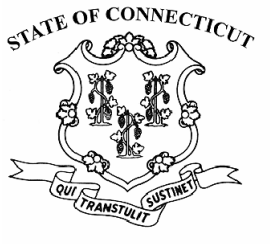

Substitute Senate Bill No. 410

Public Act No. 12-102

AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS.

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

Section 1. Section 38a-591d of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

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

(2) In determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition shall be deemed an urgent care request.

(b) With respect to a nonurgent care request:

(1) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than fifteen calendar days after the date the health carrier receives such request, and shall notify the covered person and, if applicable, the covered person's authorized representative of such determination, whether or not the carrier certifies the provision of the benefit.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

(i) Specifically describe in the notice of extension the required information necessary to complete the request; and

(ii) Provide the covered person and, if applicable, the covered person's authorized representative with not less than forty-five calendar days after the date of receipt of the notice to provide the specified information.

(B) If the covered person or the covered person's authorized representative fails to submit the specified information before the end of the period of the extension, the health carrier may deny certification of the benefit requested.

(c) With respect to an urgent care request:

(1) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than seventy-two hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments;

(2) (A) If the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, the health carrier shall notify the covered person or the covered person's representative, as applicable, as soon as possible, but not later than twenty-four hours after the health carrier receives such request.

(B) The health carrier shall provide the covered person or the covered person's authorized representative, as applicable, a reasonable period of time to submit the specified information, taking into account the covered person's medical condition, but not less than forty-eight

hours after notifying the covered person or the covered person's authorized representative, as applicable.

(3) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of its determination as soon as possible, but not later than forty-eight hours after the earlier of (A) the date on which the covered person and the covered person's authorized representative, as applicable, provides the specified information to the health carrier, or (B) the date on which the specified information was to have been submitted.

(d) (1) Whenever a health carrier receives a review request from a covered person or a covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than five calendar days after the health carrier receives such request, except that for an urgent care request, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than twenty-four hours after the health carrier receives such request.

(2) If the health carrier provides such notice orally, the health carrier shall provide confirmation in writing to the covered person and the covered person's health care professional of record not later than five calendar days after providing the oral notice.

(e) Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination.

(1) Such notice may be provided in writing or by electronic means and shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

[(1)**]** (A) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount;

[(2)**]** (B) The specific reason or reasons for the adverse determination and a description of the health carrier's standard, if any, that was used in reaching the denial;

[(3)**]** (C) Reference to the specific health benefit plan provisions on which the determination is based;

[(4)**]** (D) A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

[(5)**]** (E) A description of the health carrier's internal grievance process that includes **[**(A)**]** (i) the health carrier's expedited review procedures, **[**(B)**]** (ii) any time limits applicable to such process or procedures, **[**(C)**]** (iii) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and **[**(D)**]** (iv) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to **[**(i)**]** (I) submit written comments, documents, records and other material relating to the covered person's benefit request for consideration by the individual or individuals conducting the review, and **[**(ii)**]** (II) receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information **[**relevant to**]** and evidence regarding the covered person's benefit request;

[(6)**]** (F) If the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, **[**(A)**]** (i) the

specific rule, guideline, protocol or other similar criterion, or **[**(B)**]** (ii) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, and instructions for requesting such copy;

[(7)**]** (G) If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the adverse determination and **[**(A)**]** (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances or **[**(B)**]** (ii) a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation; and

[(8)**]** (H) A statement explaining the right of the covered person to contact the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include the contact information for said offices.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (a) of section 5 of this act.

(f) If the adverse determination is a rescission, the health carrier shall include with the advance notice of the application for rescission required to be sent to the covered person, a written statement that includes:

(1) Clear identification of the alleged fraudulent act, practice or

omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) A disclosure that the covered person or the covered person's authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, pursuant to sections 38a-591e and 38a-591f, as amended by this act;

(4) A description of the health carrier's grievance procedures established under sections 38a-591e and 38a-591f, as amended by this act, including **[**,**]** any time limits applicable to those procedures; and

(5) The date such advance notice of the proposed rescission ends and the date back to which the coverage will be retroactively rescinded.

