



General Assembly

February Session, 2014

Raised Bill No. 5578

LCO No. 2266



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE
PROCESS FOR ADVERSE DETERMINATIONS.***

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

1 Section 1. Subdivision (7) of section 38a-591a of the 2014 supplement
2 to the general statutes is repealed and the following is substituted in
3 lieu thereof (*Effective from passage*):

4 (7) "Clinical peer" means a physician or other health care
5 professional who (A) holds a nonrestricted license in a state of the
6 United States and in the same or similar specialty as typically manages
7 the medical condition, procedure or treatment under review, and (B)
8 for a review specified under subparagraph (B) or (C) of subdivision
9 (38) of this section concerning (i) a child or adolescent substance use
10 disorder or a child or adolescent mental disorder, holds a national
11 board certification in child and adolescent psychiatry where the
12 covered person's treating health care professional is a psychiatrist or
13 child and adolescent psychology where the covered person's treating
14 health care professional is a psychologist, and has training or clinical
15 experience in the treatment of child and adolescent substance use

16 disorder or child and adolescent mental disorder, as applicable, or (ii)
17 an adult substance use disorder or an adult mental disorder, holds a
18 national board certification in psychiatry where the covered person's
19 treating health care professional is a psychiatrist or psychology where
20 the covered person's treating health care professional is a psychologist,
21 and has training or clinical experience in the treatment of adult
22 substance use disorders or adult mental disorders, as applicable.

23 Sec. 2. Section 38a-591c of the 2014 supplement to the general
24 statutes is repealed and the following is substituted in lieu thereof
25 (*Effective from passage*):

26 (a) (1) Each health carrier shall contract with (A) health care
27 professionals to administer such health carrier's utilization review
28 program, and (B) clinical peers to [conduct utilization reviews and to]
29 evaluate the clinical appropriateness of an adverse determination.

30 (2) Each utilization review program shall use documented clinical
31 review criteria that are based on sound clinical evidence and are
32 evaluated periodically by the health carrier's organizational
33 mechanism specified in subparagraph (F) of subdivision (2) of
34 subsection (c) of section 38a-591b to assure such program's ongoing
35 effectiveness. A health carrier may develop its own clinical review
36 criteria or it may purchase or license clinical review criteria from
37 qualified vendors approved by the commissioner. Each health carrier
38 shall make its clinical review criteria available upon request to
39 authorized government agencies.

40 (3) (A) Notwithstanding subdivision (2) of this subsection, for any
41 utilization review for the treatment of a substance use disorder, as
42 described in section 17a-458, the clinical review criteria used shall be:
43 (i) The most recent edition of the American Society of Addiction
44 Medicine's Patient Placement Criteria; or (ii) clinical review criteria
45 that the health carrier demonstrates is consistent with the most recent
46 edition of the American Society of Addiction Medicine's Patient

47 Placement Criteria, in accordance with subparagraph (B) of this
48 subdivision.

49 (B) A health carrier that uses clinical review criteria as set forth in
50 subparagraph (A)(ii) of this subdivision shall create and maintain a
51 document in an easily accessible location on such health carrier's
52 Internet web site that (i) compares each aspect of such clinical review
53 criteria with the American Society of Addiction Medicine's Patient
54 Placement Criteria, and (ii) provides citations to peer-reviewed
55 medical literature generally recognized by the relevant medical
56 community or to professional society guidelines that justify each
57 deviation from the American Society of Addiction Medicine's Patient
58 Placement Criteria.

59 (4) (A) Notwithstanding subdivision (2) of this subsection, for any
60 utilization review for the treatment of a child or adolescent mental
61 disorder, the clinical review criteria used shall be: (i) The most recent
62 guidelines of the American Academy of Child and Adolescent
63 Psychiatry's Child and Adolescent Service Intensity Instrument; or (ii)
64 clinical review criteria that the health carrier demonstrates is consistent
65 with the most recent guidelines of the American Academy of Child
66 and Adolescent Psychiatry's Child and Adolescent Service Intensity
67 Instrument, in accordance with subparagraph (B) of this subdivision.

