (B) The health carrier shall provide the covered person or the covered
1214 person's authorized representative, as applicable, a reasonable period of
1215 time to submit the specified information, taking into account the
1216 covered person's medical condition, but not less than forty-eight hours
1217 after notifying the covered person or the covered person's authorized
1218 representative, as applicable.

1219 (3) The health carrier shall notify the covered person and, if
1220 applicable, the covered person's authorized representative of its
1221 determination as soon as possible, but not later than forty-eight hours
1222 after the earlier of (A) the date on which the covered person and the
1223 covered person's authorized representative, as applicable, provides the
1224 specified information to the health carrier, or (B) the date on which the
1225 specified information was to have been submitted.

1226 (d) (1) With respect to prior authorization requests, each health
1227 carrier shall:

1228 (A) Process prior authorization requests twenty-four hours a day,
1229 seven days a week including holidays;

1230 (B) Designate a staff member to serve, during normal business hours,
1231 as the primary contact person for each hospital under contract with such
1232 health carrier;

1233 (C) Respond to each prior authorization request immediately, and in
1234 no event later than one hour, following such health carrier's receipt of
1235 such prior authorization request, except such health carrier shall
1236 respond more quickly if a quicker response is required by applicable
1237 federal or state law; and

1238 (D) Base such health carrier's response to each prior authorization
1239 request on information that (i) the health care professional or hospital
1240 submitted with such prior authorization request, and (ii) was
1241 reasonably available to such health care professional or hospital at the
1242 time that such health care professional or hospital filed such prior
1243 authorization request.

1244 (2) No health carrier shall delay a decision on a prior authorization
1245 request by requiring a health care professional or hospital to submit
1246 additional information that was not reasonably available to the health
1247 care professional or hospital at the time that such health care
1248 professional or hospital filed the prior authorization request with such
1249 health carrier.

1250 ~~[(d)]~~ (e) (1) Whenever a health carrier receives a review request from
1251 a covered person or a covered person's authorized representative that
1252 fails to meet the health carrier's filing procedures, the health carrier shall
1253 notify the covered person and, if applicable, the covered person's
1254 authorized representative of such failure not later than five calendar
1255 days after the health carrier receives such request, except that for an
1256 urgent care request, the health carrier shall notify the covered person
1257 and, if applicable, the covered person's authorized representative of
1258 such failure not later than twenty-four hours after the health carrier
1259 receives such request.

1260 (2) If the health carrier provides such notice orally, the health carrier
1261 shall provide confirmation in writing to the covered person and the
1262 covered person's health care professional of record not later than five
1263 calendar days after providing the oral notice.

1264 ~~[(e)]~~ (f) Each health carrier shall provide promptly to a covered
1265 person and, if applicable, the covered person's authorized
1266 representative a notice of an adverse determination. If the adverse
1267 determination involves a prior authorization request, the health carrier
1268 shall also provide notice of such adverse determination to the covered
1269 person's health care professional or hospital representative.

1270 (1) Such notice may be provided in writing or by electronic means,
1271 [and] except that if such notice is provided for an adverse determination
1272 that involves a prior authorization request, such notice shall also be
1273 provided to the covered person's health care professional or hospital
1274 representative in the manner in which the health care professional or
1275 hospital filed such prior authorization request, including through
1276 electronic means required under subsection (f) of section 38a-591c, as
1277 amended by this act. Such notice shall set forth, in a manner calculated
1278 to be understood by the covered person or the covered person's
1279 authorized representative:

1280 (A) Information sufficient to identify the benefit request or claim
1281 involved, including the date of service, if applicable, the health care
1282 professional and the claim amount;

1283 (B) The specific reason or reasons for the adverse determination,
1284 including, upon request, a listing of the relevant clinical review criteria,
1285 including professional criteria and medical or scientific evidence and a
1286 description of the health carrier's standard, if any, that were used in
1287 reaching the denial;

1288 (C) Reference to the specific health benefit plan provisions on which
1289 the determination is based;

1290 (D) A description of any additional material or information necessary
1291 for the covered person to perfect the benefit request or claim, including
1292 an explanation of why the material or information is necessary to perfect
1293 the request or claim;

1294 (E) A description of the health carrier's internal grievance process that
1295 includes (i) the health carrier's expedited review procedures, (ii) any
1296 time limits applicable to such process or procedures, (iii) the contact
1297 information for the organizational unit designated to coordinate the
1298 review on behalf of the health carrier, and (iv) a statement that the
1299 covered person or, if applicable, the covered person's authorized
1300 representative is entitled, pursuant to the requirements of the health
1301 carrier's internal grievance process, to receive from the health carrier,

1302 free of charge upon request, reasonable access to and copies of all
1303 documents, records, communications and other information and
1304 evidence regarding the covered person's benefit request;

1305 (F) A statement disclosing that a health care professional or hospital
1306 may appeal the health carrier's adverse determination if the adverse
1307 determination involves a prior authorization request that is subject to
1308 the provisions of section 38a-591e, as amended by this act, and that the
1309 prior authorization appeal shall not render the covered person, or the
1310 covered person's authorized representative, ineligible to pursue the
1311 health carrier's grievance procedures or any other legal remedy;

1312 [(F)] (G) (i) (I) A copy of the specific rule, guideline, protocol or other
1313 similar criterion the health carrier relied upon to make the adverse
1314 determination, or (II) a statement that a specific rule, guideline, protocol
1315 or other similar criterion of the health carrier was relied upon to make
1316 the adverse determination and that a copy of such rule, guideline,
1317 protocol or other similar criterion will be provided to the covered person
1318 free of charge upon request, with instructions for requesting such copy,
1319 and (ii) the links to such rule, guideline, protocol or other similar
1320 criterion on such health carrier's Internet web site;

1321 [(G)] (H) If the adverse determination is based on medical necessity
1322 or an experimental or investigational treatment or similar exclusion or
1323 limit, the written statement of the scientific or clinical rationale for the
1324 adverse determination and (i) an explanation of the scientific or clinical
1325 rationale used to make the determination that applies the terms of the
1326 health benefit plan to the covered person's medical circumstances or (ii)
1327 a statement that an explanation will be provided to the covered person
1328 free of charge upon request, and instructions for requesting a copy of
1329 such explanation;

1330 [(H)] (I) A statement explaining the right of the covered person to
1331 contact the commissioner's office or the Office of the Healthcare
1332 Advocate at any time for assistance or, upon completion of the health
1333 carrier's internal grievance process, to file a civil action in a court of

1334 competent jurisdiction. Such statement shall include the contact
1335 information for said offices; and

1336 ~~[(I)]~~ (I) A statement that if the covered person or the covered person's
1337 authorized representative chooses to file a grievance of an adverse
1338 determination, (i) such appeals are sometimes successful, (ii) such
1339 covered person or covered person's authorized representative may
1340 benefit from free assistance from the Office of the Healthcare Advocate,
1341 which can assist such covered person or covered person's authorized
1342 representative with the filing of a grievance pursuant to 42 USC 300gg-
1343 93, as amended from time to time, (iii) such covered person or covered
1344 person's authorized representative is entitled and encouraged to submit
1345 supporting documentation for the health carrier's consideration during
1346 the review of an adverse determination, including narratives from such
1347 covered person or covered person's authorized representative and
1348 letters and treatment notes from such covered person's health care
1349 professional, and (iv) such covered person or covered person's
1350 authorized representative has the right to ask such covered person's
1351 health care professional for such letters or treatment notes.

1352 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of
1353 this subsection, the health carrier shall provide such copies in
1354 accordance with subsection (a) of section 38a-591n, as amended by this
1355 act.