(g) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review in accordance with the provisions of section 38a-591g, as amended by this act, regardless of whether the health carrier asserts it substantially complied with the requirements of this section or that any error it committed was de minimis.

(2) A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of

the claim.

Sec. 2. Section 38a-591e of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) (1) Each health carrier shall establish and maintain written procedures for (A) the review of grievances of adverse determinations that were based, in whole or in part, on medical necessity, (B) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility, and (C) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(2) Each health carrier shall file with the commissioner a copy of such procedures, including all forms used to process requests, and any subsequent material modifications to such procedures.

(3) In addition to a copy of such procedures, each health carrier shall file annually with the commissioner, as part of its annual report required under subsection (e) of section 38a-591b, a certificate of compliance stating that the health carrier has established and maintains grievance procedures for each of its health benefit plans that are fully compliant with the provisions of sections 38a-591a to 38a-591m, inclusive, as amended by this act, and section 5 of this act.

(b) (1) A covered person or a covered person's authorized representative may file a grievance of an adverse determination that was based, in whole or in part, on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the covered person's authorized representative, as

applicable, receives the notice of an adverse determination.

(2) For prospective or concurrent urgent care requests, a covered person or a covered person's authorized representative may make a request for an expedited review orally or in writing.

(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 individual or individuals 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) The individual or individuals 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 urgent care request, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance; and

(C) For expedited review requests, seventy-two hours after the health carrier receives the grievance.

(2) The time periods set forth in subdivision (1) of this subsection shall apply regardless of whether all of the information necessary to make a decision accompanies the filing.

(e) (1) The notice required under subsection (d) of this section shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

[(1)**]** (A) The titles and qualifying credentials of the individual or individuals participating in the review process;

[(2)**]** (B) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, if applicable, the health care professional and the claim amount;

[(3)**]** (C) A statement of such individual's or individuals' understanding of the covered person's grievance;

[(4)**]** (D) The individual's or individuals' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for such decision in sufficient detail for the covered person to respond further to the health carrier's position;

[(5)**]** (E) Reference to the evidence or documentation used as the basis for the decision;

[(6)**]** (F) For a decision that upholds the adverse determination:

[(A)**]** (i) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

[(B)**]** (ii) Reference to the specific health benefit plan provisions on which the decision is based;

[(C)**]** (iii) A statement that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, records, communications and other information **[**relevant to**]** and evidence not previously provided

regarding the adverse determination under review;

[(D)**]** (iv) If the final adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, **[**(i)**]** (I) the specific rule, guideline, protocol or other similar criterion, or **[**(ii)**]** (II) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the final adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request and instructions for requesting such copy;

[(E)**]** (v) If the final adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the final adverse determination and **[**(i)**]** (I) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances, or **[**(ii)**]** (II) a statement that an explanation will be provided to the covered person free of charge upon request and instructions for requesting a copy of such explanation;

[(F)**]** (vi) A statement describing the procedures for obtaining an external review of the final adverse determination;

[(7)**]** (G) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

[(8)**]** (H) A statement disclosing the covered person's right to contact the commissioner's office or the Office of the Healthcare Advocate at any time. Such disclosure shall include the contact information for said offices.

(2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)

of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 5 of this act.

(f) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.

(2) A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

Sec. 3. Section 38a-591f of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) Each health carrier shall establish and maintain written procedures (1) for the review of grievances of adverse determinations that were not based on medical necessity, and (2) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(b) (1) A covered person or the covered person's authorized representative may file a grievance of an adverse determination that was not based on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the covered person's representative, as applicable, receives the notice of an

adverse determination.

(2) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative not later than three business days after the health carrier receives a grievance that the covered person or the covered person's authorized representative, as applicable, is entitled to submit written material to the health carrier to be considered when conducting a review of the grievance.

(3) (A) Upon receipt of a grievance, a health carrier shall designate an individual or individuals to conduct a review of the grievance.

