



General Assembly

**Substitute Bill No. 6612**

January Session, 2013



**AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE  
PROCESS FOR ADVERSE DETERMINATIONS, THE OFFICE OF THE  
HEALTHCARE ADVOCATE AND MENTAL HEALTH PARITY  
COMPLIANCE CHECKS.**

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

1 Section 1. Subdivision (38) of section 38a-591a of the general statutes  
2 is repealed and the following is substituted in lieu thereof (*Effective*  
3 *October 1, 2013*):

4 (38) "Urgent care request" means a request for a health care service  
5 or course of treatment (A) for which the time period for making a non-  
6 urgent care request determination [(A)] (i) could seriously jeopardize  
7 the life or health of the covered person or the ability of the covered  
8 person to regain maximum function, or [(B)] (ii) in the opinion of a  
9 health care professional with knowledge of the covered person's  
10 medical condition, would subject the covered person to severe pain  
11 that cannot be adequately managed without the health care service or  
12 treatment being requested, (B) for a substance use disorder, as  
13 described in section 17a-458, or for a co-occurring mental disorder, or  
14 (C) for a mental disorder, (i) inpatient services, (ii) partial  
15 hospitalization, as defined in section 38a-496, or (iii) intensive  
16 outpatient services necessary to keep a covered person from requiring  
17 an inpatient setting.

18 Sec. 2. Subsections (a) to (c), inclusive, of section 38a-591d of the  
19 general statutes are repealed and the following is substituted in lieu  
20 thereof (*Effective October 1, 2013*):

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

29 (2) In determining whether a benefit request shall be considered an  
30 urgent care request, an individual acting on behalf of a health carrier  
31 shall apply the judgment of a prudent layperson who possesses an  
32 average knowledge of health and medicine, except that any benefit  
33 request (A) determined to be an urgent care request by a health care  
34 professional with knowledge of the covered person's medical  
35 condition, or (B) specified under subparagraph (B) or (C) of  
36 subdivision (38) of section 38a-591a, as amended by this act, shall be  
37 deemed an urgent care request.

38 (b) With respect to a nonurgent care request:

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

46 (B) If the review under subparagraph (A) of this subdivision is a  
47 concurrent review request, pursuant to 45 CFR 147.136, as amended  
48 from time to time, the treatment shall be continued without liability to

49 the covered person for the duration of such review or any grievance  
50 filed by the covered person or the covered person's authorized  
51 representative pursuant to section 38a-591e, as amended by this act, or  
52 38a-591f, as amended by this act, of an adverse determination or a final  
53 adverse determination of such concurrent review.

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

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

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

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

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

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

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

77 (B) If the covered person or the covered person's authorized

78 representative fails to submit the specified information before the end  
79 of the period of the extension, the health carrier may deny certification  
80 of the benefit requested.

81 (c) With respect to an urgent care request:

82 (1) (A) Unless the covered person or the covered person's  
83 authorized representative has failed to provide information necessary  
84 for the health carrier to make a determination and except as specified  
85 under subparagraph (B) of this subdivision, the health carrier shall  
86 make a determination as soon as possible, taking into account the  
87 covered person's medical condition, but not later than seventy-two  
88 hours after the health carrier receives such request, provided, if the  
89 urgent care request is a concurrent review request to extend a course of  
90 treatment beyond the initial period of time or the number of  
91 treatments, such request is made at least twenty-four hours prior to the  
92 expiration of the prescribed period of time or number of treatments;

93 (B) Unless the covered person or the covered person's authorized  
94 representative has failed to provide information necessary for the  
95 health carrier to make a determination, for an urgent care request  
96 specified under subparagraph (B) or (C) of subdivision (38) of section  
97 38a-591a, as amended by this act, the health carrier shall make a  
98 determination as soon as possible, taking into account the covered  
99 person's medical condition, but not later than twenty-four hours after  
100 the health carrier receives such request, provided, if the urgent care  
101 request is a concurrent review request to extend a course of treatment  
102 beyond the initial period of time or the number of treatments, such  
103 request is made at least twenty-four hours prior to the expiration of the  
104 prescribed period of time or number of treatments.

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

110 after the health carrier receives such request.

