



General Assembly

February Session, 2020

Raised Bill No. 321

LCO No. 2017



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING THE BURDEN OF PROOF DURING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.

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

1 Section 1. Subsection (a) of section 38a-591c of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective January*
3 *1, 2021*):

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

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

13 (B) Except as provided in subdivisions (3), (4) and (5) of this
14 subsection, a health carrier may develop its own clinical review criteria

15 or it may purchase or license clinical review criteria from qualified
16 vendors approved by the commissioner, provided such clinical review
17 criteria conform to the requirements of subparagraph (A) of this
18 subdivision.

19 (C) Each health carrier shall (i) post on its Internet web site (I) any
20 clinical review criteria it uses, and (II) links to any rule, guideline,
21 protocol or other similar criterion a health carrier may rely upon to make
22 an adverse determination as described in subparagraph (F) of
23 subdivision (1) of subsection (e) of section 38a-591d, and (ii) make its
24 clinical review criteria available upon request to authorized government
25 agencies.

26 (D) For each utilization review, there shall be a rebuttable
27 presumption that each health care service under review is medically
28 necessary if such service was ordered by a health care professional
29 acting within such professional's scope of practice. A health carrier, or
30 any utilization review company or designee of a health carrier that
31 performs utilization review on the health carrier's behalf, shall have the
32 burden of proving that a health care service is not medically necessary.

33 (3) For any utilization review for the treatment of a substance use
34 disorder, as described in section 17a-458, the clinical review criteria used
35 shall be: (A) The most recent edition of the American Society of
36 Addiction Medicine Treatment Criteria for Addictive, Substance-
37 Related, and Co-Occurring Conditions; or (B) clinical review criteria that
38 the health carrier demonstrates to the Insurance Department is
39 consistent with the most recent edition of the American Society of
40 Addiction Medicine Treatment Criteria for Addictive, Substance-
41 Related, and Co-Occurring Conditions, except that nothing in this
42 subdivision shall prohibit a health carrier from developing its own
43 clinical review criteria or purchasing or licensing additional clinical
44 review criteria from qualified vendors approved by the commissioner,
45 to address advancements in technology or types of care for the
46 treatment of a substance use disorder, that are not covered in the most
47 recent edition of the American Society of Addiction Medicine Treatment

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

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

72 (5) For any utilization review for the treatment of an adult mental
73 disorder, the clinical review criteria used shall be: (A) The most recent
74 guidelines of the American Psychiatric Association or the most recent
75 Standards and Guidelines of the Association for Ambulatory Behavioral
76 Healthcare; or (B) clinical review criteria that the health carrier
77 demonstrates to the Insurance Department is consistent with the most
78 recent guidelines of the American Psychiatric Association or the most
79 recent Standards and Guidelines of the Association for Ambulatory
80 Behavioral Healthcare, except that nothing in this subdivision shall
81 prohibit a health carrier from developing its own clinical review criteria

82 or purchasing or licensing additional clinical review criteria from
83 qualified vendors approved by the commissioner, to address
84 advancements in technology or types of care for the treatment of an
85 adult mental disorder, that are not covered in the most recent guidelines
86 of the American Psychiatric Association or the most recent Standards
87 and Guidelines of the Association for Ambulatory Behavioral
88 Healthcare. Any such clinical review criteria developed by a health
89 carrier or purchased or licensed from a qualified vendor shall conform
90 to the requirements of subparagraph (A) of subdivision (2) of this
91 subsection.

92 Sec. 2. Subsection (c) of section 38a-591e of the 2020 supplement to
93 the general statutes is repealed and the following is substituted in lieu
94 thereof (*Effective January 1, 2021*):

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

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

103 (C) (i) For each review of an adverse determination under this section,
104 there shall be a rebuttable presumption that each health care service
105 under review is medically necessary if such service was ordered by a
106 health care professional acting within the scope of such health care
107 professional's practice. The health carrier may rebut such presumption
108 by reasonably substantiating to the clinical peer or peers conducting the
109 review under this section that such service is not medically necessary.

110 [(C)] (ii) The clinical peer or peers conducting a review under this
111 section shall take into consideration all comments, documents, records
112 and other information relevant to the covered person's benefit request
113 that is the subject of the adverse determination under review, that are

114 submitted by the covered person or the covered person's authorized
115 representative, regardless of whether such information was submitted
116 or considered in making the initial adverse determination.

117 (D) Prior to issuing a decision, the health carrier shall provide free of
118 charge, by facsimile, electronic means or any other expeditious method
119 available, to the covered person or the covered person's authorized
120 representative, as applicable, any new or additional documents,
121 communications, information and evidence relied upon and any new or
122 additional scientific or clinical rationale used by the health carrier in
123 connection with the grievance. Such documents, communications,
124 information, evidence and rationale shall be provided sufficiently in
125 advance of the date the health carrier is required to issue a decision to
126 permit the covered person or the covered person's authorized
127 representative, as applicable, a reasonable opportunity to respond prior
128 to such date.

129 (2) If the review under subdivision (1) of this subsection is an
130 expedited review, all necessary information, including the health
131 carrier's decision, shall be transmitted between the health carrier and the
132 covered person or the covered person's authorized representative, as
133 applicable, by telephone, facsimile, electronic means or any other
134 expeditious method available.

135 (3) If the review under subdivision (1) of this subsection is an
136 expedited review of a grievance involving an adverse determination of
137 a concurrent review request, pursuant to 45 CFR 147.136, as amended
138 from time to time, the treatment shall be continued without liability to
139 the covered person until the covered person has been notified of the
140 review decision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2021	38a-591c(a)
Sec. 2	January 1, 2021	38a-591e(c)

Statement of Purpose:

To require that health carriers bear the burden of proving that certain health care services under adverse determination or utilization review are not medically necessary.

[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.]