1356 ~~[(f)]~~ (g) If the adverse determination is a rescission, the health carrier
1357 shall include with the advance notice of the application for rescission
1358 required to be sent to the covered person, a written statement that
1359 includes:

1360 (1) Clear identification of the alleged fraudulent act, practice or
1361 omission or the intentional misrepresentation of material fact;

1362 (2) An explanation as to why the act, practice or omission was
1363 fraudulent or was an intentional misrepresentation of a material fact;

1364 (3) A disclosure that the covered person or the covered person's

1365 authorized representative may file immediately, without waiting for the
1366 date such advance notice of the proposed rescission ends, a grievance
1367 with the health carrier to request a review of the adverse determination
1368 to rescind coverage, pursuant to sections 38a-591e, as amended by this
1369 act, and 38a-591f;

1370 (4) A description of the health carrier's grievance procedures
1371 established under sections 38a-591e, as amended by this act, and 38a-
1372 591f, including any time limits applicable to those procedures; and

1373 (5) The date such advance notice of the proposed rescission ends and
1374 the date back to which the coverage will be retroactively rescinded.

1375 ~~[(g)]~~ (h) (1) Whenever a health carrier fails to strictly adhere to the
1376 requirements of this section with respect to making utilization review,
1377 including, but not limited to, prior authorization, and benefit
1378 determinations of a benefit request or claim, the covered person shall be
1379 deemed to have exhausted the internal grievance process of such health
1380 carrier, or, in the case of prior authorization, the health care professional
1381 or hospital shall be deemed to have exhausted the prior authorization
1382 appeal process of such health carrier and may file a request for an
1383 external review in accordance with the provisions of section 38a-591g,
1384 as amended by this act, regardless of whether the health carrier asserts
1385 it substantially complied with the requirements of this section or that
1386 any error it committed was de minimis.

1387 (2) A covered person who has exhausted the internal grievance
1388 process of a health carrier or a health care professional who, or hospital
1389 that, has exhausted the prior authorization appeal process of a health
1390 carrier may, in addition to filing a request for an external review, pursue
1391 any available remedies under state or federal law on the basis that the
1392 health carrier failed to provide a reasonable internal grievance or prior
1393 authorization appeals process that would yield a decision on the merits
1394 of the claim.

1395 (i) If a health carrier, or a preferred provider network, utilization
1396 review company or other contractor acting on behalf of the health

1397 carrier, determines, based on a future audit, that a prior authorization
1398 request should not have been approved, the health carrier, or the
1399 preferred provider network, utilization review company or other
1400 contractor acting on behalf of such health carrier, shall be prohibited
1401 from recouping payments made to a health care professional or hospital
1402 for any hospital admission, procedure, service, surgery or treatment that
1403 such health care professional or hospital provided pursuant to the
1404 previously approved prior authorization request until such time as such
1405 health care professional or hospital has fully exhausted all of such health
1406 care professional's or hospital's contractual and legal rights to appeal, or
1407 otherwise dispute, such recoupment.

1408 Sec. 13. Section 38a-591e of the general statutes is repealed and the
1409 following is substituted in lieu thereof (*Effective October 1, 2021*):

1410 (a) (1) Each health carrier shall establish and maintain written
1411 procedures for (A) the review of grievances of adverse determinations
1412 that were based, in whole or in part, on medical necessity, (B) the
1413 expedited review of grievances of adverse determinations of urgent care
1414 requests, including concurrent review urgent care requests and
1415 expedited review of prior authorization appeals involving an
1416 admission, availability of care, continued stay or health care service for
1417 a covered person who has received emergency services but has not been
1418 discharged from a facility, and (C) notifying covered persons or covered
1419 persons' authorized representatives or, for prior authorization requests,
1420 health care professionals or hospital representatives of such adverse
1421 determinations.

1422 (2) Each health carrier shall file with the commissioner a copy of such
1423 procedures, including all forms used to process requests, and any
1424 subsequent material modifications to such procedures.

1425 (3) In addition to a copy of such procedures, each health carrier shall
1426 file annually with the commissioner, in a form prescribed by the
1427 commissioner, a certificate of compliance stating that the health carrier
1428 has established and maintains grievance procedures and prior

1429 authorization appeal procedures for each of its health benefit plans that
1430 are fully compliant with the provisions of sections 38a-591a to 38a-591n,
1431 inclusive, as amended by this act.

1432 (b) (1) A covered person or a covered person's authorized
1433 representative may file a grievance of an adverse determination that
1434 was based, in whole or in part, on medical necessity with the health
1435 carrier not later than one hundred eighty calendar days after the covered
1436 person or the covered person's authorized representative, as applicable,
1437 receives the notice of an adverse determination.

1438 (2) For prospective or concurrent urgent care requests, a covered
1439 person or a covered person's authorized representative or, for prior
1440 authorization requests, a health care professional or a hospital may
1441 make a request for an expedited review orally or in writing.

1442 (c) (1) (A) When conducting a review of an adverse determination
1443 under this section, the health carrier shall ensure that such review is
1444 conducted in a manner to ensure the independence and impartiality of
1445 the clinical peer or peers involved in making the review decision.

1446 (B) If the adverse determination involves utilization review, the
1447 health carrier shall designate an appropriate clinical peer or peers to
1448 review such adverse determination. Such clinical peer or peers shall not
1449 have been involved in the initial adverse determination.

1450 (C) The clinical peer or peers conducting a review under this section
1451 shall take into consideration all comments, documents, records and
1452 other information relevant to the covered person's benefit request that
1453 is the subject of the adverse determination under review, that are
1454 submitted by the covered person or the covered person's authorized
1455 representative, regardless of whether such information was submitted
1456 or considered in making the initial adverse determination.

1457 (D) Prior to issuing a decision, the health carrier shall provide free of
1458 charge, by facsimile, electronic means or any other expeditious method
1459 available, to the covered person or the covered person's authorized

1460 representative, as applicable, or, in the case of a prior authorization
1461 appeal, to the health care professional or hospital any new or additional
1462 documents, communications, information and evidence relied upon
1463 and any new or additional scientific or clinical rationale used by the
1464 health carrier in connection with the grievance. Such documents,
1465 communications, information, evidence and rationale shall be provided
1466 sufficiently in advance of the date the health carrier is required to issue
1467 a decision to permit the covered person or the covered person's
1468 authorized representative, as applicable, or, in the case of a prior
1469 authorization appeal, health care professional or hospital a reasonable
1470 opportunity to respond prior to such date.

1471 (2) If the review under subdivision (1) of this subsection is an
1472 expedited review, all necessary information, including the health
1473 carrier's decision, shall be transmitted between the health carrier and the
1474 covered person or the covered person's authorized representative, as
1475 applicable, or, in the case of a prior authorization appeal, health care
1476 professional or hospital by telephone, facsimile, electronic means or any
1477 other expeditious method available.

1478 (3) If the review under subdivision (1) of this subsection is an
1479 expedited review of a grievance involving an adverse determination of
1480 a concurrent review request, pursuant to 45 CFR 147.136, as amended
1481 from time to time, the treatment shall be continued without liability to
1482 the covered person until the covered person has been notified of the
1483 review decision.

1484 (d) (1) The health carrier shall notify the covered person and, if
1485 applicable, the covered person's authorized representative or, in the
1486 case of a prior authorization appeal, health care professional or hospital,
1487 in writing or by electronic means, of its decision within a reasonable
1488 period of time appropriate to the covered person's medical condition,
1489 but not later than:

1490 (A) For prospective review and concurrent review requests, thirty
1491 calendar days after the health carrier receives the grievance or prior

1492 authorization appeal;

1493 (B) For retrospective review requests, sixty calendar days after the
1494 health carrier receives the grievance or prior authorization appeal;

1495 (C) For expedited review requests, except as specified under
1496 subparagraph (D) of this subdivision, forty-eight hours after the health
1497 carrier receives the grievance or prior authorization appeal or seventy-
1498 two hours after such health carrier receives such grievance or prior
1499 authorization appeal if any portion of such forty-eight-hour period falls
1500 on a weekend; and

1501 (D) For expedited review requests of a health care service or course
1502 of treatment specified under subparagraph (B) or (C) of subdivision
1503 [(38)] (41) of section 38a-591a, as amended by this act, twenty-four hours
1504 after the health carrier receives the grievance or prior authorization
1505 appeal.

1506 (2) The time periods set forth in subdivision (1) of this subsection
1507 shall apply regardless of whether all of the information necessary to
1508 make a decision accompanies the filing.