68 (B) A health carrier that uses clinical review criteria as set forth in
69 subparagraph (A)(ii) of this subdivision for children and adolescents
70 shall create and maintain a document in an easily accessible location
71 on such health carrier's Internet web site that (i) compares each aspect
72 of such clinical review criteria with the guidelines of the American
73 Academy of Child and Adolescent Psychiatry's Child and Adolescent
74 Service Intensity Instrument, and (ii) provides citations to peer-
75 reviewed medical literature generally recognized by the relevant
76 medical community or to professional society guidelines that justify
77 each deviation from the guidelines of the American Academy of Child
78 and Adolescent Psychiatry's Child and Adolescent Service Intensity

79 Instrument.

80 (5) (A) Notwithstanding subdivision (2) of this subsection, for any
81 utilization review for the treatment of an adult mental disorder, the
82 clinical review criteria used shall be: (i) The most recent guidelines of
83 the American Psychiatric Association or the most recent Standards and
84 Guidelines of the Association for Ambulatory Behavioral Healthcare;
85 or (ii) clinical review criteria that the health carrier demonstrates is
86 consistent with the most recent guidelines of the American Psychiatric
87 Association or the most recent Standards and Guidelines of the
88 Association for Ambulatory Behavioral Healthcare, in accordance with
89 subparagraph (B) of this subdivision.

90 (B) A health carrier that uses clinical review criteria as set forth in
91 subparagraph (A)(ii) of this subdivision for adults shall create and
92 maintain a document in an easily accessible location on such health
93 carrier's Internet web site that (i) compares each aspect of such clinical
94 review criteria with the guidelines of the American Psychiatric
95 Association or the most recent Standards and Guidelines of the
96 Association for Ambulatory Behavioral Healthcare, and (ii) provides
97 citations to peer-reviewed medical literature generally recognized by
98 the relevant medical community or to professional society guidelines
99 that justify each deviation from the guidelines of the American
100 Psychiatric Association or the most recent Standards and Guidelines of
101 the Association for Ambulatory Behavioral Healthcare.

102 (b) Each health carrier shall:

103 (1) Have procedures in place to ensure that (A) the health care
104 professionals administering such health carrier's utilization review
105 program are applying the clinical review criteria consistently in
106 utilization review determinations, and (B) the appropriate or required
107 [clinical peers] individual or individuals are being designated to
108 conduct utilization reviews;

109 (2) Have data systems sufficient to support utilization review

110 program activities and to generate management reports to enable the
111 health carrier to monitor and manage health care services effectively;

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

115 (4) Coordinate the utilization review program with other medical
116 management activity conducted by the health carrier, such as quality
117 assurance, credentialing, contracting with health care professionals,
118 data reporting, grievance procedures, processes for assessing member
119 satisfaction and risk management; and

120 (5) Routinely assess the effectiveness and efficiency of its utilization
121 review program.

122 (c) If a health carrier delegates any utilization review activities to a
123 utilization review company, the health carrier shall maintain adequate
124 oversight, which shall include (1) a written description of the
125 utilization review company's activities and responsibilities, including
126 such company's reporting requirements, (2) evidence of the health
127 carrier's formal approval of the utilization review company program,
128 and (3) a process by which the health carrier shall evaluate the
129 utilization review company's performance.

130 (d) When conducting utilization review, the health carrier shall (1)
131 collect only the information necessary, including pertinent clinical
132 information, to make the utilization review or benefit determination,
133 and (2) ensure that such review is conducted in a manner to ensure the
134 independence and impartiality of the [clinical peer or peers] individual
135 or individuals involved in making the utilization review or benefit
136 determination. No health carrier shall make decisions regarding the
137 hiring, compensation, termination, promotion or other similar matters
138 of such [clinical peer or peers] individual or individuals based on the
139 likelihood that the [clinical peer or peers] individual or individuals
140 will support the denial of benefits.

141 Sec. 3. Subsection (e) of section 38a-591d of the 2014 supplement to
142 the general statutes is repealed and the following is substituted in lieu
143 thereof (*Effective from passage*):

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

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

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

153 (B) The specific reason or reasons for the adverse determination,
154 including, upon request, a listing of the relevant clinical review
155 criteria, including professional criteria and medical or scientific
156 evidence and a description of the health carrier's standard, if any, that
157 were used in reaching the denial;

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

160 (D) A description of any additional material or information
161 necessary for the covered person to perfect the benefit request or claim,
162 including an explanation of why the material or information is
163 necessary to perfect the request or claim;

164 (E) A description of the health carrier's internal grievance process
165 that includes (i) the health carrier's expedited review procedures, (ii)
166 any time limits applicable to such process or procedures, (iii) the
167 contact information for the organizational unit designated to
168 coordinate the review on behalf of the health carrier, and (iv) a
169 statement that the covered person or, if applicable, the covered

