



General Assembly

February Session, 2022

Raised Bill No. 415

LCO No. 3074



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING STEP THERAPY, 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 Subsection (a) of 38a-510 of the general statutes is repealed
2 and the following is substituted in lieu thereof (*Effective January 1, 2023*):

3 (a) No insurance company, hospital service corporation, medical
4 service corporation, health care center or other entity delivering, issuing
5 for delivery, renewing, amending or continuing an individual health
6 insurance policy or contract that provides coverage for prescription
7 drugs may:

8 (1) Require any person covered under such policy or contract to
9 obtain prescription drugs from a mail order pharmacy as a condition of
10 obtaining benefits for such drugs; or

11 (2) Require, if such insurance company, hospital service corporation,
12 medical service corporation, health care center or other entity uses step
13 therapy for such drugs, the use of step therapy for:

14 (A) [any] Any prescribed drug for longer than sixty days; [,] or

15 (B) [a] A prescribed drug for [cancer] treatment of a behavioral health
16 condition or a chronic, disabling or life-threatening condition or disease
17 for an insured who has been diagnosed with [stage IV metastatic cancer]
18 such a condition or disease, provided such prescribed drug is in
19 compliance with approved federal Food and Drug Administration
20 indications.

21 (3) At the expiration of the time period specified in subparagraph (A)
22 of subdivision (2) of this subsection, [or for a prescribed drug described
23 in subparagraph (B) of subdivision (2) of this subsection,] an insured's
24 treating health care provider may deem such step therapy drug regimen
25 clinically ineffective for the insured, at which time the insurance
26 company, hospital service corporation, medical service corporation,
27 health care center or other entity shall authorize dispensation of and
28 coverage for the drug prescribed by the insured's treating health care
29 provider, provided such drug is a covered drug under such policy or
30 contract. If such provider does not deem such step therapy drug
31 regimen clinically ineffective or has not requested an override pursuant
32 to subdivision (1) of subsection (b) of this section, such drug regimen
33 may be continued. For purposes of this section, "step therapy" means a
34 protocol or program that establishes the specific sequence in which
35 prescription drugs for a specified medical condition are to be prescribed.

36 Sec. 2. Subsection (a) of section 38a-544 of the general statutes is
37 repealed and the following is substituted in lieu thereof (*Effective January*
38 *1, 2023*):

39 (a) No insurance company, hospital service corporation, medical
40 service corporation, health care center or other entity delivering, issuing
41 for delivery, renewing, amending or continuing a group health
42 insurance policy or contract that provides coverage for prescription
43 drugs may:

44 (1) Require any person covered under such policy or contract to
45 obtain prescription drugs from a mail order pharmacy as a condition of

46 obtaining benefits for such drugs; or

47 (2) Require, if such insurance company, hospital service corporation,
48 medical service corporation, health care center or other entity uses step
49 therapy for such drugs, the use of step therapy for:

50 (A) [any] Any prescribed drug for longer than sixty days; [,] or

51 (B) [a] A prescribed drug for [cancer] treatment of a behavioral health
52 condition or a chronic, disabling or life-threatening condition or disease
53 for an insured who has been diagnosed with [stage IV metastatic cancer]
54 such a condition or disease, provided such prescribed drug is in
55 compliance with approved federal Food and Drug Administration
56 indications.

57 (3) At the expiration of the time period specified in subparagraph (A)
58 of subdivision (2) of this subsection, [or for a prescribed drug described
59 in subparagraph (B) of subdivision (2) of this subsection,] an insured's
60 treating health care provider may deem such step therapy drug regimen
61 clinically ineffective for the insured, at which time the insurance
62 company, hospital service corporation, medical service corporation,
63 health care center or other entity shall authorize dispensation of and
64 coverage for the drug prescribed by the insured's treating health care
65 provider, provided such drug is a covered drug under such policy or
66 contract. If such provider does not deem such step therapy drug
67 regimen clinically ineffective or has not requested an override pursuant
68 to subdivision (1) of subsection (b) of this section, such drug regimen
69 may be continued. For purposes of this section, "step therapy" means a
70 protocol or program that establishes the specific sequence in which
71 prescription drugs for a specified medical condition are to be prescribed.