1509 (e) (1) The notice required under subsection (d) of this section shall
1510 set forth, in a manner calculated to be understood by the covered person
1511 or the covered person's authorized representative:

1512 (A) The titles and qualifying credentials of the clinical peer or peers
1513 participating in the review process;

1514 (B) Information sufficient to identify the claim involved with respect
1515 to the grievance or prior authorization appeal, including the date of
1516 service, if applicable, the health care professional and the claim amount;

1517 (C) A statement of such clinical peer's or peers' understanding of the
1518 covered person's grievance or the prior authorization appeal;

1519 (D) The clinical peer's or peers' decision in clear terms and the health
1520 benefit plan contract basis or scientific or clinical rationale for such

1521 decision in sufficient detail for the covered person or, in the case of a
1522 prior authorization appeal, health care professional or hospital to
1523 respond further to the health carrier's position;

1524 (E) Reference to the evidence or documentation used as the basis for
1525 the decision;

1526 (F) For a decision that upholds the adverse determination:

1527 (i) The specific reason or reasons for the final adverse determination,
1528 including the denial code and its corresponding meaning, as well as a
1529 description of the health carrier's standard, if any, that was used in
1530 reaching the denial;

1531 (ii) Reference to the specific health benefit plan provisions on which
1532 the decision is based;

1533 (iii) A statement that the covered person or, in the case of a prior
1534 authorization appeal, health care professional or hospital may receive
1535 from the health carrier, free of charge and upon request, reasonable
1536 access to and copies of, all documents, records, communications and
1537 other information and evidence not previously provided regarding the
1538 adverse determination under review;

1539 (iv) If the final adverse determination is based on a health carrier's
1540 internal rule, guideline, protocol or other similar criterion, (I) the
1541 specific rule, guideline, protocol or other similar criterion, or (II) a
1542 statement that a specific rule, guideline, protocol or other similar
1543 criterion of the health carrier was relied upon to make the final adverse
1544 determination and that a copy of such rule, guideline, protocol or other
1545 similar criterion will be provided to the covered person or, in the case of
1546 a prior authorization appeal, health care professional or hospital free of
1547 charge upon request and instructions for requesting such copy;

1548 (v) If the final adverse determination is based on medical necessity or
1549 an experimental or investigational treatment or similar exclusion or
1550 limit, the written statement of the scientific or clinical rationale for the

1551 final adverse determination and (I) an explanation of the scientific or
1552 clinical rationale used to make the determination that applies the terms
1553 of the health benefit plan to the covered person's medical circumstances,
1554 or (II) a statement that an explanation will be provided to the covered
1555 person or, in the case of a prior authorization appeal, health care
1556 professional or hospital free of charge upon request and instructions for
1557 requesting a copy of such explanation;

1558 (vi) A statement describing the procedures for obtaining an external
1559 review of the final adverse determination;

1560 (G) If applicable, the following statement: "You and your plan may
1561 have other voluntary alternative dispute resolution options such as
1562 mediation. One way to find out what may be available is to contact your
1563 state Insurance Commissioner."; and

1564 (H) A statement disclosing the covered person's right to contact the
1565 commissioner's office or the Office of the Healthcare Advocate at any
1566 time. Such disclosure shall include the contact information for said
1567 offices.

1568 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)
1569 of this subsection, the health carrier shall provide such copies in
1570 accordance with subsection (b) of section 38a-591n, as amended by this
1571 act.

1572 (f) (1) Not later than January 1, 2022, the commissioner shall establish
1573 standardized procedures and deadlines for prior authorization appeals
1574 to enable hospitals and health care professionals to file expedited
1575 appeals of adverse determinations that involve a prior authorization
1576 request. Such standardized procedures shall, at a minimum:

1577 (A) Require review by a health care professional who has undergone
1578 training that is the same as, or similar to, the training that the health care
1579 professional who files, or is involved in the particular procedure, service
1580 or treatment that is the subject of, the prior authorization request has
1581 undergone; and

1582 (B) Provide an opportunity for review by a health care professional
1583 described in subparagraph (A) of this subdivision who is not affiliated
1584 with the health carrier.

1585 (2) Each health carrier shall process prior authorization appeals in a
1586 timely manner.

1587 (3) No prior authorization appeal shall limit the ability of a covered
1588 person, or the covered person's authorized representative, to dispute a
1589 prior authorization determination through the health carrier's grievance
1590 procedures or any other process authorized by law.

1591 (4) Each contract between a health carrier and a health care
1592 professional or hospital that is entered into, renewed, amended or
1593 continued on or after January 1, 2022, shall include the standardized
1594 procedures and deadlines for prior authorization appeals established by
1595 the commissioner pursuant to subdivision (1) of this subsection.

1596 ~~[(f)]~~ (g) (1) Whenever a health carrier fails to strictly adhere to the
1597 requirements of this section with respect to receiving and resolving
1598 grievances or prior authorization appeals involving an adverse
1599 determination, the covered person or the health care professional or
1600 hospital, as applicable, shall be deemed to have exhausted the internal
1601 grievance process of such health carrier and may file a request for an
1602 external review, regardless of whether the health carrier asserts that it
1603 substantially complied with the requirements of this section, or that any
1604 error it committed was de minimis.

1605 (2) A covered person who has exhausted the internal grievance
1606 process of a health carrier or a health care professional or hospital, as
1607 applicable, may, in addition to filing a request for an external review,
1608 pursue any available remedies under state or federal law on the basis
1609 that the health carrier failed to provide a reasonable internal grievance
1610 process that would yield a decision on the merits of the claim.

1611 Sec. 14. Section 38a-591g of the general statutes is repealed and the
1612 following is substituted in lieu thereof (*Effective October 1, 2021*):

1613 (a) (1) A covered person or a covered person's authorized
1614 representative or, in the case of a prior authorization, a health care
1615 professional or a hospital may file a request for an external review or an
1616 expedited external review of an adverse determination or a final adverse
1617 determination in accordance with the provisions of this section. All
1618 requests for external review or expedited external review shall be made
1619 in writing to the commissioner. The commissioner may prescribe the
1620 form and content of such requests.

1621 (2) (A) All requests for external review or expedited external review
1622 shall be accompanied by a filing fee of twenty-five dollars, except that
1623 no covered person or covered person's authorized representative shall
1624 pay more than seventy-five dollars in a calendar year for such covered
1625 person. Any filing fee paid by a covered person's authorized
1626 representative shall be deemed to have been paid by the covered person.
1627 If the commissioner finds that the covered person is indigent or unable
1628 to pay the filing fee, the commissioner shall waive such fee. Any such
1629 fees shall be deposited in the Insurance Fund established under section
1630 38a-52a.

1631 (B) The commissioner shall refund any paid filing fee to the covered
1632 person or the covered person's authorized representative, as applicable,
1633 or the health care professional or the hospital if the adverse
1634 determination or the final adverse determination that is the subject of
1635 the external review request or expedited external review request is
1636 reversed or revised.

1637 (3) The health carrier that issued the adverse determination or the
1638 final adverse determination that is the subject of the external review
1639 request or the expedited external review request shall pay the
1640 independent review organization for the cost of conducting the review.

1641 (4) An external review decision, whether such review is a standard
1642 external review or an expedited external review, shall be binding on the
1643 health carrier or a self-insured governmental plan and the covered
1644 person, except to the extent such health carrier or covered person has

1645 other remedies available under federal or state law. A covered person
1646 or a covered person's authorized representative shall not file a
1647 subsequent request for an external review or an expedited external
1648 review that involves the same adverse determination or final adverse
1649 determination for which the covered person or the covered person's
1650 authorized representative already received an external review decision
1651 or an expedited external review decision.

1652 (5) Each health carrier shall maintain written records of external
1653 reviews as set forth in section 38a-591h, as amended by this act.

1654 (6) Each independent review organization shall maintain written
1655 records as set forth in subsection (e) of section 38a-591m.