(B) The health carrier shall not designate the same individual or individuals who denied the claim or handled the matter that is the subject of the grievance to conduct the review of the grievance.

(C) The health carrier shall provide the covered person and, if applicable, the covered person's authorized representative with the name, address and telephone number of the individual or the organizational unit designated to coordinate the review on behalf of the health carrier.

(c) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative in writing, of its decision not later than twenty business days after the health carrier received the grievance.

(2) If the health carrier is unable to comply with the time period specified in subdivision (1) of this subsection due to circumstances beyond the health carrier's control, the time period may be extended by the health carrier for up to ten business days, provided that on or before the twentieth business day after the health carrier received the grievance, the health carrier provides written notice to the covered person and, if applicable, the covered person's authorized

representative of the extension and the reasons for the delay.

(d) (1) The written decision issued pursuant to subsection (c) of this section shall contain:

[(1)**]** (A) The titles and qualifying credentials of the individual or individuals participating in the review process;

[(2)**]** (B) A statement of such individual's or individuals' understanding of the covered person's grievance;

[(3)**]** (C) The individual's or individuals' decision in clear terms and the health benefit plan contract basis for such decision in sufficient detail for the covered person to respond further to the health carrier's position; **[**and**]**

[(4)**]** (D) Reference to the documents, communications, information and evidence **[**or documentation**]** used as the basis for the decision; and

(E) For a decision that upholds the adverse determination, a statement that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, communications, information and evidence regarding the adverse determination that is the subject of the final adverse determination.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 5 of this act.

Sec. 4. Section 38a-591g of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) (1) A covered person or a covered person's authorized

representative may file a request for an external review or an expedited external review of an adverse determination or a final adverse determination in accordance with the provisions of this section. All requests for external review or expedited external review shall be made in writing to the commissioner. The commissioner may prescribe the form and content of such requests.

(2) (A) All requests for external review or expedited external review shall be accompanied by a filing fee of twenty-five dollars, except that no covered person or covered person's authorized representative shall pay more than seventy-five dollars in a calendar year for such covered person. Any filing fee paid by a covered person's authorized representative shall be deemed to have been paid by the covered person. If the commissioner finds that the covered person is indigent or unable to pay the filing fee, the commissioner shall waive such fee. Any such fees shall be deposited in the Insurance Fund established under section 38a-52a.

(B) The commissioner shall refund any paid filing fee to the covered person or the covered person's authorized representative, as applicable, or the health care professional if the adverse determination or the final adverse determination that is the subject of the external review request or expedited external review request is reversed or revised.

(3) The health carrier that issued the adverse determination or the final adverse determination that is the subject of the external review request or the expedited external review request shall pay the independent review organization for the cost of conducting the review.

(4) An external review decision, whether such review is a standard external review or an expedited external review, shall be binding on the health carrier or a self-insured governmental plan and the covered person, except to the extent such health carrier or covered person has

other remedies available under federal or state law. A covered person or a covered person's authorized representative shall not file a subsequent request for an external review or an expedited external review that involves the same adverse determination or final adverse determination for which the covered person or the covered person's authorized representative already received an external review decision or an expedited external review decision.

(5) Each health carrier shall maintain written records of external reviews as set forth in section 38a-591h.

(6) Each independent review organization shall maintain written records as set forth in subsection (e) of section 38a-591m.

(b) (1) Except as otherwise provided under subdivision (2) of this subsection or subsection (d) of this section, a covered person or a covered person's authorized representative shall not file a request for an external review or an expedited external review until the covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process.

(2) A health carrier may waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external review or an expedited external review.

(c) (1) At the same time a health carrier sends to a covered person or a covered person's authorized representative a written notice of an adverse determination or a final adverse determination issued by the health carrier, the health carrier shall include a written disclosure to the covered person and, if applicable, the covered person's authorized representative of the covered person's right to request an external review.