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

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

124 Sec. 3. Subsection (e) of section 38a-591d of the general statutes is  
125 repealed and the following is substituted in lieu thereof (*Effective*  
126 *October 1, 2013*):

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

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

133 (A) Information sufficient to identify the benefit request or claim  
134 involved, including the date of service, if applicable, the health care  
135 professional and the claim amount;

136 (B) The specific reason or reasons for the adverse determination,  
137 including, upon request, a listing of any clinical review criteria,  
138 including professional criteria and medical or scientific evidence and a  
139 description of the health carrier's standard, if any, that [was] were used

140 in reaching the denial;

141 (C) Reference to the specific health benefit plan provisions on which  
142 the determination is based;

143 (D) A description of any additional material or information  
144 necessary for the covered person to perfect the benefit request or claim,  
145 including an explanation of why the material or information is  
146 necessary to perfect the request or claim;

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

162 (F) If the adverse determination is based on a health carrier's  
163 internal rule, guideline, protocol or other similar criterion, (i) the  
164 specific rule, guideline, protocol or other similar criterion, or (ii) a  
165 statement that a specific rule, guideline, protocol or other similar  
166 criterion of the health carrier was relied upon to make the adverse  
167 determination and that a copy of such rule, guideline, protocol or other  
168 similar criterion will be provided to the covered person free of charge  
169 upon request, and instructions for requesting such copy;

170 (G) If the adverse determination is based on medical necessity or an

171 experimental or investigational treatment or similar exclusion or limit,  
172 the written statement of the scientific or clinical rationale for the  
173 adverse determination and (i) an explanation of the scientific or clinical  
174 rationale used to make the determination that applies the terms of the  
175 health benefit plan to the covered person's medical circumstances or  
176 (ii) a statement that an explanation will be provided to the covered  
177 person free of charge upon request, and instructions for requesting a  
178 copy of such explanation; [and]

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

185 (I) A statement that if the covered person or the covered person's  
186 authorized representative chooses to file a grievance of an adverse  
187 determination, (i) such appeals are sometimes successful, (ii) such  
188 covered person or covered person's authorized representative may  
189 benefit from free assistance from the Office of the Healthcare  
190 Advocate, which can assist such covered person or covered person's  
191 authorized representative with the filing of a grievance pursuant to 42  
192 USC 300gg-93, as amended from time to time, (iii) such covered person  
193 or covered person's authorized representative is entitled and  
194 encouraged to submit supporting documentation for the health  
195 carrier's consideration during the review of an adverse determination,  
196 including narratives from such covered person or covered person's  
197 authorized representative and letters and treatment notes from such  
198 covered person's health care professional, and (iv) such covered person  
199 or covered person's authorized representative has the right to ask such  
200 covered person's health care professional for such letters or treatment  
201 notes.

202 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of  
203 this subsection, the health carrier shall provide such copies in

204 accordance with subsection (a) of section 38a-591n.

205 Sec. 4. Subdivision (3) of subsection (c) of section 38a-591e of the  
206 general statutes is repealed and the following is substituted in lieu  
207 thereof (*Effective October 1, 2013*):

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

214 Sec. 5. Subsection (d) of section 38a-591e of the general statutes is  
215 repealed and the following is substituted in lieu thereof (*Effective*  
216 *October 1, 2013*):

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

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

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

226 (C) For expedited review requests, except as specified under  
227 subparagraph (D) of this subdivision, seventy-two hours after the  
228 health carrier receives the grievance; [.] and

229 (D) For expedited review requests of a health care service or course  
230 of treatment specified under subparagraph (B) or (C) of subdivision  
231 (38) of section 38a-591a, as amended by this act, twenty-four hours  
232 after the health carrier receives the grievance.

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

236 Sec. 6. Subsection (d) of section 38a-591f of the general statutes is  
237 repealed and the following is substituted in lieu thereof (*Effective*  
238 *October 1, 2013*):

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

241 (A) The titles and qualifying credentials of the individual or  
242 individuals participating in the review process;

243 (B) A statement of such individual's or individuals' understanding  
244 of the covered person's grievance;

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

249 (D) Reference to the documents, communications, information and  
250 evidence used as the basis for the decision; and

251 (E) For a decision that upholds the adverse determination, a  
252 statement (i) that the covered person may receive from the health  
253 carrier, free of charge and upon request, reasonable access to and  
254 copies of, all documents, communications, information and evidence  
255 regarding the adverse determination that is the subject of the final  
256 adverse determination, and (ii) disclosing the covered person's right to  
257 contact the commissioner's office or the Office of the Healthcare  
258 Advocate at any time, and that such covered person may benefit from  
259 free assistance from the Office of the Healthcare Advocate, which can  
260 assist such covered person with the filing of a grievance pursuant to 42  
261 USC 300gg-93, as amended from time to time. Such disclosure shall  
262 include the contact information for said offices.