1656 (b) (1) Except as otherwise provided under subdivision (2) of this
1657 subsection or subsection (d) of this section; [a]

1658 (A) A covered person or a covered person's authorized representative
1659 shall not file a request for an external review or an expedited external
1660 review until the covered person or the covered person's authorized
1661 representative has exhausted the health carrier's internal grievance
1662 process; and

1663 (B) A health care professional or a hospital shall not file a request for
1664 an external review or an expedited external review until the health care
1665 professional or hospital has exhausted the health carrier's prior
1666 authorization appeals process.

1667 (2) A health carrier may waive its internal grievance process and the
1668 requirement for a covered person to exhaust such process prior to filing
1669 a request for an external review or an expedited external review.

1670 (c) (1) At the same time a health carrier sends to a covered person or
1671 a covered person's authorized representative or, in the case of a prior
1672 authorization, a health care professional or a hospital a written notice of
1673 an adverse determination or a final adverse determination issued by the
1674 health carrier, the health carrier shall include a written disclosure to the

1675 covered person and, if applicable, the covered person's authorized
1676 representative or, in the case of a prior authorization, the health care
1677 professional or the hospital of the covered person's, health care
1678 professional's or hospital's right to request an external review.

1679 (2) The written notice shall include:

1680 (A) The following statement or a statement in substantially similar
1681 language: "We have denied your request for benefit approval for a
1682 health care service or course of treatment. You may have the right to
1683 have our decision reviewed by health care professionals who have no
1684 association with us by submitting a request for external review to the
1685 office of the Insurance Commissioner, if our decision involved making
1686 a judgment as to the medical necessity, appropriateness, health care
1687 setting, level of care or effectiveness of the health care service or
1688 treatment you requested.";

1689 (B) For a notice related to an adverse determination, a statement
1690 informing the covered person that:

1691 (i) If the covered person has a medical condition for which the time
1692 period for completion of an expedited internal review of a grievance
1693 involving an adverse determination would seriously jeopardize the life
1694 or health of the covered person or would jeopardize the covered
1695 person's ability to regain maximum function, the covered person or the
1696 covered person's authorized representative may (I) file a request for an
1697 expedited external review, or (II) file a request for an expedited external
1698 review if the adverse determination involves a denial of coverage based
1699 on a determination that the recommended or requested health care
1700 service or treatment is experimental or investigational and the covered
1701 person's treating health care professional certifies in writing that such
1702 recommended or requested health care service or treatment would be
1703 significantly less effective if not promptly initiated; [and]

1704 (ii) Such request for expedited external review may be filed at the
1705 same time the covered person or the covered person's authorized
1706 representative files a request for an expedited internal review of a

1707 grievance involving an adverse determination, except that the
1708 independent review organization assigned to conduct the expedited
1709 external review shall determine whether the covered person shall be
1710 required to complete the expedited internal review of the grievance
1711 prior to conducting the expedited external review; and

1712 (iii) In the case of an adverse determination that involves prior
1713 authorization, the health care professional or hospital may file a request
1714 for expedited external review in connection with the health carrier's
1715 adverse determination at the same time that the health care professional
1716 or hospital files a request for an expedited prior authorization appeal;

1717 (C) For a notice related to a final adverse determination, a statement
1718 informing the covered person that:

1719 (i) If the covered person has a medical condition for which the time
1720 period for completion of an external review would seriously jeopardize
1721 the life or health of the covered person or would jeopardize the covered
1722 person's ability to regain maximum function, the covered person or the
1723 covered person's authorized representative may file a request for an
1724 expedited external review; or

1725 (ii) If the final adverse determination concerns (I) a prior
1726 authorization or other approval for an admission, availability of care,
1727 continued stay or health care service for which the covered person
1728 received emergency services but has not been discharged from a facility,
1729 the covered person, [or] the covered person's authorized representative,
1730 the health care professional or the hospital, as applicable, may file a
1731 request for an expedited external review, or (II) a denial of coverage
1732 based on a determination that the recommended or requested health
1733 care service or treatment is experimental or investigational and the
1734 covered person's treating health care professional certifies in writing
1735 that such recommended or requested health care service or treatment
1736 would be significantly less effective if not promptly initiated, the
1737 covered person or the covered person's authorized representative may
1738 file a request for an expedited external review;

1739 (D) (i) A copy of the description of both the standard and expedited
1740 external review procedures the health carrier is required to provide,
1741 highlighting the provisions in the external review procedures that give
1742 the covered person, [or] the covered person's authorized representative,
1743 the health care professional or the hospital, as applicable, the
1744 opportunity to submit additional information and including any forms
1745 used to process an external review or an expedited external review;

1746 (ii) As part of any forms provided under subparagraph (D)(i) of this
1747 subdivision, an authorization form or other document approved by the
1748 commissioner that complies with the requirements of 45 CFR 164.508,
1749 as amended from time to time, by which the covered person shall
1750 authorize the health carrier and the covered person's treating health care
1751 professional to release, transfer or otherwise divulge, in accordance with
1752 sections 38a-975 to 38a-999a, inclusive, the covered person's protected
1753 health information including medical records for purposes of
1754 conducting an external review or an expedited external review;

1755 (E) A statement that the covered person or the covered person's
1756 authorized representative may request, free of charge, copies of all
1757 documents, communications, information and evidence regarding the
1758 adverse determination or the final adverse determination that were not
1759 previously provided to the covered person or the covered person's
1760 authorized representative.

1761 (3) Upon request pursuant to subparagraph (E) of subdivision (2) of
1762 this subsection, the health carrier shall provide such copies in
1763 accordance with subsection (b) of section 38a-591n, as amended by this
1764 act.

1765 (d) (1) A covered person or a covered person's authorized
1766 representative or, in the case of a prior authorization, a health care
1767 professional or a hospital may file a request for an expedited external
1768 review of an adverse determination or a final adverse determination
1769 with the commissioner, except that an expedited external review shall
1770 not be provided for a retrospective review request of an adverse

1771 determination or a final adverse determination.

1772 (2) Such request may be filed at the time the covered person receives:

1773 (A) An adverse determination, if:

1774 (i) (I) The covered person has a medical condition for which the time
1775 period for completion of an expedited internal review of the adverse
1776 determination would seriously jeopardize the life or health of the
1777 covered person or would jeopardize the covered person's ability to
1778 regain maximum function; or

1779 (II) The denial of coverage is based on a determination that the
1780 recommended or requested health care service or treatment is
1781 experimental or investigational and the covered person's treating health
1782 care professional certifies in writing that such recommended or
1783 requested health care service or treatment would be significantly less
1784 effective if not promptly initiated; and

1785 (ii) The covered person or the covered person's authorized
1786 representative has filed a request for an expedited internal review of the
1787 adverse determination; or

1788 (B) A final adverse determination if:

1789 (i) The covered person has a medical condition where the time period
1790 for completion of a standard external review would seriously jeopardize
1791 the life or health of the covered person or would jeopardize the covered
1792 person's ability to regain maximum function;

1793 (ii) The final adverse determination concerns an admission,
1794 availability of care, continued stay or health care service for which the
1795 covered person received emergency services but has not been
1796 discharged from a facility; or

1797 (iii) The denial of coverage is based on a determination that the
1798 recommended or requested health care service or treatment is
1799 experimental or investigational and the covered person's treating health

1800 care professional certifies in writing that such recommended or
1801 requested health care service or treatment would be significantly less
1802 effective if not promptly initiated.

1803 (3) Such covered person or covered person's authorized
1804 representative shall not be required to file a request for an external
1805 review prior to, or at the same time as, the filing of a request for an
1806 expedited external review and shall not be precluded from filing a
1807 request for an external review, within the time periods set forth in
1808 subsection (e) of this section, if the request for an expedited external
1809 review is determined to be ineligible for such review.

1810 (e) (1) Not later than one hundred twenty calendar days after a
1811 covered person or a covered person's authorized representative receives
1812 a notice of an adverse determination or a final adverse determination,
1813 the covered person or the covered person's authorized representative
1814 may file a request for an external review or an expedited external review
1815 with the commissioner in accordance with this section.

1816 (2) Not later than one business day after the commissioner receives a
1817 request that is complete, the commissioner shall send a copy of such
1818 request to the health carrier that issued the adverse determination or the
1819 final adverse determination that is the subject of the request.