(2) The written notice shall include:

(A) The following statement or a statement in substantially similar language: "We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.";

(B) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time period for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may (I) file a request for an expedited external review, or (II) file a request for an expedited external review if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(ii) Such request for expedited external review may be filed at the same time the covered person or the covered person's authorized representative files a request for an expedited internal review of a grievance involving an adverse determination, except that the independent review organization assigned to conduct the expedited external review shall determine whether the covered person shall be

required to complete the expedited internal review of the grievance prior to conducting the expedited external review;

(C) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time period for completion of an external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or

(ii) If the final adverse determination concerns (I) an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person or the covered person's authorized representative may file a request for an expedited external review, or (II) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may file a request for an expedited external review;

(D) (i) A copy of the description of both the standard and expedited external review procedures the health carrier is required to provide, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review or an expedited external review;

(ii) As part of any forms provided under subparagraph (D)(i) of this subdivision, an authorization form or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508, as amended from time to time, by which the covered person shall authorize the health carrier and the covered person's treating health care professional to release, transfer or otherwise divulge, in accordance with sections 38a-975 to 38a-999a, inclusive, the covered person's protected health information including medical records for purposes of conducting an external review or an expedited external review;

(E) A statement that the covered person or the covered person's authorized representative may request, free of charge, copies of all documents, communications, information and evidence regarding the adverse determination or the final adverse determination that were not previously provided to the covered person or the covered person's authorized representative.

(3) Upon request pursuant to subparagraph (E) of subdivision (2) of this subsection, the health carrier shall provide such copies in accordance with subsection (b) of section 5 of this act.

(d) (1) A covered person or a covered person's authorized representative may file a request for an expedited external review of an adverse determination or a final adverse determination with the commissioner, except that an expedited external review shall not be provided for a retrospective review request of an adverse determination or a final adverse determination.

(2) Such request may be filed at the time the covered person receives:

(A) An adverse determination, if:

(i) (I) The covered person has a medical condition for which the time

period for completion of an expedited internal review of the adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(II) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(ii) The covered person or the covered person's authorized representative has filed a request for an expedited internal review of the adverse determination; or

(B) A final adverse determination if:

(i) The covered person has a medical condition where the time period for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(ii) The final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility; or

(iii) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

(3) Such covered person or covered person's authorized representative shall not be required to file a request for an external review prior to, or at the same time as, the filing of a request for an expedited external review and shall not be precluded from filing a request for an external review, within the time periods set forth in subsection (e) of this section, if the request for an expedited external review is determined to be ineligible for such review.

(e) (1) Not later than one hundred twenty calendar days after a covered person or a covered person's authorized representative receives a notice of an adverse determination or a final adverse determination, the covered person or the covered person's authorized representative may file a request for an external review or an expedited external review with the commissioner in accordance with this section.

(2) Not later than one business day after the commissioner receives a request that is complete, the commissioner shall send a copy of such request to the health carrier that issued the adverse determination or the final adverse determination that is the subject of the request.

(3) Not later than **[**(A)**]** five business days after the health carrier receives the copy of an external review request **[**,**]** or **[**(B)**]** one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

(A) The individual is or was a covered person under the health benefit plan at the time the health care service was requested or, in the case of an external review of a retrospective review request, was a covered person in the health benefit plan at the time the health care service was provided;

(B) The health care service that is the subject of the adverse

determination or the final adverse determination is a covered service under the covered person's health benefit plan but for the health carrier's determination that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(C) If the health care service or treatment is experimental or investigational:

(i) Is a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition;

(ii) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan;

(iii) The covered person's treating health care professional has certified that one of the following situations is applicable:

(I) Standard health care services or treatments have not been effective in improving the medical condition of the covered person;

(II) Standard health care services or treatments are not medically appropriate for the covered person; or

(III) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and

(iv) The covered person's treating health care professional:

(I) Has recommended a health care service or treatment that the health care professional certifies, in writing, is likely to be more beneficial to the covered person, in the health care professional's

opinion, than any available standard health care services or treatments; or

(II) Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(D) The covered person has exhausted the health carrier's internal grievance process or the covered person or the covered person's authorized representative has filed a request for an expedited external review as provided under subsection (d) of this section; and

(E) The covered person has provided all the information and forms required to process an external review or an expedited external review, including an authorization form as set forth in subparagraph (D)(ii) of subdivision (2) of subsection (c) of this section.