72 Sec. 3. Subdivision (7) of section 38a-591a of the general statutes is
73 repealed and the following is substituted in lieu thereof (*Effective January*
74 *1, 2023*):

75 (7) "Clinical peer" means a physician or other health care professional
76 who;

77 (A) [holds] For a review other than as specified under subparagraph
78 (B) or (C) of subdivision (38) of this section:

79 (i) Holds a nonrestricted license in a state of the United States [and]
80 in the same [or similar] specialty as [typically manages the medical
81 condition, procedure or treatment] the treating physician or other health
82 care professional under review; [, and]

83 (ii) Holds a doctoral or medical degree; and

84 (iii) (I) Holds an applicable national board certification including at
85 the subspecialty level, where available, or (II) actively practices and
86 typically manages the medical condition under review or provides the
87 procedure or treatment under review; or

88 (B) [for] For a review specified under subparagraph (B) or (C) of
89 subdivision (38) of this section concerning:

90 (i) [a] A child or adolescent substance use disorder or a child or
91 adolescent mental disorder, holds (I) a national board certification in
92 child and adolescent psychiatry, or (II) a doctoral level psychology
93 degree with training and clinical experience in the treatment of child
94 and adolescent substance use disorder or child and adolescent mental
95 disorder, as applicable; [,] or

96 (ii) [an] An adult substance use disorder or an adult mental disorder,
97 holds (I) a national board certification in psychiatry, or (II) a doctoral
98 level psychology degree with training and clinical experience in the
99 treatment of adult substance use disorders or adult mental disorders, as
100 applicable.

101 Sec. 4. Subsection (a) of section 38a-591c of the general statutes is
102 repealed and the following is substituted in lieu thereof (*Effective January*
103 *1, 2023*):

104 (a) (1) Each health carrier shall contract with (A) health care
105 professionals to administer such health carrier's utilization review
106 program, and (B) clinical peers to evaluate the clinical appropriateness

107 of an adverse determination.

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

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

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

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

134 (3) For any utilization review for the treatment of a substance use
135 disorder, as described in section 17a-458, the clinical review criteria used
136 shall be: (A) The most recent edition of the American Society of
137 Addiction Medicine Treatment Criteria for Addictive, Substance-
138 Related, and Co-Occurring Conditions; or (B) clinical review criteria that

139 the health carrier demonstrates to the Insurance Department is
140 consistent with the most recent edition of the American Society of
141 Addiction Medicine Treatment Criteria for Addictive, Substance-
142 Related, and Co-Occurring Conditions, except that nothing in this
143 subdivision shall prohibit a health carrier from developing its own
144 clinical review criteria or purchasing or licensing additional clinical
145 review criteria from qualified vendors approved by the commissioner,
146 to address advancements in technology or types of care for the
147 treatment of a substance use disorder, that are not covered in the most
148 recent edition of the American Society of Addiction Medicine Treatment
149 Criteria for Addictive, Substance-Related, and Co-Occurring
150 Conditions. Any such clinical review criteria developed by a health
151 carrier or purchased or licensed from a qualified vendor shall conform
152 to the requirements of subparagraph (A) of subdivision (2) of this
153 subsection.

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

173 (5) For any utilization review for the treatment of an adult mental
174 disorder, the clinical review criteria used shall be: (A) The most recent
175 guidelines of the American Psychiatric Association or the most recent
176 Standards and Guidelines of the Association for Ambulatory Behavioral
177 Healthcare; or (B) clinical review criteria that the health carrier
178 demonstrates to the Insurance Department is consistent with the most
179 recent guidelines of the American Psychiatric Association or the most
180 recent Standards and Guidelines of the Association for Ambulatory
181 Behavioral Healthcare, except that nothing in this subdivision shall
182 prohibit a health carrier from developing its own clinical review criteria
183 or purchasing or licensing additional clinical review criteria from
184 qualified vendors approved by the commissioner, to address
185 advancements in technology or types of care for the treatment of an
186 adult mental disorder, that are not covered in the most recent guidelines
187 of the American Psychiatric Association or the most recent Standards
188 and Guidelines of the Association for Ambulatory Behavioral
189 Healthcare. Any such clinical review criteria developed by a health
190 carrier or purchased or licensed from a qualified vendor shall conform
191 to the requirements of subparagraph (A) of subdivision (2) of this
192 subsection.