1820 (3) Not later than five business days after the health carrier receives
1821 the copy of an external review request or one calendar day after the
1822 health carrier receives the copy of an expedited external review request,
1823 from the commissioner, the health carrier shall complete a preliminary
1824 review of the request to determine whether:

1825 (A) The individual is or was a covered person under the health
1826 benefit plan at the time the health care service was requested or, in the
1827 case of an external review of a retrospective review request, was a
1828 covered person in the health benefit plan at the time the health care
1829 service was provided;

1830 (B) The health care service that is the subject of the adverse

1831 determination or the final adverse determination is a covered service
1832 under the covered person's health benefit plan but for the health
1833 carrier's determination that the health care service is not covered
1834 because it does not meet the health carrier's requirements for medical
1835 necessity, appropriateness, health care setting, level of care or
1836 effectiveness;

1837 (C) If the health care service or treatment is experimental or
1838 investigational:

1839 (i) Is a covered benefit under the covered person's health benefit plan
1840 but for the health carrier's determination that the service or treatment is
1841 experimental or investigational for a particular medical condition;

1842 (ii) Is not explicitly listed as an excluded benefit under the covered
1843 person's health benefit plan;

1844 (iii) The covered person's treating health care professional has
1845 certified that one of the following situations is applicable:

1846 (I) Standard health care services or treatments have not been effective
1847 in improving the medical condition of the covered person;

1848 (II) Standard health care services or treatments are not medically
1849 appropriate for the covered person; or

1850 (III) There is no available standard health care service or treatment
1851 covered by the health carrier that is more beneficial than the
1852 recommended or requested health care service or treatment; and

1853 (iv) The covered person's treating health care professional:

1854 (I) Has recommended a health care service or treatment that the
1855 health care professional certifies, in writing, is likely to be more
1856 beneficial to the covered person, in the health care professional's
1857 opinion, than any available standard health care services or treatments;
1858 or

1859 (II) Is a licensed, board certified or board eligible health care
1860 professional qualified to practice in the area of medicine appropriate to
1861 treat the covered person's condition and has certified in writing that
1862 scientifically valid studies using accepted protocols demonstrate that
1863 the health care service or treatment requested by the covered person that
1864 is the subject of the adverse determination or the final adverse
1865 determination is likely to be more beneficial to the covered person than
1866 any available standard health care services or treatments;

1867 (D) The covered person has exhausted the health carrier's internal
1868 grievance process or the covered person or the covered person's
1869 authorized representative has filed a request for an expedited external
1870 review as provided under subsection (d) of this section; and

1871 (E) The covered person has provided all the information and forms
1872 required to process an external review or an expedited external review,
1873 including an authorization form as set forth in subparagraph (D)(ii) of
1874 subdivision (2) of subsection (c) of this section.

1875 (4) (A) Not later than one business day after the preliminary review
1876 of an external review request or the day the preliminary review of an
1877 expedited external review request is completed, the health carrier shall
1878 notify the commissioner, the covered person and, if applicable, the
1879 covered person's authorized representative in writing whether the
1880 request for an external review or an expedited external review is
1881 complete and eligible for such review. The commissioner may specify
1882 the form for the health carrier's notice of initial determination under this
1883 subdivision and any supporting information required to be included in
1884 the notice.

1885 (B) If the request:

1886 (i) Is not complete, the health carrier shall notify the commissioner
1887 and the covered person and, if applicable, the covered person's
1888 authorized representative in writing and include in the notice what
1889 information or materials are needed to perfect the request; or

1890 (ii) Is not eligible for external review or expedited external review,
1891 the health carrier shall notify the commissioner, the covered person and,
1892 if applicable, the covered person's authorized representative in writing
1893 and include in the notice the reasons for its ineligibility.

1894 (C) The notice of initial determination shall include a statement
1895 informing the covered person and, if applicable, the covered person's
1896 authorized representative that a health carrier's initial determination
1897 that the request for an external review or an expedited external review
1898 is ineligible for review may be appealed to the commissioner.

1899 (D) Notwithstanding a health carrier's initial determination that a
1900 request for an external review or an expedited external review is
1901 ineligible for review, the commissioner may determine, pursuant to the
1902 terms of the covered person's health benefit plan, that such request is
1903 eligible for such review and assign an independent review organization
1904 to conduct such review. Any such review shall be conducted in
1905 accordance with this section.

1906 (f) (1) Whenever the commissioner is notified pursuant to
1907 subparagraph (A) of subdivision (4) of subsection (e) of this section that
1908 a request is eligible for external review or expedited external review, the
1909 commissioner shall, not later than one business day after receiving such
1910 notice for an external review or one calendar day after receiving such
1911 notice for an expedited external review:

1912 (A) Assign an independent review organization from the list of
1913 approved independent review organizations compiled and maintained
1914 by the commissioner pursuant to section 38a-591l to conduct the review
1915 and notify the health carrier of the name of the assigned independent
1916 review organization. Such assignment shall be done on a random basis
1917 among those approved independent review organizations qualified to
1918 conduct the particular review based on the nature of the health care
1919 service that is the subject of the adverse determination or the final
1920 adverse determination and other circumstances, including conflict of
1921 interest concerns as set forth in section 38a-591m; and

1922 (B) Notify the covered person and, if applicable, the covered person's
1923 authorized representative in writing of the request's eligibility and
1924 acceptance for external review or expedited external review. For an
1925 external review, the commissioner shall include in such notice (i) a
1926 statement that the covered person or the covered person's authorized
1927 representative may submit, not later than five business days after the
1928 covered person or the covered person's authorized representative, as
1929 applicable, received such notice, additional information in writing to the
1930 assigned independent review organization that such organization shall
1931 consider when conducting the external review, and (ii) where and how
1932 such additional information is to be submitted. If additional information
1933 is submitted later than five business days after the covered person or the
1934 covered person's authorized representative, as applicable, received such
1935 notice, the independent review organization may, but shall not be
1936 required to, accept and consider such additional information.

1937 (2) Not later than five business days for an external review or one
1938 calendar day for an expedited external review, after the health carrier
1939 receives notice of the name of the assigned independent review
1940 organization from the commissioner, the health carrier or its designee
1941 utilization review company shall provide to the assigned independent
1942 review organization the documents and any information such health
1943 carrier or utilization review company considered in making the adverse
1944 determination or the final adverse determination.

1945 (3) The failure of the health carrier or its designee utilization review
1946 company to provide the documents and information within the time
1947 specified in subdivision (2) of this subsection shall not delay the
1948 conducting of the review.

1949 (4) (A) If the health carrier or its designee utilization review company
1950 fails to provide the documents and information within the time period
1951 specified in subdivision (2) of this subsection, the independent review
1952 organization may terminate the review and make a decision to reverse
1953 the adverse determination or the final adverse determination.

1954 (B) Not later than one business day after terminating the review and
1955 making the decision to reverse the adverse determination or the final
1956 adverse determination, the independent review organization shall
1957 notify the commissioner, the health carrier, the covered person and, if
1958 applicable, the covered person's authorized representative in writing of
1959 such decision.

1960 (g) (1) The assigned independent review organization shall review all
1961 the information and documents received pursuant to subsection (f) of
1962 this section. In reaching a decision, the independent review organization
1963 shall not be bound by any decisions or conclusions reached during the
1964 health carrier's utilization review process.

1965 (2) Not later than one business day after receiving any information
1966 submitted by the covered person or the covered person's authorized
1967 representative pursuant to subparagraph (B) of subdivision (1) of
1968 subsection (f) of this section, the independent review organization shall
1969 forward such information to the health carrier.

1970 (3) (A) Upon the receipt of any information forwarded pursuant to
1971 subdivision (2) of this subsection, the health carrier may reconsider its
1972 adverse determination or the final adverse determination that is the
1973 subject of the review. Such reconsideration shall not delay or terminate
1974 the review.

1975 (B) The independent review organization shall terminate the review
1976 if the health carrier decides, upon completion of its reconsideration and
1977 notice to such organization as provided in subparagraph (C) of this
1978 subdivision, to reverse its adverse determination or its final adverse
1979 determination and provide coverage or payment for the health care
1980 service or treatment that is the subject of the adverse determination or
1981 the final adverse determination.

