



General Assembly

**Substitute Bill No. 5392**

February Session, 2006

\* \_\_\_\_\_ HB05392PRI INS031006 \_\_\_\_\_ \*

**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2 to the general statutes is repealed and the following is substituted in  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<sub>2</sub> 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.

196 Sec. 3. (NEW) (*Effective October 1, 2006*) The Insurance  
197 Commissioner shall provide written notification to each insurance  
198 company, fraternal benefit society, hospital service corporation,  
199 medical service corporation, health care center or any other entity  
200 which delivers or issues for delivery in this state any health insurance  
201 plan (1) of any benefits required to be provided in such plan pursuant  
202 to chapter 700c of the general statutes or modifications to such benefits  
203 on or after October 1, 2006, at least thirty days prior to the date such  
204 benefit or modification becomes effective, and (2) informing such

205 company, society, corporation, center or other entity that it shall  
206 submit a filing to said commissioner of policy forms in accordance  
207 with the provisions of 38a-481 or 38a-513 of the general statutes, as  
208 applicable, that reflect such benefits or modifications prior to the date  
209 such benefit or modification becomes effective.

|   |                        |             |
|---|------------------------|-------------|
| 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    |
| Sec. 3  | <i>October 1, 2006</i> | New section |

**PRI**

*Joint Favorable Subst. C/R*

INS