



# House of Representatives

**File No. 703**

General Assembly

February Session, 2014

**(Reprint of File No. 362)**

House Bill No. 5578  
As Amended by House Amendment  
Schedule "A"

Approved by the Legislative Commissioner  
April 28, 2014

***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2 to the general statutes is repealed and the following is substituted in  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 (I) a national  
11 board certification in child and adolescent psychiatry, or [child and  
12 adolescent psychology, and has] (II) a doctoral level psychology  
13 degree with training [or] and clinical experience in the treatment of  
14 child and adolescent substance use disorder or child and adolescent

15 mental disorder, as applicable, or (ii) an adult substance use disorder  
16 or an adult mental disorder, holds (I) a national board certification in  
17 psychiatry, or [psychology, and has] (II) a doctoral level psychology  
18 degree with training [or] and clinical experience in the treatment of  
19 adult substance use disorders or adult mental disorders, as applicable.

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21 statutes is repealed and the following is substituted in lieu thereof  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

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

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

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

46 (B) A health carrier that uses clinical review criteria as set forth in

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

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

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

77 (5) (A) Notwithstanding subdivision (2) of this subsection, for any  
78 utilization review for the treatment of an adult mental disorder, the  
79 clinical review criteria used shall be: (i) The most recent guidelines of

80 the American Psychiatric Association or the most recent Standards and  
81 Guidelines of the Association for Ambulatory Behavioral Healthcare;  
82 or (ii) clinical review criteria that the health carrier demonstrates is  
83 consistent with the most recent guidelines of the American Psychiatric  
84 Association or the most recent Standards and Guidelines of the  
85 Association for Ambulatory Behavioral Healthcare, in accordance with  
86 subparagraph (B) of this subdivision.

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

99 (b) Each health carrier shall:

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

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

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

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

117 (5) Routinely assess the effectiveness and efficiency of its utilization  
118 review program.

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

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

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

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

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

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

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

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

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

161 (E) A description of the health carrier's internal grievance process  
162 that includes (i) the health carrier's expedited review procedures, (ii)  
163 any time limits applicable to such process or procedures, (iii) the  
164 contact information for the organizational unit designated to  
165 coordinate the review on behalf of the health carrier, and (iv) a  
166 statement that the covered person or, if applicable, the covered  
167 person's authorized representative is entitled, pursuant to the  
168 requirements of the health carrier's internal grievance process, to  
169 receive from the health carrier, free of charge upon request, reasonable  
170 access to and copies of all documents, records, communications and  
171 other information and evidence regarding the covered person's benefit  
172 request;

173 (F) If the adverse determination is based on a health carrier's  
174 internal rule, guideline, protocol or other similar criterion, (i) the

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

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

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

204 (I) A statement that if the covered person or the covered person's  
205 authorized representative chooses to file a grievance of an adverse  
206 determination, (i) such appeals are sometimes successful, (ii) such  
207 covered person or covered person's authorized representative may

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

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

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

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

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

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

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

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

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

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

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

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 makes several changes to private insurers' utilization review processes. As the bill addresses the operations of private insurance companies, there is no fiscal impact.

House "A" changed a definition in the underlying bill. It had no fiscal impact.

***The Out Years******State Impact:*** None***Municipal Impact:*** None

**OLR Bill Analysis****HB 5578 (as amended by House "A")\******AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE PROCESS FOR ADVERSE DETERMINATIONS.*****SUMMARY:**

This bill eliminates the requirement that health carriers (insurers) contract with "clinical peers" to conduct utilization reviews. It requires carriers to have procedures to ensure that appropriate or required individuals, rather than clinical peers, are designated to conduct these reviews. By law, clinical peers are health care professionals licensed in the same or a similar specialty as the one that typically manages the medical condition, procedure, or treatment under review. Carriers must contract with health care professionals to administer their utilization review programs.

By law, carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations (e.g., claims denials). For cases when an urgent care request involves a substance use or mental disorder, the clinical peer must be a psychiatrist or psychologist with specified qualifications. In such cases involving psychologists, the bill requires the psychologist to hold a doctoral level psychology degree. It also requires the psychologist to have both, rather than either, training and relevant experience in the relevant field (i.e., child and adolescent substance use disorder, child and adolescent mental disorder, adult substance use disorder or adult mental disorder).

By law, a carrier must notify an insured and, if applicable, his or her authorized representative, of an adverse determination. The bill eliminates the requirement that the notice state that the insured or

representative may benefit from free assistance from the Insurance Department's Division of Consumer Affairs ("division"). Similarly, the law requires the carrier to provide notice when an internal review of an adverse determination that was not based on medical necessity upholds the initial decision. The bill eliminates the requirement that the notice disclose the insured's right to contact the commissioner's office. The bill retains parallel notice requirements regarding the Office of the Healthcare Advocate.

The bill also makes conforming changes.

\*House Amendment "A" (1) eliminates the bill's requirement that a clinical peer for certain substance use or mental disorder cases be a psychiatrist or psychologist, depending on the treating health care provider's profession; (2) requires psychologists who serve as clinical peers in such cases hold a doctoral level degree; and (3) requires that these psychologists have both, rather than either, training and relevant experience in the relevant field.

EFFECTIVE DATE: Upon passage

## **BACKGROUND**

### ***Utilization Reviews***

Utilization reviews are techniques carriers use to monitor the use or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Among other things, they can include monitoring or evaluating activities conducted to manage the care of patients with serious, complicated, or protracted health conditions or to review care on a prospective, concurrent review, or retrospective basis.

## **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 19    Nay 0    (03/20/2014)