1982 (C) Not later than one business day after making the decision to
1983 reverse its adverse determination or its final adverse determination, the
1984 health carrier shall notify the commissioner, the assigned independent
1985 review organization, the covered person and, if applicable, the covered

1986 person's authorized representative in writing of such decision.

1987 (h) In addition to the documents and information received pursuant
1988 to subsection (f) of this section, the independent review organization
1989 shall consider, to the extent the documents or information are available
1990 and the independent review organization considers them appropriate,
1991 the following in reaching a decision:

1992 (1) The covered person's medical records;

1993 (2) The attending health care professional's recommendation;

1994 (3) Consulting reports from appropriate health care professionals and
1995 other documents submitted by the health carrier, the covered person,
1996 the covered person's authorized representative or the covered person's
1997 treating health care professional;

1998 (4) The terms of coverage under the covered person's health benefit
1999 plan to ensure that the independent review organization's decision is
2000 not contrary to the terms of coverage under such health benefit plan;

2001 (5) The most appropriate practice guidelines, which shall include
2002 applicable evidence-based standards and may include any other
2003 practice guidelines developed by the federal government, national or
2004 professional medical societies, medical boards or medical associations;

2005 (6) Any applicable clinical review criteria developed and used by the
2006 health carrier or its designee utilization review company; and

2007 (7) The opinion or opinions of the independent review organization's
2008 clinical peer or peers who conducted the review after considering
2009 subdivisions (1) to (6), inclusive, of this subsection.

2010 (i) (1) The independent review organization shall notify the
2011 commissioner, the health carrier, the covered person and, if applicable,
2012 the covered person's authorized representative in writing of its decision
2013 to uphold, reverse or revise the adverse determination or the final
2014 adverse determination, not later than:

2015 (A) For external reviews, forty-five calendar days after such
2016 organization receives the assignment from the commissioner to conduct
2017 such review;

2018 (B) For external reviews involving a determination that the
2019 recommended or requested health care service or treatment is
2020 experimental or investigational, twenty calendar days after such
2021 organization receives the assignment from the commissioner to conduct
2022 such review;

2023 (C) For expedited external reviews, except as specified under
2024 subparagraph (D) of this subdivision, as expeditiously as the covered
2025 person's medical condition requires, but not later than forty-eight hours
2026 after such organization receives the assignment from the commissioner
2027 to conduct such review or seventy-two hours after such organization
2028 receives such assignment if any portion of such forty-eight-hour period
2029 falls on a weekend;

2030 (D) For expedited external reviews involving a health care service or
2031 course of treatment specified under subparagraph (B) or (C) of
2032 subdivision [(38)] (41) of section 38a-591a, as amended by this act, as
2033 expeditiously as the covered person's medical condition requires, but
2034 not later than twenty-four hours after such organization receives the
2035 assignment from the commissioner to conduct such review; and

2036 (E) For expedited external reviews involving a determination that the
2037 recommended or requested health care service or treatment is
2038 experimental or investigational, as expeditiously as the covered person's
2039 medical condition requires, but not later than five calendar days after
2040 such organization receives the assignment from the commissioner to
2041 conduct such review.

2042 (2) Such notice shall include:

2043 (A) A general description of the reason for the request for the review;

2044 (B) The date the independent review organization received the

2045 assignment from the commissioner to conduct the review;

2046 (C) The date the review was conducted;

2047 (D) The date the organization made its decision;

2048 (E) The principal reason or reasons for its decision, including what
2049 applicable evidence-based standards, if any, were used as a basis for its
2050 decision;

2051 (F) The rationale for the organization's decision;

2052 (G) Reference to the evidence or documentation, including any
2053 evidence-based standards, considered by the organization in reaching
2054 its decision; and

2055 (H) For a review involving a determination that the recommended or
2056 requested health care service or treatment is experimental or
2057 investigational:

2058 (i) A description of the covered person's medical condition;

2059 (ii) A description of the indicators relevant to determining whether
2060 there is sufficient evidence to demonstrate that (I) the recommended or
2061 requested health care service or treatment is likely to be more beneficial
2062 to the covered person than any available standard health care services
2063 or treatments, and (II) the adverse risks of the recommended or
2064 requested health care service or treatment would not be substantially
2065 increased over those of available standard health care services or
2066 treatments;

2067 (iii) A description and analysis of any medical or scientific evidence
2068 considered in reaching the opinion;

2069 (iv) A description and analysis of any evidence-based standard; and

2070 (v) Information on whether the clinical peer's rationale for the
2071 opinion is based on the documents and information set forth in
2072 subsection (f) of this section.

2073 (3) Upon the receipt of a notice of the independent review
2074 organization's decision to reverse or revise an adverse determination or
2075 a final adverse determination, the health carrier shall immediately
2076 approve the coverage that was the subject of the adverse determination
2077 or the final adverse determination.

2078 Sec. 15. Section 38a-591h of the general statutes is repealed and the
2079 following is substituted in lieu thereof (*Effective October 1, 2021*):

2080 (a) (1) Each health carrier shall maintain written records to document
2081 all grievances and prior authorization appeals of adverse
2082 determinations it receives, including the notices and claims associated
2083 with such grievances or prior authorization appeals, during a calendar
2084 year.

2085 (2) (A) Each health carrier shall maintain such records for not less
2086 than six years after the notice of an adverse determination that is the
2087 subject of a grievance or a prior authorization appeal was provided to a
2088 covered person or the covered person's authorized representative, as
2089 applicable, under section 38a-591d, as amended by this act.

2090 (B) The health carrier shall make such records available for
2091 examination by covered persons, to the extent such records are
2092 permitted to be disclosed by law, the commissioner and appropriate
2093 federal oversight agencies upon request. Such records shall be
2094 maintained in a manner that is reasonably clear and accessible to the
2095 commissioner.

2096 (b) For each grievance and each prior authorization appeal the record
2097 shall contain, at a minimum, the following information: (1) A general
2098 description of the reason for the grievance or prior authorization appeal;
2099 (2) the date the health carrier received the grievance or prior
2100 authorization appeal; (3) the date of each review or, if applicable, review
2101 meeting of the grievance; (4) the resolution at each level of the grievance
2102 or prior authorization appeal, if applicable; (5) the date of resolution at
2103 each such level, if applicable; and (6) the name of the covered person for
2104 whom the grievance or prior authorization appeal was filed.

2105 (c) (1) Each health carrier shall maintain written records of all
2106 requests for external reviews, whether such requests are for standard or
2107 expedited external reviews, that such health carrier receives notice of
2108 from the commissioner in a calendar year. The health carrier shall
2109 maintain such records in the aggregate by state where the covered
2110 person requesting such review resides and by each type of health benefit
2111 plan offered by the health carrier, and shall submit a report to the
2112 commissioner upon request, in a format prescribed by the
2113 commissioner.

2114 (2) Such report shall include, in the aggregate by state where the
2115 covered person requesting such review resides and by each type of
2116 health benefit plan:

2117 (A) The total number of requests for an external review, whether such
2118 requests were for a standard or expedited external review;

2119 (B) From the total number of such requests reported under
2120 subparagraph (A) of this subdivision, the number of requests
2121 determined eligible for a full external review, whether such requests
2122 were for a standard or expedited external review; and

2123 (C) Any other information the commissioner may request or require.

2124 (3) The health carrier shall retain the written records required
2125 pursuant to subdivision (1) of this subsection for not less than six years
2126 after the request for an external review or an expedited external review
2127 was received.

2128 Sec. 16. Section 38a-591j of the general statutes is repealed and the
2129 following is substituted in lieu thereof (*Effective October 1, 2021*):

2130 (a) No utilization review company shall conduct utilization review in
2131 this state for a health benefit plan under the jurisdiction of the
2132 commissioner unless it is licensed by the commissioner. All licenses
2133 shall be renewed on an annual basis.

