



Senate

General Assembly

File No. 442

February Session, 2016

Substitute Senate Bill No. 372

Senate, April 4, 2016

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 CLINICAL REVIEW CRITERIA FOR UTILIZATION REVIEW AND ADVERSE DETERMINATION NOTICES.

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

1 Section 1. Subsection (a) of section 38a-591c of the 2016 supplement
2 to the general statutes is repealed and the following is substituted in
3 lieu thereof (*Effective January 1, 2017*):

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

8 (2) (A) Each utilization review program shall use 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]

14 (B) Except as provided in subdivisions (3), (4) and (5) of this
15 subsection, a health carrier may develop its own clinical review criteria
16 or it may purchase or license clinical review criteria from qualified
17 vendors approved by the commissioner, provided such clinical review
18 criteria conform to the requirements of subparagraph (A) of this
19 subdivision.

20 (C) Each health carrier shall (i) post on its Internet web site (I) any
21 clinical review criteria it uses, and (II) links to any rule, guideline,
22 protocol or other similar criterion a health carrier may rely upon to
23 make an adverse determination as described in subparagraph (F) of
24 subdivision (1) of subsection (e) of section 38a-591d, as amended by
25 this act, and (ii) make its clinical review criteria available upon request
26 to authorized government agencies.

27 (3) [(A) Notwithstanding subdivision (2) of this subsection, for] For
28 any utilization review for the treatment of a substance use disorder, as
29 described in section 17a-458, the clinical review criteria used shall be:
30 [(i)] (A) The most recent edition of the American Society of Addiction
31 Medicine Treatment Criteria for Addictive, Substance-Related, and Co-
32 Occurring Conditions; or [(ii)] (B) clinical review criteria that the health
33 carrier demonstrates to the Insurance Department is consistent with
34 the most recent edition of the American Society of Addiction Medicine
35 Treatment Criteria for Addictive, Substance-Related, and Co-
36 Occurring Conditions, [in accordance with subparagraph (B) of this
37 subdivision] except that nothing in this subdivision shall prohibit a
38 health carrier from developing its own clinical review criteria or
39 purchasing or licensing additional clinical review criteria from
40 qualified vendors approved by the commissioner, to address
41 advancements in technology or types of care for the treatment of a
42 substance use disorder, that are not covered in the most recent edition
43 of the American Society of Addiction Medicine Treatment Criteria for
44 Addictive, Substance-Related, and Co-Occurring Conditions. Any such
45 clinical review criteria developed by a health carrier or purchased or
46 licensed from a qualified vendor shall conform to the requirements of
47 subparagraph (A) of subdivision (2) of this subsection.

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

59 (4) [(A) Notwithstanding subdivision (2) of this subsection, for] For
60 any utilization review for the treatment of a child or adolescent mental
61 disorder, the clinical review criteria used shall be: [(i)] (A) The most
62 recent guidelines of the American Academy of Child and Adolescent
63 Psychiatry's Child and Adolescent Service Intensity Instrument; or
64 [(ii)] (B) clinical review criteria that the health carrier demonstrates to
65 the Insurance Department is consistent with the most recent guidelines
66 of the American Academy of Child and Adolescent Psychiatry's Child
67 and Adolescent Service Intensity Instrument, [in accordance with
68 subparagraph (B) of this subdivision] except that nothing in this
69 subdivision shall prohibit a health carrier from developing its own
70 clinical review criteria or purchasing or licensing additional clinical
71 review criteria from qualified vendors approved by the commissioner,
72 to address advancements in technology or types of care for the
73 treatment of a child or adolescent mental disorder, that are not covered
74 in the most recent guidelines of the American Academy of Child and
75 Adolescent Psychiatry's Child and Adolescent Service Intensity
76 Instrument. Any such clinical review criteria developed by a health
77 carrier or purchased or licensed from a qualified vendor shall conform
78 to the requirements of subparagraph (A) of subdivision (2) of this
79 subsection.