263 (2) Upon request pursuant to subparagraph (E) of subdivision (1) of  
264 this subsection, the health carrier shall provide such copies in  
265 accordance with subsection (b) of section 38a-591n.

266 Sec. 7. Subdivision (1) of subsection (i) of section 38a-591g of the  
267 general statutes is repealed and the following is substituted in lieu  
268 thereof (*Effective October 1, 2013*):

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

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

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

282 (C) For expedited external reviews, except as specified under  
283 subparagraph (D) of this subdivision, as expeditiously as the covered  
284 person's medical condition requires, but not later than seventy-two  
285 hours after such organization receives the assignment from the  
286 commissioner to conduct such review; [and]

287 (D) For expedited external reviews involving a health care service or  
288 course of treatment specified under subparagraph (B) or (C) of  
289 subdivision (38) of section 38a-591a, as amended by this act, as  
290 expeditiously as the covered person's medical condition requires, but  
291 not later than twenty-four hours after such organization receives the  
292 assignment from the commissioner to conduct such review; and

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

299 Sec. 8. Subdivision (7) of section 38a-591a of the general statutes is  
300 repealed and the following is substituted in lieu thereof (*Effective July*  
301 *1, 2014*):

302 (7) "Clinical peer" means a [physician or other] health care  
303 professional who (A) holds a nonrestricted license in a state of the  
304 United States and in the same or similar specialty as typically manages  
305 the medical condition, procedure or treatment under review, and (B)  
306 for a review concerning a child or adolescent substance use disorder  
307 treatment, as such disorder is described in section 17a-458, or a child or  
308 adolescent mental disorder, holds a national board certification in  
309 child and adolescent psychiatry or child and adolescent psychology,  
310 and has training or clinical experience in the treatment of child and  
311 adolescent substance use or child and adolescent mental disorder, as  
312 applicable.

313 Sec. 9. Section 38a-591c of the general statutes is repealed and the  
314 following is substituted in lieu thereof (*Effective July 1, 2014*):

315 (a) (1) Each health carrier shall contract with (A) health care  
316 professionals to administer such health carrier's utilization review  
317 program, [and oversee utilization review determinations,] and (B)  
318 [with] clinical peers to conduct utilization reviews and to evaluate the  
319 clinical appropriateness of an adverse determination.

320 (2) (A) Each utilization review program shall use documented  
321 clinical review criteria that are based on sound clinical evidence and  
322 are evaluated periodically by the health carrier's organizational  
323 mechanism specified in subparagraph (F) of subdivision (2) of

324 subsection (c) of section 38a-591b to assure such program's ongoing  
325 effectiveness. A health carrier may develop its own clinical review  
326 criteria or it may purchase or license clinical review criteria from  
327 qualified vendors approved by the commissioner. Each health carrier  
328 shall make its clinical review criteria available upon request to  
329 authorized government agencies.

330 (B) Notwithstanding subparagraph (A) of this subdivision, for any  
331 utilization review for the treatment of a substance use disorder, as  
332 described in section 17a-458, the clinical review criteria used shall be:  
333 (i) The most recent edition of the American Society of Addiction  
334 Medicine's Patient Placement Criteria; or (ii) clinical review criteria  
335 that are (I) developed as required under state law, and (II) reviewed  
336 and accepted by the Department of Mental Health and Addiction  
337 Services for adults and the Department of Children and Families for  
338 children and adolescents, as adhering to the prevailing standard of  
339 care.

340 (C) A health carrier that uses clinical review criteria as set forth in  
341 subparagraph (B)(ii) of this subdivision shall create and maintain a  
342 document that (i) compares each aspect of such clinical review criteria  
343 with the American Society of Addiction Medicine's Patient Placement  
344 Criteria, and (ii) provides citations to peer-reviewed medical literature  
345 generally recognized by the relevant medical community or to  
346 professional society guidelines that justify each deviation from the  
347 American Society of Addiction Medicine's Patient Placement Criteria.

