



General Assembly

February Session, 2006

Raised Bill No. 5392

LCO No. 1248

01248 _____ PRI

Referred to Committee on Program Review and Investigations

Introduced by:
(PRI)

***AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE RELATIVE TO MENTAL HEALTH PARITY: INSURANCE
COVERAGE AND UTILIZATION.***

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

1 Section 1. Subsection (a) of section 38a-226c of the 2006 supplement
2 to the general statutes is repealed and the following is substituted in
3 lieu thereof (*Effective October 1, 2006*):

4 (a) All utilization review companies shall meet the following
5 minimum standards:

6 (1) Each utilization review company shall maintain and make
7 available procedures for providing notification of its determinations
8 regarding certification in accordance with the following:

9 (A) Notification of any prospective determination by the utilization
10 review company shall be mailed or otherwise communicated to the
11 provider of record or the enrollee or other appropriate individual
12 within two business days of the receipt of all information necessary to
13 complete the review, provided any determination not to certify an

14 admission, service, procedure or extension of stay shall be in writing.
15 After a prospective determination that authorizes an admission,
16 service, procedure or extension of stay has been communicated to the
17 appropriate individual, based on accurate information from the
18 provider, the utilization review company may not reverse such
19 determination if such admission, service, procedure or extension of
20 stay has taken place in reliance on such determination.

21 (B) Notification of a concurrent determination shall be mailed or
22 otherwise communicated to the provider of record within two business
23 days of receipt of all information necessary to complete the review or,
24 provided all information necessary to perform the review has been
25 received, prior to the end of the current certified period and provided
26 any determination not to certify an admission, service, procedure or
27 extension of stay shall be in writing.

28 (C) The utilization review company shall not make a determination
29 not to certify based on incomplete information unless it has clearly
30 indicated, in writing, to the provider of record or the enrollee all the
31 information that is needed to make such determination.

32 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this
33 subdivision, the utilization review company may give authorization
34 orally, electronically or communicated other than in writing. If the
35 determination is an approval for a request, the company shall provide
36 a confirmation number corresponding to the authorization.

37 (E) Except as provided in subparagraph (F) of this subdivision with
38 respect to a final notice, each notice of a determination not to certify an
39 admission, service, procedure or extension of stay shall include in
40 writing (i) the principal reasons for the determination, (ii) the
41 procedures to initiate an appeal of the determination or the name and
42 telephone number of the person to contact with regard to an appeal
43 pursuant to the provisions of this section, and (iii) the procedure to
44 appeal to the commissioner pursuant to section 38a-478n, as amended.

45 (F) Each notice of a final determination not to certify an admission,
46 service, procedure or extension of stay shall include in writing (i) the
47 principal reasons for the determination, (ii) a statement that all internal
48 appeal mechanisms have been exhausted, and (iii) a copy of the
49 application and procedures prescribed by the commissioner for filing
50 an appeal to the commissioner pursuant to section 38a-478n, as
51 amended.

52 (2) Each utilization review company shall maintain and make
53 available a written description of the appeal procedure by which either
54 the enrollee or the provider of record may seek review of
55 determinations not to certify an admission, service, procedure or
56 extension of stay. The procedures for appeals shall include the
57 following:

58 (A) Each utilization review company shall notify in writing the
59 enrollee and provider of record of its determination on the appeal as
60 soon as practical, but in no case later than thirty days after receiving
61 the required documentation on the appeal.

62 (B) On appeal, all determinations not to certify an admission,
63 service, procedure or extension of stay shall be made by a licensed
64 practitioner of the medical arts.

65 (3) The process established by each utilization review company may
66 include a reasonable period within which an appeal must be filed to be
67 considered.

68 (4) Each utilization review company shall also provide for an
69 expedited appeals process for emergency or life threatening situations.
70 Each utilization review company shall complete the adjudication of
71 such expedited appeals within two business days of the date the
72 appeal is filed and all information necessary to complete the appeal is
73 received by the utilization review company.

74 (5) Each utilization review company shall utilize written clinical

75 criteria and review procedures which are established and periodically
76 evaluated and updated with appropriate involvement from
77 practitioners.

78 (6) Physicians, nurses and other licensed health professionals
79 making utilization review decisions shall have current licenses from a
80 state licensing agency in the United States or appropriate certification
81 from a recognized accreditation agency in the United States, provided,
82 any final determination not to certify an admission, service, procedure
83 or extension of stay for an enrollee within this state, except for a claim
84 brought pursuant to chapter 568, shall be made by a physician, nurse
85 or other licensed health professional under the authority of a
86 physician, nurse or other licensed health professional who has a
87 current Connecticut license from the Department of Public Health.

88 (7) In cases where an appeal to reverse a determination not to certify
89 is unsuccessful, each utilization review company shall assure that a
90 practitioner in a specialty related to the condition is reasonably
91 available to review the case. When the reason for the determination not
92 to certify is based on medical necessity, including whether a treatment
93 is experimental or investigational, each utilization review company
94 shall have the case reviewed by a physician who is a specialist in the
95 field related to the condition that is the subject of the appeal. Any such
96 review, except for a claim brought pursuant to chapter 568, that
97 upholds a final determination not to certify in the case of an enrollee
98 within this state shall be conducted by such practitioner or physician
99 under the authority of a practitioner or physician who has a current
100 Connecticut license from the Department of Public Health. The review
101 shall be completed within thirty days of the request for review. The
102 utilization review company shall be financially responsible for the
103 review and shall maintain, for the commissioner's verification,
104 documentation of the review, including the name of the reviewing
105 physician.

