



# Senate

General Assembly

**File No. 33**

January Session, 2013

Substitute Senate Bill No. 861

*Senate, March 11, 2013*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## **AN ACT CONCERNING THE MODERNIZATION OF CERTAIN MEDICAL FORMS.**

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

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 Section 38a-591c of the general statutes is repealed and the  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

3 (a) (1) Each health carrier shall contract with (A) health care  
4 professionals to administer such health carrier's utilization review  
5 program and oversee utilization review determinations, and (B) with  
6 clinical peers to evaluate the clinical appropriateness of an adverse  
7 determination.

8 (2) Each utilization review program shall use current, documented  
9 clinical review criteria that are based on sound clinical evidence and  
10 are evaluated periodically by the health carrier's organizational  
11 mechanism specified in subparagraph (F) of subdivision (2) of  
12 subsection (c) of section 38a-591b to assure such program's ongoing  
13 effectiveness. A health carrier may develop its own clinical review

14 criteria or it may purchase or license clinical review criteria from  
15 qualified vendors approved by the commissioner. Each health carrier  
16 shall make its clinical review criteria available electronically to health  
17 care professionals with whom such carrier has contracted to provide  
18 health care services to its covered persons and upon request to  
19 authorized government agencies.

20 (b) Each health carrier shall:

21 (1) Have procedures in place to ensure that the health care  
22 professionals administering such health carrier's utilization review  
23 program are applying the clinical review criteria consistently in  
24 utilization review determinations;

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

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

31 (4) Coordinate the utilization review program with other medical  
32 management activity conducted by the health carrier, such as quality  
33 assurance, credentialing, contracting with health care professionals,  
34 data reporting, grievance procedures, processes for assessing member  
35 satisfaction and risk management; and

36 (5) Routinely assess the effectiveness and efficiency of its utilization  
37 review program.

38 (c) If a health carrier delegates any utilization review activities to a  
39 utilization review company, the health carrier shall maintain adequate  
40 oversight, which shall include (1) a written description of the  
41 utilization review company's activities and responsibilities, including  
42 such company's reporting requirements, (2) evidence of the health  
43 carrier's formal approval of the utilization review company program,  
44 and (3) a process by which the health carrier shall evaluate the

45 utilization review company's performance.

46 (d) When conducting utilization review, the health carrier shall (1)  
47 collect only the information necessary, including pertinent clinical  
48 information, to make the utilization review or benefit determination,  
49 and (2) ensure that such review is conducted in a manner to ensure the  
50 independence and impartiality of the individual or individuals  
51 involved in making the utilization review or benefit determination. No  
52 health carrier shall make decisions regarding the hiring, compensation,  
53 termination, promotion or other similar matters of such individual or  
54 individuals based on the likelihood that the individual or individuals  
55 will support the denial of benefits.

56 (e) (1) Not later than January 1, 2014, the commissioner shall  
57 develop uniform prior authorization forms for health care services,  
58 including, but not limited to, health care professional office visits,  
59 prescription drug benefits, and imaging and other diagnostic or  
60 laboratory testing. The commissioner shall seek input from health  
61 carriers, utilization review companies, health care professionals and  
62 other stakeholders for the development of such forms. The  
63 commissioner may develop different forms for different health care  
64 services as the commissioner deems necessary or appropriate.

65 (2) Any such forms shall (A) not exceed two pages, (B) be available  
66 in paper format and electronic format, (C) be capable of being  
67 completed and submitted electronically, and (D) be consistent with  
68 existing prior authorization forms established by the Centers for  
69 Medicare and Medicaid Services and with any national standards  
70 pertaining to electronic prior authorization procedures.

71 (3) Upon developing such forms, the commissioner shall notify  
72 health carriers of the availability of such forms. Each health carrier  
73 shall notify and make such forms available to utilization review  
74 companies to which such carrier has delegated any utilization review  
75 activities and to health care professionals with whom such carrier has  
76 contracted to provide health care services to its covered persons. Not  
77 later than one hundred eighty days after the commissioner provides

78 such notification, each such health care professional shall use, and each  
79 health carrier or utilization review company that requires prior  
80 authorization for a health care service shall use and accept, such forms.  
81 If such carrier or company fails to accept a prior authorization form  
82 developed pursuant to this subsection, for which all required  
83 information is submitted, or such carrier or company fails to grant or  
84 deny such prior authorization within twenty-four hours of such carrier  
85 or company's receipt of such prior authorization request, such prior  
86 authorization shall be deemed granted.

87 (4) Nothing in this subsection shall prohibit a health carrier or  
88 utilization review company from using, in lieu of paper format, a prior  
89 authorization system that utilizes an Internet web site, an Internet-  
90 based portal or other electronic systems to access or submit a prior  
91 authorization form developed pursuant to this subsection.