348 (D) Notwithstanding subparagraph (A) of this subdivision, for any  
349 utilization review for the treatment of a mental disorder, the clinical  
350 review criteria used shall be: (i) For children and adolescents, the most  
351 recent guidelines in the American Academy of Child and Adolescent  
352 Psychiatry's Child and Adolescent Service Intensity Instrument; or (ii)  
353 clinical review criteria that are (I) developed as required under state  
354 law, and (II) reviewed and accepted by the Department of Mental  
355 Health and Addiction Services for adults and the Department of  
356 Children and Families for children and adolescents, as adhering to the

357 prevailing standard of care.

358 (E) A health carrier that uses clinical review criteria as set forth in  
359 subparagraph (D)(ii) of this subdivision for children and adolescents  
360 shall create and maintain a document that (i) compares each aspect of  
361 such clinical review criteria with the guidelines in the American  
362 Academy of Child and Adolescent Psychiatry's Child and Adolescent  
363 Service Intensity Instrument, and (ii) provides citations to peer-  
364 reviewed medical literature generally recognized by the relevant  
365 medical community or to professional society guidelines that justify  
366 each deviation from the guidelines in the American Academy of Child  
367 and Adolescent Psychiatry's Child and Adolescent Service Intensity  
368 Instrument.

369 (b) Each health carrier shall:

370 (1) Have procedures in place to ensure that (A) the health care  
371 professionals administering such health carrier's utilization review  
372 program are applying the clinical review criteria consistently in  
373 utilization review determinations, and (B) the appropriate or required  
374 clinical peers are being designated to conduct utilization reviews;

375 (2) Have data systems sufficient to support utilization review  
376 program activities and to generate management reports to enable the  
377 health carrier to monitor and manage health care services effectively;

378 (3) Provide covered persons and participating providers with access  
379 to its utilization review staff through a toll-free telephone number or  
380 any other free calling option or by electronic means;

381 (4) Coordinate the utilization review program with other medical  
382 management activity conducted by the health carrier, such as quality  
383 assurance, credentialing, contracting with health care professionals,  
384 data reporting, grievance procedures, processes for assessing member  
385 satisfaction and risk management; and

386 (5) Routinely assess the effectiveness and efficiency of its utilization

387 review program.

388 (c) If a health carrier delegates any utilization review activities to a  
389 utilization review company, the health carrier shall maintain adequate  
390 oversight, which shall include (1) a written description of the  
391 utilization review company's activities and responsibilities, including  
392 such company's reporting requirements, (2) evidence of the health  
393 carrier's formal approval of the utilization review company program,  
394 and (3) a process by which the health carrier shall evaluate the  
395 utilization review company's performance.

396 (d) When conducting utilization review, the health carrier shall (1)  
397 collect only the information necessary, including pertinent clinical  
398 information, to make the utilization review or benefit determination,  
399 and (2) ensure that such review is conducted in a manner to ensure the  
400 independence and impartiality of the [individual or individuals]  
401 clinical peer or peers involved in making the utilization review or  
402 benefit determination. No health carrier shall make decisions  
403 regarding the hiring, compensation, termination, promotion or other  
404 similar matters of such [individual or individuals] clinical peer or  
405 peers based on the likelihood that the [individual or individuals]  
406 clinical peer or peers will support the denial of benefits.

407 Sec. 10. Section 38a-591e of the general statutes, as amended by  
408 sections 4 and 5 of this act, is repealed and the following is substituted  
409 in lieu thereof (*Effective July 1, 2014*):

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

419 adverse determinations.

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

423 (3) In addition to a copy of such procedures, each health carrier shall  
424 file annually with the commissioner, as part of its annual report  
425 required under subsection (e) of section 38a-591b, a certificate of  
426 compliance stating that the health carrier has established and  
427 maintains grievance procedures for each of its health benefit plans that  
428 are fully compliant with the provisions of sections 38a-591a to 38a-  
429 591n, inclusive, as amended by this act.

