



General Assembly

January Session, 2021

Raised Bill No. 1045

LCO No. 3686



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING STEP THERAPY, ADVERSE DETERMINATION AND UTILIZATION REVIEWS, AND HEALTH INSURANCE COVERAGE FOR CHILDREN, STEPCHILDREN AND OTHER DEPENDENT CHILDREN.

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

1 Section 1. Section 38a-497 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2022*):

3 Each individual health insurance policy providing coverage of the
4 type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section
5 38a-469 delivered, issued for delivery, amended, renewed or continued
6 in this state shall provide that coverage of a child, stepchild or other
7 dependent child shall terminate [no] not earlier than the policy
8 anniversary date [on or] after [whichever of the following occurs first,]
9 the date on which the child, [: Becomes covered under a group health
10 plan through the dependent's own employment; or] stepchild or other
11 dependent child attains the age of twenty-six. Each such policy shall
12 cover a stepchild or other dependent child on the same basis as a
13 biological child.

14 Sec. 2. Section 38a-512b of the general statutes is repealed and the
15 following is substituted in lieu thereof (*Effective January 1, 2022*):

16 Each group health insurance policy providing coverage of the type
17 specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-
18 469 delivered, issued for delivery, amended, renewed or continued in
19 this state shall provide that coverage of a child, stepchild or other
20 dependent child shall terminate [no] not earlier than the policy
21 anniversary date [on or] after [whichever of the following occurs first,]
22 the date on which the child, [Becomes covered under a group health
23 plan through the dependent's own employment; or] stepchild or other
24 dependent child attains the age of twenty-six. Each such policy shall
25 cover a stepchild or other dependent child on the same basis as a
26 biological child.

27 Sec. 3. Subsection (a) of section 38a-510 of the general statutes is
28 repealed and the following is substituted in lieu thereof (*Effective January*
29 *1, 2022*):

30 (a) No insurance company, hospital service corporation, medical
31 service corporation, health care center or other entity delivering, issuing
32 for delivery, renewing, amending or continuing an individual health
33 insurance policy or contract that provides coverage for prescription
34 drugs may:

35 (1) Require any person covered under such policy or contract to
36 obtain prescription drugs from a mail order pharmacy as a condition of
37 obtaining benefits for such drugs; or

38 (2) Require, if such insurance company, hospital service corporation,
39 medical service corporation, health care center or other entity uses step
40 therapy for such drugs, the use of step therapy for:

41 (A) [any] Any prescribed drug for longer than sixty days; [,] or

42 (B) [a] A prescribed drug for [cancer] treatment of a behavioral health
43 condition or a chronic, disabling or life-threatening condition or disease

44 for an insured who has been diagnosed with [stage IV metastatic cancer]
45 such a condition or disease, provided such prescribed drug is in
46 compliance with approved federal Food and Drug Administration
47 indications.

48 (3) At the expiration of the time period specified in subparagraph (A)
49 of subdivision (2) of this subsection, [or for a prescribed drug described
50 in subparagraph (B) of subdivision (2) of this subsection,] an insured's
51 treating health care provider may deem such step therapy drug regimen
52 clinically ineffective for the insured, at which time the insurance
53 company, hospital service corporation, medical service corporation,
54 health care center or other entity shall authorize dispensation of and
55 coverage for the drug prescribed by the insured's treating health care
56 provider, provided such drug is a covered drug under such policy or
57 contract. If such provider does not deem such step therapy drug
58 regimen clinically ineffective or has not requested an override pursuant
59 to subdivision (1) of subsection (b) of this section, such drug regimen
60 may be continued. For purposes of this section, "step therapy" means a
61 protocol or program that establishes the specific sequence in which
62 prescription drugs for a specified medical condition are to be prescribed.

63 Sec. 4. Subsection (a) of section 38a-544 of the general statutes is
64 repealed and the following is substituted in lieu thereof (*Effective January*
65 *1, 2022*):

66 (a) No insurance company, hospital service corporation, medical
67 service corporation, health care center or other entity delivering, issuing
68 for delivery, renewing, amending or continuing a group health
69 insurance policy or contract that provides coverage for prescription
70 drugs may:

71 (1) Require any person covered under such policy or contract to
72 obtain prescription drugs from a mail order pharmacy as a condition of
73 obtaining benefits for such drugs; or

74 (2) Require, if such insurance company, hospital service corporation,

75 medical service corporation, health care center or other entity uses step
76 therapy for such drugs, the use of step therapy for:

77 (A) [any] Any prescribed drug for longer than sixty days; [,] or

78 (B) [a] A prescribed drug for [cancer] treatment of a behavioral health
79 condition or a chronic, disabling or life-threatening condition or disease
80 for an insured who has been diagnosed with [stage IV metastatic cancer]
81 such a condition or disease, provided such prescribed drug is in
82 compliance with approved federal Food and Drug Administration
83 indications.