170 person's authorized representative is entitled, pursuant to the
171 requirements of the health carrier's internal grievance process, to
172 receive from the health carrier, free of charge upon request, reasonable
173 access to and copies of all documents, records, communications and
174 other information and evidence regarding the covered person's benefit
175 request;

176 (F) If the adverse determination is based on a health carrier's
177 internal rule, guideline, protocol or other similar criterion, (i) the
178 specific rule, guideline, protocol or other similar criterion, or (ii) (I) a
179 statement that a specific rule, guideline, protocol or other similar
180 criterion of the health carrier was relied upon to make the adverse
181 determination and that a copy of such rule, guideline, protocol or other
182 similar criterion will be provided to the covered person free of charge
183 upon request, (II) instructions for requesting such copy, and (III) the
184 links to such rule, guideline, protocol or other similar criterion on such
185 health carrier's Internet web site. If the adverse determination involves
186 the treatment of a substance use disorder, as described in section 17a-
187 458, or a mental disorder, the notice of adverse determination shall
188 also include, if applicable, a link to the document created and
189 maintained by such health carrier pursuant to subdivision (3), (4) or (5)
190 of subsection (a) of section 38a-591c, as applicable, on such health
191 carrier's Internet web site;

192 (G) If the adverse determination is based on medical necessity or an
193 experimental or investigational treatment or similar exclusion or limit,
194 the written statement of the scientific or clinical rationale for the
195 adverse determination and (i) an explanation of the scientific or clinical
196 rationale used to make the determination that applies the terms of the
197 health benefit plan to the covered person's medical circumstances or
198 (ii) a statement that an explanation will be provided to the covered
199 person free of charge upon request, and instructions for requesting a
200 copy of such explanation;

201 (H) A statement explaining the right of the covered person to

202 contact the commissioner's office or the Office of the Healthcare
203 Advocate at any time for assistance or, upon completion of the health
204 carrier's internal grievance process, to file a civil suit in a court of
205 competent jurisdiction. Such statement shall include the contact
206 information for said offices; and

207 (I) A statement that if the covered person or the covered person's
208 authorized representative chooses to file a grievance of an adverse
209 determination, (i) such appeals are sometimes successful, (ii) such
210 covered person or covered person's authorized representative may
211 benefit from free assistance from the Office of the Healthcare
212 Advocate, which can assist such covered person or covered person's
213 authorized representative with the filing of a grievance pursuant to 42
214 USC 300gg-93, as amended from time to time, [or from the Division of
215 Consumer Affairs within the Insurance Department,] (iii) such covered
216 person or covered person's authorized representative is entitled and
217 encouraged to submit supporting documentation for the health
218 carrier's consideration during the review of an adverse determination,
219 including narratives from such covered person or covered person's
220 authorized representative and letters and treatment notes from such
221 covered person's health care professional, and (iv) such covered person
222 or covered person's authorized representative has the right to ask such
223 covered person's health care professional for such letters or treatment
224 notes.

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

228 Sec. 4. Subsection (d) of section 38a-591f of the 2014 supplement to
229 the general statutes is repealed and the following is substituted in lieu
230 thereof (*Effective from passage*):

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

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

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

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

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

243 (E) For a decision that upholds the adverse determination, a
244 statement (i) that the covered person may receive from the health
245 carrier, free of charge and upon request, reasonable access to and
246 copies of, all documents, communications, information and evidence
247 regarding the adverse determination that is the subject of the final
248 adverse determination, and (ii) disclosing the covered person's right to
249 contact [the commissioner's office or] the Office of the Healthcare
250 Advocate at any time, and that such covered person may benefit from
251 free assistance from the Office of the Healthcare Advocate, which can
252 assist such covered person with the filing of a grievance pursuant to 42
253 USC 300gg-93, as amended from time to time. [, or from the Division of
254 Consumer Affairs within the Insurance Department.] Such disclosure
255 shall include the contact information for said [offices] office.

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

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| This act shall take effect as follows and shall amend the following sections: | | |
| Section 1 | <i>from passage</i> | 38a-591a(7) |
| Sec. 2 | <i>from passage</i> | 38a-591c |

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| Sec. 3 | <i>from passage</i> | 38a-591d(e) |
| Sec. 4 | <i>from passage</i> | 38a-591f(d) |

Statement of Purpose:

To specify the clinical peers for psychiatrists and psychologists, to change references to clinical peers to individuals for purposes of conducting utilization reviews, and to delete references to the Division of Consumer Affairs within the Insurance Department in certain notices provided to covered persons.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]