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

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

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

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

448 (C) The [individual or individuals] clinical peer or peers conducting

449 a review under this section shall take into consideration all comments,  
450 documents, records and other information relevant to the covered  
451 person's benefit request that is the subject of the adverse determination  
452 under review, that are submitted by the covered person or the covered  
453 person's authorized representative, regardless of whether such  
454 information was submitted or considered in making the initial adverse  
455 determination.

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

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

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

480 (d) (1) The health carrier shall notify the covered person and, if

481 applicable, the covered person's authorized representative, in writing  
482 or by electronic means, of its decision within a reasonable period of  
483 time appropriate to the covered person's medical condition, but not  
484 later than:

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

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

489 (C) For expedited review requests, twenty-four hours after the  
490 health carrier receives the grievance.

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

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

497 (A) The titles and qualifying credentials of the [individual or  
498 individuals] clinical peer or peers participating in the review process;

499 (B) Information sufficient to identify the claim involved with respect  
500 to the grievance, including the date of service, if applicable, the health  
501 care professional and the claim amount;

502 (C) A statement of such [individual's or individuals'] clinical peer's  
503 or peers' understanding of the covered person's grievance;

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

508 (E) Reference to the evidence or documentation used as the basis for

509 the decision;

510 (F) For a decision that upholds the adverse determination:

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

515 (ii) Reference to the specific health benefit plan provisions on which  
516 the decision is based;

517 (iii) A statement that the covered person may receive from the  
518 health carrier, free of charge and upon request, reasonable access to  
519 and copies of, all documents, records, communications and other  
520 information and evidence not previously provided regarding the  
521 adverse determination under review;

522 (iv) If the final adverse determination is based on a health carrier's  
523 internal rule, guideline, protocol or other similar criterion, (I) the  
524 specific rule, guideline, protocol or other similar criterion, or (II) a  
525 statement that a specific rule, guideline, protocol or other similar  
526 criterion of the health carrier was relied upon to make the final adverse  
527 determination and that a copy of such rule, guideline, protocol or other  
528 similar criterion will be provided to the covered person free of charge  
529 upon request and instructions for requesting such copy;

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

539 (vi) A statement describing the procedures for obtaining an external  
540 review of the final adverse determination;

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

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

549 (2) Upon request pursuant to subparagraph (F)(iii) of subdivision (1)  
550 of this subsection, the health carrier shall provide such copies in  
551 accordance with subsection (b) of section 38a-591n.

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

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

566 Sec. 11. Subsection (a) of section 38a-591d of the general statutes, as  
567 amended by section 2 of this act, is repealed and the following is  
568 substituted in lieu thereof (*Effective July 1, 2014*):

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

577 (2) [In determining whether a benefit request shall be considered an  
578 urgent care request, an individual acting on behalf of a health carrier  
579 shall apply the judgment of a prudent layperson who possesses an  
580 average knowledge of health and medicine, except that any] Any  
581 benefit request (A) determined to be an urgent care request by a health  
582 care professional with knowledge of the covered person's medical  
583 condition, or (B) specified under subparagraph (B) or (C) of  
584 subdivision (38) of section 38a-591a, as amended by this act, shall be  
585 deemed an urgent care request.

586 Sec. 12. Subsection (c) of section 38a-591l of the general statutes is  
587 repealed and the following is substituted in lieu thereof (*Effective July*  
588 *1, 2014*):

589 (c) To be eligible for approval by the commissioner, an independent  
590 review organization shall:

591 (1) Have and maintain written policies and procedures that govern  
592 all aspects of both the standard external review process and the  
593 expedited external review process set forth in section 38a-591g, as  
594 amended by this act, that include, at a minimum:

595 (A) A quality assurance mechanism in place that ensures:

596 (i) That external reviews and expedited external reviews are  
597 conducted within the specified time frames and required notices are  
598 provided in a timely manner;

599 (ii) (I) The selection of qualified and impartial clinical peers to  
600 conduct such reviews on behalf of the independent review  
601 organization and the suitable matching of such peers to specific cases,  
602 and (II) the employment of or the contracting with an adequate  
603 number of clinical peers to meet this objective;

604 (iii) The confidentiality of medical and treatment records and  
605 clinical review criteria;

606 (iv) That any person employed by or under contract with the  
607 independent review organization adheres to the requirements of  
608 section 38a-591g, as amended by this act; and