80 [(B) A health carrier that uses clinical review criteria as set forth in
81 subparagraph (A)(ii) of this subdivision for children and adolescents

82 shall create and maintain a document in an easily accessible location
83 on such health carrier's Internet web site that (i) compares each aspect
84 of such clinical review criteria with the guidelines of the American
85 Academy of Child and Adolescent Psychiatry's Child and Adolescent
86 Service Intensity Instrument, and (ii) provides citations to peer-
87 reviewed medical literature generally recognized by the relevant
88 medical community or to professional society guidelines that justify
89 each deviation from the guidelines of the American Academy of Child
90 and Adolescent Psychiatry's Child and Adolescent Service Intensity
91 Instrument.]

92 (5) [(A) Notwithstanding subdivision (2) of this subsection, for] For
93 any utilization review for the treatment of an adult mental disorder,
94 the clinical review criteria used shall be: [(i)] (A) The most recent
95 guidelines of the American Psychiatric Association or the most recent
96 Standards and Guidelines of the Association for Ambulatory
97 Behavioral Healthcare; or [(ii)] (B) clinical review criteria that the
98 health carrier demonstrates to the Insurance Department is consistent
99 with the most recent guidelines of the American Psychiatric
100 Association or the most recent Standards and Guidelines of the
101 Association for Ambulatory Behavioral Healthcare, [in accordance
102 with subparagraph (B) of this subdivision] except that nothing in this
103 subdivision shall prohibit a health carrier from developing its own
104 clinical review criteria or purchasing or licensing additional clinical
105 review criteria from qualified vendors approved by the commissioner,
106 to address advancements in technology or types of care for the
107 treatment of an adult mental disorder, that are not covered in the most
108 recent guidelines of the American Psychiatric Association or the most
109 recent Standards and Guidelines of the Association for Ambulatory
110 Behavioral Healthcare. Any such clinical review criteria developed by
111 a health carrier or purchased or licensed from a qualified vendor shall
112 conform to the requirements of subparagraph (A) of subdivision (2) of
113 this subsection.

114 [(B) A health carrier that uses clinical review criteria as set forth in
115 subparagraph (A)(ii) of this subdivision for adults shall create and

116 maintain a document in an easily accessible location on such health
117 carrier's Internet web site that (i) compares each aspect of such clinical
118 review criteria with the guidelines of the American Psychiatric
119 Association or the most recent Standards and Guidelines of the
120 Association for Ambulatory Behavioral Healthcare, and (ii) provides
121 citations to peer-reviewed medical literature generally recognized by
122 the relevant medical community or to professional society guidelines
123 that justify each deviation from the guidelines of the American
124 Psychiatric Association or the most recent Standards and Guidelines of
125 the Association for Ambulatory Behavioral Healthcare.]

126 Sec. 2. Subsection (e) of section 38a-591d of the 2016 supplement to
127 the general statutes is repealed and the following is substituted in lieu
128 thereof (*Effective January 1, 2017*):

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

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

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

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

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

145 (D) A description of any additional material or information
146 necessary for the covered person to perfect the benefit request or claim,

147 including an explanation of why the material or information is
148 necessary to perfect the request or claim;

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

161 (F) (i) (I) [If the adverse determination is based on a health carrier's
162 internal rule, guideline, protocol or other similar criterion, (i) the
163 specific rule, guideline, protocol or other similar criterion, or (ii) (I)] A
164 copy of the specific rule, guideline, protocol or other similar criterion
165 the health carrier relied upon to make the adverse determination, or
166 (II) a statement that a specific rule, guideline, protocol or other similar
167 criterion of the health carrier was relied upon to make the adverse
168 determination and that a copy of such rule, guideline, protocol or other
169 similar criterion will be provided to the covered person free of charge
170 upon request, [(II)] with instructions for requesting such copy, and
171 [(III)] (ii) the links to such rule, guideline, protocol or other similar
172 criterion on such health carrier's Internet web site; [If the adverse
173 determination involves the treatment of a substance use disorder, as
174 described in section 17a-458, or a mental disorder, the notice of adverse
175 determination shall also include, if applicable, a link to the document
176 created and maintained by such health carrier pursuant to subdivision
177 (3), (4) or (5) of subsection (a) of section 38a-591c, as applicable, on
178 such health carrier's Internet web site;]

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

180 experimental or investigational treatment or similar exclusion or limit,
181 the written statement of the scientific or clinical rationale for the
182 adverse determination and (i) an explanation of the scientific or clinical
183 rationale used to make the determination that applies the terms of the
184 health benefit plan to the covered person's medical circumstances or
185 (ii) a statement that an explanation will be provided to the covered
186 person free of charge upon request, and instructions for requesting a
187 copy of such explanation;