84 (3) At the expiration of the time period specified in subparagraph (A)
85 of subdivision (2) of this subsection, [or for a prescribed drug described
86 in subparagraph (B) of subdivision (2) of this subsection,] an insured's
87 treating health care provider may deem such step therapy drug regimen
88 clinically ineffective for the insured, at which time the insurance
89 company, hospital service corporation, medical service corporation,
90 health care center or other entity shall authorize dispensation of and
91 coverage for the drug prescribed by the insured's treating health care
92 provider, provided such drug is a covered drug under such policy or
93 contract. If such provider does not deem such step therapy drug
94 regimen clinically ineffective or has not requested an override pursuant
95 to subdivision (1) of subsection (b) of this section, such drug regimen
96 may be continued. For purposes of this section, "step therapy" means a
97 protocol or program that establishes the specific sequence in which
98 prescription drugs for a specified medical condition are to be prescribed.

99 Sec. 5. Subdivision (7) of section 38a-591a of the general statutes is
100 repealed and the following is substituted in lieu thereof (*Effective January*
101 *1, 2022*):

102 (7) "Clinical peer" means a physician or other health care professional
103 who:

104 (A) [holds] For a review other than as specified under subparagraph
105 (B) or (C) of subdivision (38) of this section:

106 (i) Holds a nonrestricted license in a state of the United States [and]
107 in the same [or similar] specialty as [typically manages the medical
108 condition, procedure or treatment] the treating physician or other health
109 care professional under review; [, and]

110 (ii) Holds a doctoral or medical degree; and

111 (iii) (I) Holds an appropriate national board certification including at
112 the subspecialty level, where available, or (II) actively practices and
113 typically manages the medical condition under review or provides the
114 procedure or treatment under review; or

115 (B) [for] For a review specified under subparagraph (B) or (C) of
116 subdivision (38) of this section concerning:

117 (i) [a] A child or adolescent substance use disorder or a child or
118 adolescent mental disorder, holds (I) a national board certification in
119 child and adolescent psychiatry, or (II) a doctoral level psychology
120 degree with training and clinical experience in the treatment of child
121 and adolescent substance use disorder or child and adolescent mental
122 disorder, as applicable; [,] or

123 (ii) [an] An adult substance use disorder or an adult mental disorder,
124 holds (I) a national board certification in psychiatry, or (II) a doctoral
125 level psychology degree with training and clinical experience in the
126 treatment of adult substance use disorders or adult mental disorders, as
127 applicable.

128 Sec. 6. Subsection (a) of section 38a-591c of the general statutes is
129 repealed and the following is substituted in lieu thereof (*Effective January*
130 *1, 2022*):

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

135 (2) (A) Each utilization review program shall use documented clinical
136 review criteria that are based on sound clinical evidence and are
137 evaluated periodically by the health carrier's organizational mechanism
138 specified in subparagraph (F) of subdivision (2) of subsection (c) of
139 section 38a-591b to assure such program's ongoing effectiveness.

140 (B) Except as provided in subdivisions (3), (4) and (5) of this
141 subsection, a health carrier may develop its own clinical review criteria
142 or it may purchase or license clinical review criteria from qualified
143 vendors approved by the commissioner, provided such clinical review
144 criteria conform to the requirements of subparagraph (A) of this
145 subdivision.

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

153 (D) For each utilization review, there shall be a rebuttable
154 presumption that each health care service under review is medically
155 necessary if such health care service was ordered by a health care
156 professional acting within the health care professional's scope of
157 practice. A health carrier, or any utilization review company or designee
158 of a health carrier that performs utilization review on behalf of the
159 health carrier, shall have the burden of proving that a health care service
160 is not medically necessary.