(4) (A) Not later than **[**(i)**]** one business day after the preliminary review of an external review request **[**,**]** or **[**(ii)**]** the day the preliminary review of an expedited external review request is completed, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing whether the request for an external review or an expedited external review is complete and eligible for such review. The commissioner may specify the form for the health carrier's notice of initial determination under this subdivision and any supporting information required to be included in the notice.

(B) If the request:

(i) Is not complete, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are needed to perfect the request; or

(ii) Is not eligible for external review or expedited external review, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

(C) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the request for an external review or an expedited external review is ineligible for review may be appealed to the commissioner.

(D) Notwithstanding a health carrier's initial determination that a request for an external review or an expedited external review is ineligible for review, the commissioner may determine, pursuant to the terms of the covered person's health benefit plan, that such request is eligible for such review and assign an independent review organization to conduct such review. Any such review shall be conducted in accordance with this section.

(f) (1) Whenever the commissioner is notified pursuant to subparagraph (A) of subdivision (4) of subsection (e) of this section that a request is eligible for external review or expedited external review, the commissioner shall, not later than **[**(A)**]** one business day after receiving such notice for an external review **[**,**]** or **[**(B)**]** one calendar day after receiving such notice for an expedited external review:

[(i)**]** (A) Assign an independent review organization from the list of approved independent review organizations compiled and maintained

by the commissioner pursuant to section 38a-591*l* to conduct the review and notify the health carrier of the name of the assigned independent review organization. Such assignment shall be done on a random basis among those approved independent review organizations qualified to conduct the particular review based on the nature of the health care service that is the subject of the adverse determination or the final adverse determination and other circumstances, including conflict of interest concerns as set forth in section 38a-591m; and

[(ii)**]** (B) Notify the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the commissioner shall include in such notice **[**(I)**]** (i) a statement that the covered person or the covered person's authorized representative may submit, not later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and **[**(II)**]** (ii) where and how such additional information is to be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.

(2) Not later than **[**(A)**]** five business days for an external review **[**,**]** or **[**(B)**]** one calendar day for an expedited external review, after the health carrier receives notice of the name of the assigned independent review organization from the commissioner, the health carrier or its designee utilization review company shall provide to the assigned independent review organization the documents and any information

such health carrier or utilization review company considered in making the adverse determination or the final adverse determination.

(3) The failure of the health carrier or its designee utilization review company to provide the documents and information within the time specified in subdivision (2) of this subsection shall not delay the conducting of the review.

(4) **[**(i)**]** (A) If the health carrier or its designee utilization review company fails to provide the documents and information within the time period specified in subdivision (2) of this subsection, the independent review organization may terminate the review and make a decision to reverse the adverse determination or the final adverse determination.

[(ii)**]** (B) Not later than one business day after terminating the review and making the decision to reverse the adverse determination or the final adverse determination, the independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of such decision.

(g) (1) The assigned independent review organization shall review all the information and documents received pursuant to subsection (f) of this section. In reaching a decision, the independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process.

(2) Not later than one business day after receiving any information submitted by the covered person or the covered person's authorized representative pursuant to subparagraph (B) of subdivision (1) of subsection (f) of this section, the independent review organization shall forward such information to the health carrier.

(3) (A) Upon the receipt of any information forwarded pursuant to

subdivision (2) of this subsection, the health carrier may reconsider its adverse determination or the final adverse determination that is the subject of the review. Such reconsideration shall not delay or terminate the review.

(B) The independent review organization shall terminate the review if the health carrier decides, upon completion of its reconsideration and notice to such organization as provided in subparagraph (C) of this subdivision, to reverse its adverse determination or its final adverse determination and provide coverage or payment for the health care service or treatment that is the subject of the adverse determination or the final adverse determination.

(C) Not later than one business day after making the decision to reverse its adverse determination or its final adverse determination, the health carrier shall notify the commissioner, the assigned independent review organization, the covered person and, if applicable, the covered person's authorized representative in writing of such decision.