188 (H) A statement explaining the right of the covered person to
189 contact the commissioner's office or the Office of the Healthcare
190 Advocate at any time for assistance or, upon completion of the health
191 carrier's internal grievance process, to file a civil action in a court of
192 competent jurisdiction. Such statement shall include the contact
193 information for said offices; and

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2017	38a-591c(a)
Sec. 2	January 1, 2017	38a-591d(e)

Statement of Legislative Commissioners:

In Section 1(a)(3), (4) and (5), "(i)" and "(ii)" were changed to "[i] (A)" and "[ii] (B)", respectively, for consistency with standard drafting conventions, and in Section 1(a)(4), "an" before references to adolescent were deleted for clarity.

INS *Joint Favorable Subst. -LCO*

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.

OFA Fiscal Note***State Impact:*** None***Municipal Impact:*** None***Explanation***

The bill, which changes requirements for health carriers related to clinical review criteria, does not result in a fiscal impact to the state or municipalities.

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

OLR Bill Analysis**sSB 372****AN ACT CONCERNING CLINICAL REVIEW CRITERIA FOR UTILIZATION REVIEW AND ADVERSE DETERMINATION NOTICES.****SUMMARY:**

This bill expands the clinical review criteria that health carriers (e.g., insurers and HMOs) may use for utilization reviews. Under the bill, these may include criteria intended to address technological or treatment advances not covered in certain professional medical society treatment criteria publications. Clinical review criteria are the standards health carriers use to determine appropriate care for specific treatments.

The bill also repeals a health carrier's disclosure requirement specific to clinical review criteria for (1) substance use disorders, (2) child or adolescent mental disorders, and (3) adult mental disorders. It replaces these specific requirements with a general disclosure applicable to all clinical review criteria. The new disclosure does not include a requirement, repealed by the bill, that a health carrier show how its criteria differed from those of certain professional societies.

The bill also makes minor, technical and conforming changes.

EFFECTIVE DATE: January 1, 2017.

CLINICAL REVIEW CRITERIA

Health carriers and independent review organizations conduct utilization reviews to determine whether a covered person's health insurance covers a specific medical service. By law, a health carrier's utilization review program must use documented clinical review criteria that are based on sound clinical evidence and evaluated

periodically by the carrier. The law also allows a health carrier to develop its own clinical review criteria or purchase or license such criteria from qualified vendors approved by the insurance commissioner. The bill specifies that such health carrier-developed, -purchased, or -licensed review criteria must meet the same clinical evidence and evaluation standards as the documented review criteria described above.

The bill also specifies that nothing may prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional criteria from qualified vendors approved by the commissioner to address advancements in technology or types of care for the treatment of a:

1. substance use disorder, even if such criteria are not covered in the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions;
2. child or adolescent mental disorder, even if such criteria are not covered in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument guidelines; or
3. adult mental disorder, even if such criteria are not covered in the American Psychiatric Association guidelines or the Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare.

By law, health carriers must, for certain utilization reviews, demonstrate that clinical review criteria are consistent with these professional societies. The bill specifies that this must be demonstrated to the insurance commissioner.

CLINICAL REVIEW DISCLOSURE REQUIREMENTS

The bill repeals a requirement that a health carrier maintain, in an easily accessible location on its website, a document that compares its clinical review criteria with a specific medical publication's review

criteria and provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or professional society guidelines that justify any difference between the two review criteria. The document must compare a health carrier’s clinical review criteria with the following:

1. for treatment of a substance use disorder, the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions;
2. for treatment of a child or adolescent mental disorder, the American Academy of Child and Adolescent Psychiatry’s Child and Adolescent Service Intensity Instrument guidelines; and
3. for treatment of an adult mental disorder, the American Psychiatric Association guidelines or the Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare.

Under the bill, health carriers must instead post on their websites any clinical review criteria they use and links to any rule, guidelines, protocol, or other similar criterion relied upon to make adverse determination decisions. As under existing law, health carriers must still make clinical review criteria available upon request to authorized government agencies.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 0 (03/17/2016)