161 (3) For any utilization review for the treatment of a substance use
162 disorder, as described in section 17a-458, the clinical review criteria used
163 shall be: (A) The most recent edition of the American Society of
164 Addiction Medicine Treatment Criteria for Addictive, Substance-
165 Related, and Co-Occurring Conditions; or (B) clinical review criteria that
166 the health carrier demonstrates to the Insurance Department is

167 consistent with the most recent edition of the American Society of
168 Addiction Medicine Treatment Criteria for Addictive, Substance-
169 Related, and Co-Occurring Conditions, except that nothing in this
170 subdivision shall prohibit a health carrier from developing its own
171 clinical review criteria or purchasing or licensing additional clinical
172 review criteria from qualified vendors approved by the commissioner,
173 to address advancements in technology or types of care for the
174 treatment of a substance use disorder, that are not covered in the most
175 recent edition of the American Society of Addiction Medicine Treatment
176 Criteria for Addictive, Substance-Related, and Co-Occurring
177 Conditions. Any such clinical review criteria developed by a health
178 carrier or purchased or licensed from a qualified vendor shall conform
179 to the requirements of subparagraph (A) of subdivision (2) of this
180 subsection.

181 (4) For any utilization review for the treatment of a child or
182 adolescent mental disorder, the clinical review criteria used shall be: (A)
183 The most recent guidelines of the American Academy of Child and
184 Adolescent Psychiatry's Child and Adolescent Service Intensity
185 Instrument; or (B) clinical review criteria that the health carrier
186 demonstrates to the Insurance Department is consistent with the most
187 recent guidelines of the American Academy of Child and Adolescent
188 Psychiatry's Child and Adolescent Service Intensity Instrument, except
189 that nothing in this subdivision shall prohibit a health carrier from
190 developing its own clinical review criteria or purchasing or licensing
191 additional clinical review criteria from qualified vendors approved by
192 the commissioner, to address advancements in technology or types of
193 care for the treatment of a child or adolescent mental disorder, that are
194 not covered in the most recent guidelines of the American Academy of
195 Child and Adolescent Psychiatry's Child and Adolescent Service
196 Intensity Instrument. Any such clinical review criteria developed by a
197 health carrier or purchased or licensed from a qualified vendor shall
198 conform to the requirements of subparagraph (A) of subdivision (2) of
199 this subsection.

200 (5) For any utilization review for the treatment of an adult mental
201 disorder, the clinical review criteria used shall be: (A) The most recent
202 guidelines of the American Psychiatric Association or the most recent
203 Standards and Guidelines of the Association for Ambulatory Behavioral
204 Healthcare; or (B) clinical review criteria that the health carrier
205 demonstrates to the Insurance Department is consistent with the most
206 recent guidelines of the American Psychiatric Association or the most
207 recent Standards and Guidelines of the Association for Ambulatory
208 Behavioral Healthcare, except that nothing in this subdivision shall
209 prohibit a health carrier from developing its own clinical review criteria
210 or purchasing or licensing additional clinical review criteria from
211 qualified vendors approved by the commissioner, to address
212 advancements in technology or types of care for the treatment of an
213 adult mental disorder, that are not covered in the most recent guidelines
214 of the American Psychiatric Association or the most recent Standards
215 and Guidelines of the Association for Ambulatory Behavioral
216 Healthcare. Any such clinical review criteria developed by a health
217 carrier or purchased or licensed from a qualified vendor shall conform
218 to the requirements of subparagraph (A) of subdivision (2) of this
219 subsection.

220 Sec. 7. Subsection (a) of section 38a-591d of the general statutes is
221 repealed and the following is substituted in lieu thereof (*Effective January*
222 *1, 2022*):

223 (a) (1) Each health carrier shall maintain written procedures for (A)
224 utilization review and benefit determinations, (B) expedited utilization
225 review and benefit determinations with respect to prospective urgent
226 care requests and concurrent review urgent care requests, and (C)
227 notifying covered persons or covered persons' authorized
228 representatives of such review and benefit determinations. Each health
229 carrier shall make such review and benefit determinations within the
230 specified time periods under this section.

231 (2) In determining whether a benefit request shall be considered an
232 urgent care request, an individual acting on behalf of a health carrier

233 shall apply the judgment of a prudent layperson who possesses an
234 average knowledge of health and medicine, except that any benefit
235 request (A) determined to be an urgent care request by a health care
236 professional with knowledge of the covered person's medical condition,
237 or (B) specified under subparagraph (B) or (C) of subdivision (38) of
238 section 38a-591a, as amended by this act, shall be deemed an urgent care
239 request.

