General Assembly

Raised Bill No. 321

February Session, 2020

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:

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 Subsection (a) of section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.]