106 (8) Except as provided in subsection (e) of this section, each

107 utilization review company shall make review staff available by toll-
108 free telephone, at least forty hours per week during normal business
109 hours.

110 (9) Each utilization review company shall comply with all
111 applicable federal and state laws to protect the confidentiality of
112 individual medical records. Summary and aggregate data shall not be
113 considered confidential if it does not provide sufficient information to
114 allow identification of individual patients.

115 (10) Each utilization review company shall allow a minimum of
116 twenty-four hours following an emergency admission, service or
117 procedure for an enrollee or his representative to notify the utilization
118 review company and request certification or continuing treatment for
119 that condition.

120 (11) No utilization review company may give an employee any
121 financial incentive based on the number of denials of certification such
122 employee makes.

123 (12) Each utilization review company shall annually file with the
124 commissioner (A) the names of all managed care organizations, as
125 defined in section 38a-478, as amended, that the utilization review
126 company services in Connecticut, (B) any utilization review services
127 for which the utilization review company has contracted out for
128 services and the name of such company providing the services, [and]
129 (C) the number of utilization review determinations not to certify an
130 admission, service, procedure or extension of stay and the outcome of
131 such determination upon appeal within the utilization review
132 company. Determinations related to mental or nervous conditions, as
133 defined in section 38a-514, shall be reported separately from all other
134 determinations reported under this subdivision, and (D) the following
135 information relative to requests for utilization review of mental health
136 services for enrollees of fully insured health benefit plans or self-
137 insured or self-funded employee health benefit plans, separately and
138 by category, the reason for the request, including, but not limited to, an

139 inpatient admission, service, procedure or extension of inpatient stay
140 or an outpatient treatment, the number of requests denied by type of
141 request, and whether the request was denied or partially denied.

142 (13) Any utilization review decision to initially deny services shall
143 be made by a licensed health professional.

144 Sec. 2. Section 38a-478l of the general statutes is repealed and the
145 following is substituted in lieu thereof (*Effective October 1, 2006*):

146 (a) Not later than March 15, 1999, and annually thereafter, the
147 [Insurance Commissioner] Healthcare Advocate, after consultation
148 with the Commissioner of Public Health, shall develop and distribute a
149 consumer report card on all managed care organizations. The
150 [commissioner] Healthcare Advocate shall develop the consumer
151 report card in a manner permitting consumer comparison across
152 organizations.

153 (b) The consumer report card shall include (1) all health care centers
154 licensed pursuant to chapter 698a, and (2) the fifteen largest licensed
155 health insurers that use provider networks and that are not included in
156 subdivision (1) of this subsection. The insurers selected pursuant to
157 subdivision (2) of this subsection shall be selected on the basis of
158 Connecticut direct written health premiums from such network plans.

159 (c) With respect to mental health services, the consumer report card
160 shall include the following information or measures:

161 (1) The number of requests for utilization review of mental health
162 services for enrollees of fully insured health benefit plans or self-
163 insured or self-funded employee health benefit plans, separately and
164 by category: (A) The reason for the request, including, but not limited
165 to, an inpatient admission, service, procedure, extension of inpatient
166 stay or an outpatient treatment; (B) the number of requests denied by
167 type of request; and (C) whether the request was denied or partially
168 denied;

169 (2) Discharge rates from inpatient mental health and substance
170 abuse care;

171 (3) The average lengths of stay and the number of treatment
172 sessions for enrollees receiving inpatient and outpatient mental health
173 and substance abuse care and treatment;

174 (4) The percentage of enrollees receiving mental health services
175 overall and categorized by inpatient and outpatient mental health and
176 substance abuse care and treatment;

177 (5) The percentage of enrollees who receive seven and thirty-day
178 follow-up care after hospitalization for mental illness;

179 (6) The percentage of enrollees who receive antidepressant
180 medication management;

181 (7) Claims expenses on a per member per month basis by inpatient
182 mental health, inpatient substance abuse, outpatient mental health,
183 outpatient substance abuse, and overall;

184 (8) The ratio of mental health providers in an insurer's provider
185 network to the total number of enrollees having access to the network;

186 (9) The method by which mental health benefits are managed; and

187 (10) If mental health benefits are covered under a separate policy,
188 whether the utilization review company has received accreditation
189 from the National Committee for Quality Assurance or a professional
190 peer review organization.

191 [(c)] (d) The [commissioner] Healthcare Advocate shall test market a
192 draft of the consumer report card prior to its publication and
193 distribution. As a result of such test marketing, the [commissioner]
194 Healthcare Advocate may make any necessary modification to its form
195 or substance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2006</i>	38a-226c(a)
Sec. 2	<i>October 1, 2006</i>	38a-478l

Statement of Purpose:

To implement the Legislative Program Review and Investigations Committee's recommendations relative to mental health parity.

[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.]