240 (3) (A) At the time a health carrier notifies a covered person, a covered
241 person's authorized representative or a covered person's health care
242 professional of an initial adverse determination that was based, in whole
243 or in part, on medical necessity, of a concurrent or prospective
244 utilization review or of a benefit request, the health carrier shall notify
245 the covered person's health care professional (i) of the opportunity for a
246 conference as provided in subparagraph (B) of this subdivision, and (ii)
247 that such conference shall not be considered a grievance of such initial
248 adverse determination as long as a grievance has not been filed as set
249 forth in subparagraph (B) of this subdivision.

250 (B) After a health carrier notifies a covered person, a covered person's
251 authorized representative or a covered person's health care professional
252 of an initial adverse determination that was based, in whole or in part,
253 on medical necessity, of a concurrent or prospective utilization review
254 or of a benefit request, the health carrier shall offer a covered person's
255 health care professional the opportunity to confer, at the request of the
256 covered person's health care professional, with a clinical peer of such
257 health carrier, provided such covered person, covered person's
258 authorized representative or covered person's health care professional
259 has not filed a grievance of such initial adverse determination prior to
260 such conference. Such conference shall not be considered a grievance of
261 such initial adverse determination. Such health carrier shall grant such
262 clinical peer authority to reverse such initial adverse determination.

263 Sec. 8. Subsection (c) of section 38a-591e of the general statutes is
264 repealed and the following is substituted in lieu thereof (*Effective January*
265 *1, 2022*):

266 (c) (1) (A) When conducting a review of an adverse determination
267 under this section, the health carrier shall ensure that such review is
268 conducted in a manner to ensure the independence and impartiality of
269 the clinical peer or peers involved in making the review decision.

270 (B) If the adverse determination involves utilization review, the
271 health carrier shall designate an appropriate clinical peer or peers to
272 review such adverse determination. Such clinical peer or peers shall not
273 have been involved in the initial adverse determination.

274 (C) (i) For each review of an adverse determination under this section,
275 there shall be a rebuttable presumption that each health care service
276 under review is medically necessary if such health care service was
277 ordered by a health care professional acting within the scope of the
278 health care professional's practice. The health carrier may rebut such
279 presumption by reasonably substantiating to the clinical peer or peers
280 conducting the review under this section that such health care service is
281 not medically necessary.

282 [(C)] (ii) The clinical peer or peers conducting a review under this
283 section shall take into consideration all comments, documents, records
284 and other information relevant to the covered person's benefit request
285 that is the subject of the adverse determination under review, that are
286 submitted by the covered person or the covered person's authorized
287 representative, regardless of whether such information was submitted
288 or considered in making the initial adverse determination.

289 (D) Prior to issuing a decision, the health carrier shall provide free of
290 charge, by facsimile, electronic means or any other expeditious method
291 available, to the covered person or the covered person's authorized
292 representative, as applicable, any new or additional documents,
293 communications, information and evidence relied upon and any new or
294 additional scientific or clinical rationale used by the health carrier in
295 connection with the grievance. Such documents, communications,
296 information, evidence and rationale shall be provided sufficiently in
297 advance of the date the health carrier is required to issue a decision to

298 permit the covered person or the covered person's authorized
299 representative, as applicable, a reasonable opportunity to respond prior
300 to such date.

301 (2) If the review under subdivision (1) of this subsection is an
302 expedited review, all necessary information, including the health
303 carrier's decision, shall be transmitted between the health carrier and the
304 covered person or the covered person's authorized representative, as
305 applicable, by telephone, facsimile, electronic means or any other
306 expeditious method available.

307 (3) If the review under subdivision (1) of this subsection is an
308 expedited review of a grievance involving an adverse determination of
309 a concurrent review request, pursuant to 45 CFR 147.136, as amended
310 from time to time, the treatment shall be continued without liability to
311 the covered person until the covered person has been notified of the
312 review decision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2022</i>	38a-497
Sec. 2	<i>January 1, 2022</i>	38a-512b
Sec. 3	<i>January 1, 2022</i>	38a-510(a)
Sec. 4	<i>January 1, 2022</i>	38a-544(a)
Sec. 5	<i>January 1, 2022</i>	38a-591a(7)
Sec. 6	<i>January 1, 2022</i>	38a-591c(a)
Sec. 7	<i>January 1, 2022</i>	38a-591d(a)
Sec. 8	<i>January 1, 2022</i>	38a-591e(c)

INS *Joint Favorable*