193 Sec. 5. Subsection (a) of section 38a-591d of the general statutes is
194 repealed and the following is substituted in lieu thereof (*Effective January*
195 *1, 2023*):

196 (a) (1) Each health carrier shall maintain written procedures for (A)
197 utilization review and benefit determinations, (B) expedited utilization
198 review and benefit determinations with respect to prospective urgent
199 care requests and concurrent review urgent care requests, and (C)
200 notifying covered persons or covered persons' authorized
201 representatives of such review and benefit determinations. Each health
202 carrier shall make such review and benefit determinations within the
203 specified time periods under this section.

204 (2) In determining whether a benefit request shall be considered an
205 urgent care request, an individual acting on behalf of a health carrier

206 shall apply the judgment of a prudent layperson who possesses an
207 average knowledge of health and medicine, except that any benefit
208 request (A) determined to be an urgent care request by a health care
209 professional with knowledge of the covered person's medical condition,
210 or (B) specified under subparagraph (B) or (C) of subdivision (38) of
211 section 38a-591a, as amended by this act, shall be deemed an urgent care
212 request.

213 (3) (A) At the time a health carrier notifies a covered person, a covered
214 person's authorized representative or a covered person's health care
215 professional of an initial adverse determination that was based, in whole
216 or in part, on medical necessity, of a concurrent or prospective
217 utilization review or of a benefit request, the health carrier shall notify
218 the covered person's health care professional (i) of the opportunity for a
219 conference as provided in subparagraph (B) of this subdivision, and (ii)
220 that such conference shall not be considered a grievance of such initial
221 adverse determination as long as a grievance has not been filed as set
222 forth in subparagraph (B) of this subdivision.

223 (B) After a health carrier notifies a covered person, a covered person's
224 authorized representative or a covered person's health care professional
225 of an initial adverse determination that was based, in whole or in part,
226 on medical necessity, of a concurrent or prospective utilization review
227 or of a benefit request, the health carrier shall offer a covered person's
228 health care professional the opportunity to confer, at the request of the
229 covered person's health care professional, with a clinical peer of such
230 health carrier, provided such covered person, covered person's
231 authorized representative or covered person's health care professional
232 has not filed a grievance of such initial adverse determination prior to
233 such conference. Such conference shall not be considered a grievance of
234 such initial adverse determination. Such health carrier shall grant such
235 clinical peer authority to reverse such initial adverse determination.

236 Sec. 6. Subsection (c) of section 38a-591e of the general statutes is
237 repealed and the following is substituted in lieu thereof (*Effective January*
238 *1, 2023*):

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

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

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

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

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

271 permit the covered person or the covered person's authorized
272 representative, as applicable, a reasonable opportunity to respond prior
273 to such date.

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2023</i>	38a-510(a)
Sec. 2	<i>January 1, 2023</i>	38a-544(a)
Sec. 3	<i>January 1, 2023</i>	38a-591a(7)
Sec. 4	<i>January 1, 2023</i>	38a-591c(a)
Sec. 5	<i>January 1, 2023</i>	38a-591d(a)
Sec. 6	<i>January 1, 2023</i>	38a-591e(c)

Statement of Purpose:

To (1) prohibit certain health carriers from requiring the use of step therapy for drugs prescribed to treat behavioral health conditions or chronic, disabling or life-threatening conditions or diseases; (2) redefine "clinical peer" for the purposes of adverse determination and utilization reviews; (3) require health carriers to bear the burden of proving that certain health care services under adverse determination or utilization review are not medically necessary; and (4) require health carriers to provide certain clinical peers with authority to reverse initial adverse determinations.

[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.]