609 (B) A toll-free telephone number to receive information twenty-four  
610 hours a day, seven days a week, related to external reviews and  
611 expedited external reviews and that is capable of accepting, recording  
612 or providing appropriate instruction to incoming telephone callers  
613 during other than normal business hours;

614 (2) Agree to maintain and provide to the commissioner the  
615 information set forth in section 38a-591m;

616 (3) Not own or control, be a subsidiary of, be owned or controlled in  
617 any way by, or exercise control with a health benefit plan, a national,  
618 state or local trade association of health benefit plans, or a national,  
619 state or local trade association of health care professionals; and

620 [(4) Assign as a clinical peer a health care professional who meets  
621 the following minimum qualifications:

622 (A) Is an expert in the treatment of the covered person's medical  
623 condition that is the subject of the review;

624 (B) Is knowledgeable about the recommended health care service or  
625 treatment through recent or current actual clinical experience treating  
626 patients with the same or similar medical condition of the covered  
627 person;

628 (C) Holds a nonrestricted license in a state of the United States and,  
629 for physicians, a current certification by a recognized American  
630 medical specialty board in the area or areas appropriate to the subject  
631 of the review; and]

632 [(D) Has] (4) Assign as a clinical peer a health care professional who  
633 has no history of disciplinary actions or sanctions, including loss of  
634 staff privileges or participation restrictions, that have been taken or are  
635 pending by any hospital, governmental agency or unit or regulatory  
636 body that raise a substantial question as to the clinical peer's physical,  
637 mental or professional competence or moral character.

638 Sec. 13. Section 38a-478l of the general statutes is amended by  
639 adding subsection (e) as follows (*Effective October 1, 2013*):

640 (NEW) (e) The commissioner shall analyze annually the data  
641 submitted under subparagraphs (E) and (F) of subdivision (1) of  
642 subsection (b) of this section for the accuracy of, trends in and  
643 statistically significant differences in such data among the health care  
644 centers and licensed health insurers included in the consumer report  
645 card. The commissioner shall investigate any such differences to  
646 determine whether further action by the commissioner is warranted.

647 Sec. 14. Section 38a-1040 of the general statutes is repealed and the  
648 following is substituted in lieu thereof (*Effective October 1, 2013*):

649 As used in sections 38a-1040 to 38a-1050, inclusive:

650 (1) "Consumer" means an individual who receives or is attempting  
651 to receive services from a managed care organization and is a resident  
652 of this state, or such individual's authorized representative, as defined  
653 in section 38a-591a, as amended by this act.

654 (2) "Managed care organization" means an insurer, health care  
655 center, hospital [or] service corporation, medical service corporation or  
656 other organization delivering, issuing for delivery, renewing, [or]  
657 amending or continuing any individual or group health managed care

658 plan in this state.

659 (3) "Managed care plan" means (A) a product offered by a managed  
660 care organization that provides for the financing or delivery of health  
661 care services to persons enrolled in the plan through: [(A)] (i)  
662 Arrangements with selected providers to furnish health care services;  
663 [(B)] (ii) explicit standards for the selection of participating providers;  
664 [(C)] (iii) financial incentives for enrollees to use the participating  
665 providers and procedures provided for by the plan; or [(D)] (iv)  
666 arrangements that share risks with providers, provided the  
667 organization offering a plan described under subparagraph [(A), (B),  
668 (C) or (D)] (A)(i), (A)(ii), (A)(iii) or (A)(iv) of this subdivision is  
669 licensed by the Insurance Department pursuant to chapter 698, 698a or  
670 700 and that the plan includes utilization review, as defined in section  
671 38a-591a, as amended by this act; or (B) a health insurance policy or  
672 health care plan that provides coverage of the types specified in section  
673 38a-469.

674 Sec. 15. Section 38a-1046 of the general statutes is repealed and the  
675 following is substituted in lieu thereof (*Effective October 1, 2013*):

676 Each employer [, other than a self-insured employer,] that provides  
677 health insurance or health care benefits to employees shall obtain from  
678 the Healthcare Advocate and post, in a conspicuous location, a notice  
679 concerning the services that the Healthcare Advocate provides.