(h) In addition to the documents and information received pursuant to subsection (f) of this section, the independent review organization shall consider, to the extent the documents or information are available and the independent review organization considers them appropriate, the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative or the covered person's treating health care professional;

(4) The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of coverage under such health benefit plan;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, medical boards or medical associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review company; and

(7) The opinion or opinions of the independent review organization's clinical peer or peers who conducted the review after considering subdivisions (1) to (6), inclusive, of this subsection.

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, as expeditiously as the covered person's medical condition requires, but not later than seventy-two hours after such organization receives the assignment from the

commissioner to conduct such review; and

(D) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

(2) Such notice shall include:

(A) A general description of the reason for the request for the review;

(B) The date the independent review organization received the assignment from the commissioner to conduct the review;

(C) The date the review was conducted;

(D) The date the organization made its decision;

(E) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were used as a basis for its decision;

(F) The rationale for the organization's decision;

(G) Reference to the evidence or documentation, including any evidence-based standards, considered by the organization in reaching its decision; and

(H) For a review involving a determination that the recommended or requested health care service or treatment is experimental or investigational:

(i) A description of the covered person's medical condition;

(ii) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that (I) the recommended or requested health care service or treatment is likely to be more beneficial to the covered person than any available standard health care services or treatments, and (II) the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(iii) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) A description and analysis of any evidence-based standard; and

(v) Information on whether the clinical peer's rationale for the opinion is based on the documents and information set forth in subsection (f) of this section.

(3) Upon the receipt of a notice of the independent review organization's decision to reverse or revise an adverse determination or a final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or the final adverse determination.

Sec. 5. (NEW) (*Effective October 1, 2012*) (a) (1) Upon request pursuant to subparagraph (E) of subdivision (1) of subsection (e) of section 38a-591d of the general statutes, as amended by this act, the health carrier shall provide free of charge to a covered person or a covered person's authorized representative, as applicable, copies of all documents, communications, information and evidence, including citations to any medical journals, regarding the covered person's benefit request that is the subject of the adverse determination that were not submitted by the covered person or the covered person's authorized representative and were available to the health carrier or

the utilization review entity that made the adverse determination at the time such adverse determination was made.

(2) The health carrier shall provide such copies by facsimile, electronic means or any other expeditious method available not later than five business days after the health carrier receives such request in the case of an adverse determination of a nonurgent care request or one calendar day after the health carrier receives such request in the case of an adverse determination of an urgent care request.

(b) (1) Upon request pursuant to subparagraph (F)(iii) of subdivision (1) of subsection (e) of section 38a-591e of the general statutes, as amended by this act, subparagraph (E) of subdivision (1) of subsection (d) of section 38a-591f of the general statutes, as amended by this act, or subparagraph (E) of subdivision (2) of subsection (c) of section 38a-591g of the general statutes, as amended by this act, the health carrier shall provide free of charge to a covered person or a covered person's authorized representative, as applicable, copies of all documents, communications, information and evidence, including citations to any medical journals, if applicable, regarding the adverse determination or the final adverse determination, as applicable, that were not submitted by the covered person or the covered person's authorized representative and were not previously provided by the health carrier to the covered person or the covered person's authorized representative.

(2) The health carrier shall provide such copies by facsimile, electronic means or any other expeditious method available not later than:

(A) Five business days after the health carrier receives such request (i) in the case of a final adverse determination of a prospective, concurrent or retrospective review request under section 38a-591e of the general statutes, as amended by this act, (ii) in the case of a final

adverse determination of a review request under section 38a-591f of the general statutes, as amended by this act, or (iii) pursuant to section 38a-591g of the general statutes, as amended by this act, except if the covered person or the covered person's authorized representative notifies the health carrier at the time of such request that any of the provisions set forth in subparagraph (B)(i) or subparagraph (C) of subdivision (2) of subsection (c) of section 38a-591g of the general statutes, as amended by this act, applies, the health carrier shall provide such copies by facsimile, electronic means or any other expeditious method available not later than one calendar day after the health carrier receives such request; or

(B) One calendar day after the health carrier receives such request in the case of a final adverse determination of an expedited review request under 38a-591e of the general statutes, as amended by this act.