92 Sec. 2. Section 38a-478e of the general statutes is repealed and the  
93 following is substituted in lieu thereof (*Effective October 1, 2013*):

94 (a) Each managed care organization shall, prior to implementing  
95 new medical protocols or substantially or materially altering existing  
96 medical protocols, obtain input from physicians actively practicing in  
97 Connecticut and practicing in the relevant specialty areas. The  
98 managed care organization shall also seek input from physicians who  
99 are not employees of or consultants, other than to the extent a person is  
100 an employee or consultant solely for the purposes of this subsection, to  
101 the managed care organization provided the input is not unreasonably  
102 withheld. The managed care organization shall obtain the input in a  
103 manner permitting verification by the commissioner and shall  
104 document the process by which it obtained the input. For the purpose  
105 of this section, "medical protocols" shall include, but not be limited to,  
106 drug formularies or lists of covered drugs and clinical criteria used for  
107 utilization review, as defined in section 38a-591a.

108 (b) Each managed care organization shall (1) make available [, upon  
109 the request of a] to its participating [provider] providers on such  
110 organization's Internet web site, its current medical protocols, [for

111 examination during regular business hours at the principal  
112 Connecticut headquarters of the managed care organization,] and (2) if  
113 a managed care organization denies a treatment, service or procedure,  
114 the organization shall furnish, upon the request of a participating  
115 provider, a copy of the relevant medical protocol to the participating  
116 provider, along with an explanation of the denial at the time the denial  
117 is made.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2013</i>	38a-591c
Sec. 2	<i>October 1, 2013</i>	38a-478e

**INS**      *Joint Favorable Subst.*

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The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

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***OFA Fiscal Note***

***State Impact:*** None

***Municipal Impact:*** None

***Explanation***

The bill requires the Department of Insurance to develop uniform health care prior authorization forms. This is not anticipated to result in a fiscal impact.

***The Out Years***

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis****sSB 861*****AN ACT CONCERNING THE MODERNIZATION OF CERTAIN MEDICAL FORMS.*****SUMMARY:**

This bill requires the insurance commissioner to develop, by January 1, 2014, uniform prior authorization forms for health care services. The forms must at least cover professional office visits, prescription drug benefits, imaging, and other diagnostic or laboratory testing.

Under the bill, all health care professionals must use the forms. All insurers, other health carriers, or utilization review companies that require prior authorization for health care services must accept and use them. Prior authorization is considered to have been granted if a carrier or company fails to (1) accept a fully completed form or (2) grant or deny prior authorization within 24 hours of receiving the prior authorization request.

The bill requires managed care organizations (MCOs) to get input from physicians when altering or replacing utilization review criteria. It expands access to medical protocols, including utilization review criteria, drug formularies, and lists of covered drugs.

EFFECTIVE DATE: October 1, 2013

**PRIOR AUTHORIZATION FORMS**

Under the bill, when developing the forms, the commissioner must seek input from health carriers, utilization review companies, health care professionals, and other stakeholders. He may develop different

forms for different services as he considers necessary or appropriate.

The forms must:

1. not exceed two pages,
2. be available in paper and electronic formats,
3. be capable of being completed and submitted electronically, and
4. be consistent with existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and any national standards on electronic prior authorization procedures.

After developing the forms, the commissioner must notify health carriers of their availability. Health carriers must notify and make the forms available to (1) utilization review companies they use and (2) health care professionals they contract with to provide health care services to their insureds. Within 180 days after the commissioner provides his notice, health care professionals must use the forms, and health carriers or utilization review companies that require prior authorization for health care services must use and accept them.

A carrier or utilization review company may use a prior authorization system that uses an Internet web site, an Internet-based portal, or other electronic systems to access or submit the prior authorization form, instead of a paper form.

## **MEDICAL PROTOCOLS**

The bill requires MCOs to treat utilization review criteria as medical protocols when making substantive changes to these criteria. By law, MCOs must obtain input from physicians actively practicing in Connecticut in relevant specialty areas before establishing new protocols or substantially modifying existing protocols. Utilization review (1) evaluates the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings or (2)

monitors the use of such services, procedures, or settings.

Under current law, MCOs must make their medical protocols available to their participating providers, upon request, to examine at their principal Connecticut headquarters during regular business hours. The bill instead requires MCOs to make protocols available to their participating providers on their Internet web sites. The bill also specifies that these must be the current protocols.

**UTILIZATION REVIEW CRITERIA**

By law, each utilization review program must use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically. The bill specifies that these criteria must be current.

By law, carriers must make their criteria available, upon request, to authorized government agencies. The bill additionally requires them to make the criteria available electronically to health care professionals with whom they contract to provide health care services.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 17 Nay 2 (02/26/2013)