
OLR Bill Analysis

sHB 5529

AN ACT CONCERNING THE DEFINITION OF MEDICAL NECESSITY.

SUMMARY:

This bill amends the definition of “medically necessary” or “medical necessity” that insurers, HMOs, and other entities must include in individual and group health insurance policies. It:

1. broadens what is considered medically necessary or a medical necessity, by removing the requirement that the services be based on credible scientific evidence published in peer-reviewed medical literature;
2. explicitly applies the definition to health care services for mental illness or its effects; and
3. specifies that the determination of medical necessity must be based on an assessment of the patient and his or her medical condition.

EFFECTIVE DATE: October 1, 2014

MEDICAL NECESSITY

Existing law prohibits insurers, HMOs, hospital and medical service corporations, and other entities from delivering or issuing individual or group health insurance policies that do not contain a specified definition of “medically necessary” or “medical necessity.”

Under the current definition, these terms mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that meet certain criteria, discussed below. The bill makes clear that “illness”

includes mental illness or its effects.

Under the current definition, the services must be:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
3. not primarily for the convenience of the patient, physician, or other health care provider and no more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

The bill adds the requirement that the services be based on an assessment of the patient and his or her medical condition.

It also broadens the definition of "generally accepted standards of medical practice." That term currently means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

The bill removes the reference to evidence in peer-reviewed literature. Thus, it defines "generally accepted standards of medical practice" as standards that are generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Application

By law, the requirement to include this definition of "medically necessary" or "medical necessity" in health insurance policies applies to insurers, HMOs, hospital and medical service corporations, and other entities delivering, issuing, renewing, continuing, or amending

individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) accidents only, (5) limited benefits, or (6) hospital or medical services.

Various provisions in the insurance statutes mandate coverage for specified treatment or services when medically necessary. The definition of medically necessary or medical necessity also applies to the statutes concerning the process to challenge a claims denial or other adverse determination by a health carrier.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 17 Nay 9 (03/21/2014)