Sec. 6. Section 38a-591a of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

As used in this section and sections 38a-591b to 38a-591m, inclusive, as amended by this act, and section 5 of this act:

(1) "Adverse determination" means:

(A) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional, based on a determination by a health carrier or its designee utilization review company:

(i) That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or (II) is determined to

be experimental or investigational;

(ii) Of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(B) Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional.

"Adverse determination" includes a rescission of coverage determination for grievance purposes.

(2) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person for the purposes of this section and sections 38a-591b to 38a-591m, inclusive, as amended by this act, and section 5 of this act;

(B) A person authorized by law to provide substituted consent for a covered person;

(C) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(D) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(E) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

(3) "Best evidence" means evidence based on (A) randomized

clinical trials, (B) if randomized clinical trials are not available, cohort studies or case-control studies, (C) if such trials and studies are not available, case-series, or (D) if such trials, studies and case-series are not available, expert opinion.

(4) "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(5) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(6) "Certification" means a determination by a health carrier or its designee utilization review company that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(7) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

(8) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

(9) "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or specific interventions.

(10) "Commissioner" means the Insurance Commissioner.

(11) "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting, including home care.

(12) "Covered benefits" or "benefits" means health care services to which a covered person is entitled under the terms of a health benefit plan.

(13) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

(14) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(15) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

(16) "Evidence-based standard" means the conscientious, explicit

and judicious use of the current best evidence based on an overall systematic review of medical research when making determinations about the care of individual patients.

(17) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

(18) "Facility" means an institution providing health care services or a health care setting. "Facility" includes a hospital and other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing center, residential treatment center, diagnostic, laboratory and imaging center, and rehabilitation and other therapeutic health care setting.

(19) "Final adverse determination" means an adverse determination (A) that has been upheld by the health carrier at the completion of its internal grievance process, or (B) for which the internal grievance process has been deemed exhausted.

(20) "Grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding:

(A) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(B) Claims payment, handling or reimbursement for health care services; or

(C) Any matter pertaining to the contractual relationship between a covered person and a health carrier.

(21) (A) "Health benefit plan" means an insurance policy or contract,

certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5) to (9), inclusive, (14) and (15) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

(viii) Other insurance coverage similar to the coverages specified in subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) (I) Limited scope dental or vision benefits, (II) benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, or (III) other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, provided any benefits specified in subparagraphs

(B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided under a separate insurance policy, certificate or contract and are not otherwise an integral part of a health benefit plan; or

(x) Coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (I) they are provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor.

(22) "Health care center" has the same meaning as provided in section 38a-175.

(23) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(24) "Health care services" has the same meaning as provided in section 38a-478.

(25) "Health carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health care center, a managed care organization, a hospital service corporation, a medical service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

(26) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information

about events or relationships that relate to (A) the past, present or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family, (B) the provision of health care services to a covered person, or (C) payment for the provision of health care services to a covered person.

(27) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations. Such review entities include, but are not limited to, medical peer review organizations, independent utilization review companies, provided such organizations or companies are not related to or associated with any health carrier, and nationally recognized health experts or institutions approved by the Insurance Commissioner.

(28) "Medical or scientific evidence" means evidence found in the following sources:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) or Elsevier Science for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the Secretary of the United States Department of Health and Human Services under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: (i) The American Hospital Formulary Service - Drug Information; (ii) Drug Facts and Comparisons; (iii) The American Dental Association's Accepted Dental Therapeutics; and (iv) The United States Pharmacopoeia - Drug Information;

(E) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: (i) The Agency for Healthcare Research and Quality; (ii) the National Institutes of Health; (iii) the National Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers for Medicare and Medicaid Services; (vi) the Food and Drug Administration; and (vii) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(F) Any other findings, studies or research conducted by or under the auspices of a source comparable to those listed in subparagraphs (E)(i) to (E)(v), inclusive, of this subdivision.