2134 (b) The annual license fee shall be three thousand dollars and shall be

2135 dedicated to the regulation of utilization review, except that the
2136 commissioner shall be authorized to use such funds as is necessary to
2137 (1) implement the provisions of sections 38a-91aa to 38a-91tt, inclusive,
2138 and (2) contract with The University of Connecticut School of Medicine
2139 to provide any medical consultations necessary to carry out the
2140 commissioner's responsibilities under this title with respect to consumer
2141 and market conduct matters.

2142 (c) The request for licensure or renewal shall include the name,
2143 address, telephone number and normal business hours of the utilization
2144 review company, and the name and telephone number of a person for
2145 the commissioner to contact. Any material changes in the information
2146 filed in accordance with this subsection shall be filed with the
2147 commissioner not later than thirty calendar days after the change.

2148 (d) The commissioner shall receive and investigate all grievances
2149 filed against utilization review companies by a covered person, facility
2150 or health care professional. The commissioner shall code, track and
2151 review all grievances. The commissioner may impose such penalties as
2152 authorized, in accordance with section 38a-591k.

2153 (e) In the absence of any contractual agreement to the contrary, the
2154 covered person or the covered person's authorized representative shall
2155 be responsible for requesting certification and for authorizing the
2156 covered person's treating health care professional to release, in a timely
2157 manner, all information necessary to conduct the review. A utilization
2158 review company shall permit the covered person, the covered person's
2159 authorized representative or the covered person's treating health care
2160 professional to assist in fulfilling that responsibility.

2161 Sec. 17. Subdivision (1) of subsection (a) of section 38a-591n of the
2162 general statutes is repealed and the following is substituted in lieu
2163 thereof (*Effective October 1, 2021*):

2164 (a) (1) Upon request pursuant to subparagraph (E) of subdivision (1)
2165 of subsection [(e)] (f) of section 38a-591d, as amended by this act, the
2166 health carrier shall provide free of charge to a covered person or a

2167 covered person's authorized representative, as applicable, copies of all
2168 documents, communications, information and evidence, including
2169 citations to any medical journals, regarding the covered person's benefit
2170 request that is the subject of the adverse determination that were not
2171 submitted by the covered person or the covered person's authorized
2172 representative and were available to the health carrier or the utilization
2173 review entity that made the adverse determination at the time such
2174 adverse determination was made.

2175 Sec. 18. Section 38a-478c of the general statutes is repealed and the
2176 following is substituted in lieu thereof (*Effective October 1, 2021*):

2177 (a) On or before May first of each year, each managed care
2178 organization shall submit to the commissioner:

2179 (1) A report on its quality assurance plan that includes, but is not
2180 limited to, information on complaints related to providers and quality
2181 of care, on decisions related to patient requests for coverage and on prior
2182 authorization statistics. Statistical information shall be submitted in a
2183 manner permitting comparison across plans and shall include, but not
2184 be limited to: (A) The ratio of the number of complaints received to the
2185 number of enrollees; (B) a summary of the complaints received related
2186 to providers and delivery of care or services and the action taken on the
2187 complaint; (C) the ratio of the number of prior authorizations denied to
2188 the number of prior authorizations requested; (D) the number of
2189 utilization review determinations made by or on behalf of a managed
2190 care organization not to certify an admission, service, procedure or
2191 extension of stay, and the denials upheld and reversed on appeal within
2192 the managed care organization's utilization review procedure; (E) the
2193 percentage of those employers or groups that renew their contracts
2194 within the previous twelve months; and (F) notwithstanding the
2195 provisions of this subsection, on or before July first of each year, all data
2196 required by the National Committee for Quality Assurance for its
2197 Health Plan Employer Data and Information Set. If an organization does
2198 not provide information for the National Committee for Quality
2199 Assurance for its Health Plan Employer Data and Information Set, then

2200 it shall provide such other equivalent data as the commissioner may
2201 require by regulations adopted in accordance with the provisions of
2202 chapter 54. The commissioner shall find that the requirements of this
2203 subdivision have been met if the managed care plan has received a one-
2204 year or higher level of accreditation by the National Committee for
2205 Quality Assurance and has submitted the Health Plan Employee Data
2206 Information Set data required by subparagraph (F) of this subdivision;

2207 (2) A model contract that contains the provisions currently in force in
2208 contracts between the managed care organization and preferred
2209 provider networks in this state, and the managed care organization and
2210 participating providers in this state and, upon the commissioner's
2211 request, a copy of any individual contracts between such parties,
2212 provided the contract may withhold or redact proprietary fee schedule
2213 information;

2214 (3) A written statement of the types of financial arrangements or
2215 contractual provisions that the managed care organization has with
2216 hospitals, utilization review companies, physicians, preferred provider
2217 networks and any other health care providers including, but not limited
2218 to, compensation based on a fee-for-service arrangement, a risk-sharing
2219 arrangement or a capitated risk arrangement;

2220 (4) Such information as the commissioner deems necessary to
2221 complete the consumer report card required pursuant to section 38a-
2222 478l, as amended by this act. Such information may include, but need
2223 not be limited to: (A) The organization's characteristics, including its
2224 model, its profit or nonprofit status, its address and telephone number,
2225 the length of time it has been licensed in this and any other state, its
2226 number of enrollees and whether it has received any national or regional
2227 accreditation; (B) a summary of the information required by subdivision
2228 (3) of this subsection, including any change in a plan's rates over the
2229 prior three years, its state medical loss ratio and its federal medical loss
2230 ratio, as both terms are defined in section 38a-478l, as amended by this
2231 act, how it compensates health care providers and its premium level; (C)
2232 a description of services, the number of primary care physicians and

2233 specialists, the number and nature of participating preferred provider
2234 networks and the distribution and number of hospitals, by county; (D)
2235 utilization review information, including the name or source of any
2236 established medical protocols and the utilization review standards; (E)
2237 medical management information, including the provider-to-patient
2238 ratio by primary care provider and specialty care provider, the
2239 percentage of primary and specialty care providers who are board
2240 certified, and how the medical protocols incorporate input as required
2241 in section 38a-478e; (F) the quality assurance information required to be
2242 submitted under the provisions of subdivision (1) of subsection (a) of
2243 this section; (G) the status of the organization's compliance with the
2244 reporting requirements of this section; (H) whether the organization
2245 markets to individuals and Medicare recipients; (I) the number of
2246 hospital days per thousand enrollees; and (J) the average length of
2247 hospital stays for specific procedures, as may be requested by the
2248 commissioner;

2249 (5) A summary of the procedures used by managed care
2250 organizations to credential providers; [and]

2251 (6) A report on claims denial data for lives covered in the state for the
2252 prior calendar year, in a format prescribed by the commissioner, that
2253 includes: (A) The total number of claims received; (B) the total number
2254 of claims denied; (C) the total number of denials that were appealed; (D)
2255 the total number of denials that were reversed upon appeal; (E) (i) the
2256 reasons for the denials, including, but not limited to, "not a covered
2257 benefit", "not medically necessary" and "not an eligible enrollee", (ii) the
2258 total number of times each reason was used, and (iii) the percentage of
2259 the total number of denials each reason was used; and (F) other
2260 information the commissioner deems necessary; and

2261 (7) For each year beginning on or after January 1, 2022, a report on
2262 prior authorizations for such year, in a format prescribed by the
2263 commissioner, that includes the following information for all managed
2264 care plans that the managed care organization delivered, issued for
2265 delivery, renewed, amended or continued in this state for such year: (A)

2266 The number of prior authorization requests that such managed care
2267 organization received; (B) the number and percentage of prior
2268 authorization requests that such managed care organization approved;
2269 (C) the number and percentage of prior authorization requests that such
2270 managed care organization initially denied and were the subject of a
2271 prior authorization appeal; (D) the number and percentage of prior
2272 authorization requests that such managed care organization initially
2273 denied but subsequently overturned following a prior authorization
2274 appeal; (E) the average and median number of hours that elapsed
2275 between such managed care organization's receipt of a prior
2276 authorization request and response thereto; and (F) such other
2277 information that the commissioner, in the commissioner's discretion,
2278 deems necessary. The managed care organization shall disclose the
2279 information required under this subdivision, with a breakdown for each
2280 type of covered benefit, in the aggregate for such managed care plans
2281 and separately for each hospital that provided a covered benefit under
2282 any such managed care plan. For the purposes of this subdivision,
2283 "covered benefit", "prior authorization" and "prior authorization appeal"
2284 have the same meanings as provided in section 38a-591a, as amended
2285 by this act, and "hospital" has the same meaning as provided in section
2286 19a-490.