680 Sec. 16. (*Effective from passage*) (a) Not later than September 1, 2013,  
681 the Insurance Commissioner shall submit a report, in accordance with  
682 the provisions of section 11-4a of the general statutes, to the joint  
683 standing committees of the General Assembly having cognizance of  
684 matters relating to insurance and public health on the method the  
685 Insurance Department shall use to check for compliance with state and  
686 federal mental health parity laws by health insurance companies and  
687 other entities under its jurisdiction. In selecting such method, the  
688 commissioner shall examine and assess for fitness the methods set  
689 forth by the United States Department of Labor and URAC, in addition

690 to any other methods discovered by or brought to the attention of the  
691 Insurance Department. As part of the evaluation process, the  
692 commissioner shall hold at least one public meeting at which  
693 stakeholders, including, but not limited to, relevant state agency  
694 personnel, health insurance companies and the general public, are  
695 invited to share their input and propose other compliance check  
696 methods.

697 (b) The report under subsection (a) of this section shall describe and  
698 address the comments shared at the public meeting or meetings,  
699 include an assessment of each potential method examined and append  
700 written comments and suggestions of the Healthcare Advocate.

701 (c) On or before October 1, 2013, the commissioner shall begin such  
702 compliance checks using the compliance check method selected.

703 Sec. 17. Section 38a-478a of the general statutes is repealed and the  
704 following is substituted in lieu thereof (*Effective October 1, 2013*):

705 On March first annually, the Insurance Commissioner shall submit a  
706 report to the Governor and to the joint standing committees of the  
707 General Assembly having cognizance of matters relating to public  
708 health and insurance, concerning the commissioner's responsibilities  
709 under the provisions of sections 38a-478 to 38a-478u, inclusive, 38a-  
710 479aa, 38a-591a to 38a-591h, inclusive, and 38a-993. The report shall  
711 include: (1) A summary of the quality assurance plans submitted by  
712 managed care organizations pursuant to section 38a-478c along with  
713 suggested changes to improve such plans; (2) suggested modifications  
714 to the consumer report card developed under the provisions of section  
715 38a-478l; (3) a summary of the commissioner's procedures and  
716 activities in conducting market conduct examinations of utilization  
717 review companies and preferred provider networks, including, but not  
718 limited to: (A) The number of desk and field audits completed during  
719 the previous calendar year; (B) a summary of findings of the desk and  
720 field audits, including any recommendations made for improvements  
721 or modifications; (C) a description of complaints concerning managed

722 care companies, and any preferred provider network that provides  
 723 services to enrollees on behalf of the managed care organization,  
 724 including a summary and analysis of any trends or similarities found  
 725 in the managed care complaints filed by enrollees; (4) a summary of  
 726 the complaints concerning managed care organizations received by the  
 727 Insurance Department's Consumer Affairs Division and the  
 728 commissioner under section 38a-591g, as amended by this act,  
 729 including a summary and analysis of any trends or similarities found  
 730 in the complaints received; (5) a summary of any violations the  
 731 commissioner has found against any managed care organization or  
 732 any preferred provider network that provides services to enrollees on  
 733 behalf of the managed care organization; [and] (6) a summary of the  
 734 issues discussed related to health care or managed care organizations  
 735 at the Insurance Department's quarterly forums throughout the state;  
 736 and (7) a summary of the method used by the department to check for  
 737 compliance with state and federal mental health parity laws by health  
 738 insurance companies and other entities under its jurisdiction, and  
 739 results of such compliance checks.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2013	38a-591a(38)
Sec. 2	October 1, 2013	38a-591d(a) to (c)
Sec. 3	October 1, 2013	38a-591d(e)
Sec. 4	October 1, 2013	38a-591e(c)(3)
Sec. 5	October 1, 2013	38a-591e(d)
Sec. 6	October 1, 2013	38a-591f(d)
Sec. 7	October 1, 2013	38a-591g(i)(1)
Sec. 8	July 1, 2014	38a-591a(7)
Sec. 9	July 1, 2014	38a-591c
Sec. 10	July 1, 2014	38a-591e
Sec. 11	July 1, 2014	38a-591d(a)
Sec. 12	July 1, 2014	38a-591l(c)
Sec. 13	October 1, 2013	38a-478l
Sec. 14	October 1, 2013	38a-1040
Sec. 15	October 1, 2013	38a-1046

Sec. 16	<i>from passage</i>	New section
Sec. 17	<i>October 1, 2013</i>	38a-478a

**INS**      *Joint Favorable Subst.*