(29) "Medical necessity" has the same meaning as provided in sections 38a-482a and 38a-513c.

(30) "Participating provider" means a health care professional who, under a contract with the health carrier, its contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment or reimbursement directly or indirectly from the health carrier, other than coinsurance, copayments or deductibles.

(31) "Person" has the same meaning as provided in section 38a-1.

(32) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment, in accordance with a health carrier's requirement that such

service or treatment be approved, in whole or in part, prior to such service's or treatment's provision.

(33) "Protected health information" means health information (A) that identifies an individual who is the subject of the information, or (B) for which there is a reasonable basis to believe that such information could be used to identify such individual.

(34) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study, with only the experimental group of patients receiving a specific intervention, and that includes study of the groups for variables and anticipated outcomes over time.

(35) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if (A) such cancellation or discontinuance has a prospective effect only, or (B) such cancellation or discontinuance is effective retroactively to the extent it is attributable to the covered person's failure to timely pay required premiums or contributions towards the cost of such coverage.

(36) "Retrospective review" means any review of a request for a benefit that is not a prospective review or concurrent review. "Retrospective review" does not include a review of a request that is limited to the veracity of documentation or the accuracy of coding.

(37) "Stabilize" means, with respect to an emergency medical condition, that (A) no material deterioration of such condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or (B) with respect to a pregnant woman, the woman has delivered, including the placenta.

(38) "Urgent care request" means a request for a health care service or course of treatment for which the time period for making a non-urgent care request determination (A) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (B) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested.

(39) "Utilization review" means the use of a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy or efficiency of, health care services, health care procedures or health care settings. Such techniques may include the monitoring of or evaluation of (A) health care services performed or provided in an outpatient setting, (B) the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility, (C) opportunities or requirements to obtain a clinical evaluation by a health care professional other than the one originally making a recommendation for a proposed health care service, (D) coordinated sets of activities conducted for individual patient management of serious, complicated, protracted or other health conditions, or (E) prospective review, concurrent review, retrospective review or certification.

(40) "Utilization review company" means an entity that conducts utilization review.

Sec. 7. Subsections (a) and (b) of section 38a-591b of the 2012 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) Sections 38a-591a to 38a-591m, inclusive, <u>as amended by this act,</u>

and section 5 of this act shall apply to (1) any health carrier offering a health benefit plan and that provides or performs utilization review including prospective, concurrent or retrospective review benefit determinations, and (2) any utilization review company or designee of a health carrier that performs utilization review on the health carrier's behalf, including prospective, concurrent or retrospective review benefit determinations.

(b) Each health carrier shall be responsible for monitoring all utilization review program activities carried out by or on behalf of such health carrier. Such health carrier shall comply with the provisions of sections 38a-591a to 38a-591m, inclusive, as amended by this act, and section 5 of this act and any regulations adopted thereunder, and shall be responsible for ensuring that any utilization review company or other entity such health carrier contracts with to perform utilization review complies with said sections and regulations. Each health carrier shall ensure that appropriate personnel have operational responsibility for the activities of the health carrier's utilization review program.

Sec. 8. Section 38a-591i of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

The commissioner shall adopt regulations, in accordance with chapter 54, to implement the provisions of sections 38a-591a to 38a-591m, inclusive, as amended by this act, and section 5 of this act.

Sec. 9. Section 38a-478s of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) Nothing in sections 38a-478 to 38a-478o, inclusive, **[**or**]** sections 38a-591a to 38a-591h, inclusive, as amended by this act, or section 5 of

this act shall be construed to apply to the arrangements of managed care organizations or health insurers offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974.

(b) The provisions of sections 38a-478 to 38a-478o, inclusive, **[**and**]** sections 38a-591a to 38a-591h, inclusive, as amended by this act, and section 5 of this act shall not apply to any plan that provides for the financing or delivery of health care services solely for the purposes of workers' compensation benefits pursuant to chapter 568.