2287 (b) The information required pursuant to subsection (a) of this section
2288 shall be consistent with the data required by the National Committee for
2289 Quality Assurance (NCQA) for its Health Plan Employer Data and
2290 Information Set (HEDIS).

2291 (c) The commissioner may accept electronic filing for any of the
2292 requirements under this section.

2293 (d) No managed care organization shall be liable for a claim arising
2294 out of the submission of any information concerning complaints
2295 concerning providers, provided the managed care organization
2296 submitted the information in good faith.

2297 (e) (1) The information required under subdivision (6) of subsection

2298 (a) of this section shall be posted on the Insurance Department's Internet
2299 web site.

2300 (2) Each managed care organization shall make the information
2301 required under subdivision (7) of subsection (a) of this section publicly
2302 available on the managed care organization's Internet web site, and
2303 disclose the address of such Internet web site in such managed care
2304 organization's enrollment materials.

2305 Sec. 19. Section 38a-478a of the general statutes is repealed and the
2306 following is substituted in lieu thereof (*Effective October 1, 2021*):

2307 On March first annually, the [Insurance Commissioner]
2308 commissioner shall submit a report to the Governor and to the joint
2309 standing committees of the General Assembly having cognizance of
2310 matters relating to public health and insurance, concerning the
2311 commissioner's responsibilities under the provisions of sections 38a-478
2312 to 38a-478u, inclusive, 38a-479aa, 38a-591a to 38a-591h, inclusive, [and]
2313 as amended by this act, 38a-993 and section 6 of this act. The report shall
2314 include: (1) A summary of the quality assurance plans submitted by
2315 managed care organizations pursuant to section 38a-478c, as amended
2316 by this act, along with suggested changes to improve such plans; (2)
2317 suggested modifications to the consumer report card developed under
2318 the provisions of section 38a-478l, as amended by this act; (3) a summary
2319 of the commissioner's procedures and activities in conducting market
2320 conduct examinations of utilization review companies and preferred
2321 provider networks, including, but not limited to: (A) The number of
2322 desk and field audits completed during the previous calendar year; (B)
2323 a summary of findings of the desk and field audits, including any
2324 recommendations made for improvements or modifications; (C) a
2325 description of complaints concerning managed care companies, and any
2326 preferred provider network that provides services to enrollees on behalf
2327 of the managed care organization, including a summary and analysis of
2328 any trends or similarities found in the managed care complaints filed by
2329 enrollees; (4) a summary of the complaints concerning managed care
2330 organizations received by the Insurance Department's Consumer

2331 Affairs Division and the commissioner under section 38a-591g, as
2332 amended by this act, including a summary and analysis of any trends
2333 or similarities found in the complaints received; (5) a summary of any
2334 violations the commissioner has found against any managed care
2335 organization or any preferred provider network that provides services
2336 to enrollees on behalf of the managed care organization; [and] (6) a
2337 summary of the issues discussed related to health care or managed care
2338 organizations at the Insurance Department's quarterly forums
2339 throughout the state; and (7) the information submitted to the
2340 commissioner pursuant to section 6 of this act and subdivision (7) of
2341 subsection (a) of section 38a-478c, as amended by this act.

2342 Sec. 20. Section 38a-478l of the general statutes is repealed and the
2343 following is substituted in lieu thereof (*Effective October 1, 2021*):

2344 (a) For the purposes of this section and sections 38a-477c, 38a-478c, as
2345 amended by this act, and 38a-478g:

2346 (1) "Federal medical loss ratio" has the same meaning as provided in,
2347 and shall be calculated in accordance with, the Patient Protection and
2348 Affordable Care Act, P.L. 111-148, as amended from time to time, and
2349 regulations adopted thereunder; and

2350 (2) "State medical loss ratio" means the ratio of incurred claims to
2351 earned premiums for the prior calendar year for managed care plans
2352 issued in the state. Claims shall be limited to medical expenses for
2353 services and supplies provided to enrollees and shall not include
2354 expenses for stop-loss coverage, reinsurance, enrollee educational
2355 programs or other cost containment programs or features;

2356 [(a)] (b) Not later than October fifteenth of each year, the Insurance
2357 Commissioner, after consultation with the Commissioner of Public
2358 Health, shall develop and distribute a consumer report card on all
2359 managed care organizations. The commissioner shall develop the
2360 consumer report card in a manner permitting consumer comparison
2361 across organizations.

2362 [(b) (1)] (c) The consumer report card shall be known as the
2363 "Consumer Report Card on Health Insurance Carriers in Connecticut"
2364 and shall include: [(A) all]

2365 (1) All health care centers licensed pursuant to chapter 698a;

2366 [, (B) the] (2) The fifteen largest licensed health insurers, measured on
2367 the basis of Connecticut direct written health premiums, that use
2368 provider networks and that are not included in [subparagraph (A) of
2369 this] subdivision (1) of this subsection;

2370 [, (C) the] (3) The state medical loss ratio of each [such] health care
2371 center or licensed health insurer described in subdivision (1) or (2) of
2372 this subsection;

2373 [, (D) the] (4) The federal medical loss ratio of each [such] health care
2374 center or licensed health insurer described in subdivision (1) or (2) of
2375 this subsection;

2376 [, (E) the] (5) The information required under subdivision (6) of
2377 subsection (a) of section 38a-478c, as amended by this act

2378 [and (F) information] (6) Information concerning mental health
2379 services, as specified in subsection [(c)] (d) of this section; and [. The
2380 insurers selected pursuant to subparagraph (B) of this subdivision shall
2381 be selected on the basis of Connecticut direct written health premiums
2382 from such network plans.

2383 (2) For the purposes of this section and sections 38a-477c, 38a-478c
2384 and 38a-478g:

2385 (A) "State medical loss ratio" means the ratio of incurred claims to
2386 earned premiums for the prior calendar year for managed care plans
2387 issued in the state. Claims shall be limited to medical expenses for
2388 services and supplies provided to enrollees and shall not include
2389 expenses for stop loss coverage, reinsurance, enrollee educational
2390 programs or other cost containment programs or features;

2391 (B) "Federal medical loss ratio" has the same meaning as provided in,
 2392 and shall be calculated in accordance with, the Patient Protection and
 2393 Affordable Care Act, P.L. 111-148, as amended from time to time, and
 2394 regulations adopted thereunder]

2395 (7) The results of the most recent health care provider satisfaction
 2396 survey conducted by the commissioner pursuant to section 9 of this act.

2397 [(c)] (d) With respect to mental health services, the consumer report
 2398 card shall include information or measures with respect to the
 2399 percentage of enrollees receiving mental health services, utilization of
 2400 mental health and chemical dependence services, inpatient and
 2401 outpatient admissions, discharge rates and average lengths of stay. Such
 2402 data shall be collected in a manner consistent with the National
 2403 Committee for Quality Assurance Health Plan Employer Data and
 2404 Information Set measures.

2405 [(d)] (e) The commissioner shall test market a draft of the consumer
 2406 report card prior to its publication and distribution. As a result of such
 2407 test marketing, the commissioner may make any necessary modification
 2408 to its form or substance. The Insurance Department shall prominently
 2409 display a link to the consumer report card on the department's Internet
 2410 web site.

2411 [(e)] (f) The commissioner shall analyze annually the data submitted
 2412 under [subparagraphs (E) and (F) of subdivision (1)] subdivisions (5)
 2413 and (6) of subsection [(b)] (c) of this section for the accuracy of, trends in
 2414 and statistically significant differences in such data among the health
 2415 care centers and licensed health insurers included in the consumer
 2416 report card. The commissioner may investigate any such differences to
 2417 determine whether further action by the commissioner is warranted.

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

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

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.]