



Senate

General Assembly

File No. 18

February Session, 2024

Senate Bill No. 180

Senate, March 13, 2024

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.

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 2024 supplement
2 to the general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective January 1, 2025*):

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

6 (A) [holds] For a review other than one specified under subparagraph
7 (B) or (C) of subdivision (38) of this section, holds a nonrestricted license
8 in a state of the United States [and] in the same [or similar] specialty as
9 [typically manages the medical condition, procedure or treatment] the
10 treating physician or other health care professional under review; [, and]
11 or

12 (B) [for] For a review specified under subparagraph (B) or (C) of

13 subdivision (38) of this section concerning:

14 (i) [a] A child or adolescent substance use disorder or a child or
15 adolescent mental disorder, holds (I) a national board certification in
16 child and adolescent psychiatry, or (II) a doctoral level psychology
17 degree with training and clinical experience in the treatment of child
18 and adolescent substance use disorder or child and adolescent mental
19 disorder, as applicable; [,] or

20 (ii) [an] An adult substance use disorder or an adult mental disorder,
21 holds (I) a national board certification in psychiatry, or (II) a doctoral
22 level psychology degree with training and clinical experience in the
23 treatment of adult substance use disorders or adult mental disorders, as
24 applicable.

25 Sec. 2. Subsection (a) of section 38a-591c of the 2024 supplement to
26 the general statutes is repealed and the following is substituted in lieu
27 thereof (*Effective January 1, 2025*):

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

32 (2) (A) Each utilization review program shall use documented clinical
33 review criteria that are based on sound clinical evidence and are
34 evaluated periodically by the health carrier's organizational mechanism
35 specified in subparagraph (F) of subdivision (2) of subsection (c) of
36 section 38a-591b to [assure] ensure such program's ongoing
37 effectiveness.

38 (B) Except as provided in subdivisions (3), (4) and (5) of this
39 subsection, a health carrier may develop its own clinical review criteria
40 or it may purchase or license clinical review criteria from qualified
41 vendors approved by the commissioner, provided such clinical review
42 criteria conform to the requirements of subparagraph (A) of this
43 subdivision.

44 (C) Each health carrier shall (i) post on its Internet web site (I) any
45 clinical review criteria it uses, and (II) links to any rule, guideline,
46 protocol or other similar criterion a health carrier may rely upon to make
47 an adverse determination as described in subparagraph (F) of
48 subdivision (1) of subsection (e) of section 38a-591d, and (ii) make its
49 clinical review criteria available upon request to authorized government
50 agencies.

51 (D) For each utilization review, there shall be a rebuttable
52 presumption that each health care service under review is medically
53 necessary if such health care service was ordered by a health care
54 professional acting within the health care professional's scope of
55 practice. A health carrier, or any utilization review company or designee
56 of a health carrier that performs utilization review on behalf of the
57 health carrier, shall have the burden of proving that a health care service
58 is not medically necessary.

59 (3) For any utilization review for the treatment of a substance use
60 disorder, as described in section 17a-458, the clinical review criteria used
61 shall be: (A) The most recent edition of the American Society of
62 Addiction Medicine Treatment Criteria for Addictive, Substance-
63 Related, and Co-Occurring Conditions; or (B) clinical review criteria that
64 the health carrier demonstrates to the Insurance Department is
65 consistent with the most recent edition of the American Society of
66 Addiction Medicine Treatment Criteria for Addictive, Substance-
67 Related, and Co-Occurring Conditions, except that nothing in this
68 subdivision shall prohibit a health carrier from developing its own
69 clinical review criteria or purchasing or licensing additional clinical
70 review criteria from qualified vendors approved by the commissioner,
71 to address advancements in technology or types of care for the
72 treatment of a substance use disorder, that are not covered in the most
73 recent edition of the American Society of Addiction Medicine Treatment
74 Criteria for Addictive, Substance-Related, and Co-Occurring
75 Conditions. Any such clinical review criteria developed by a health
76 carrier or purchased or licensed from a qualified vendor shall conform
77 to the requirements of subparagraph (A) of subdivision (2) of this

78 subsection.

79 (4) For any utilization review for the treatment of a child or
80 adolescent mental disorder, the clinical review criteria used shall be: (A)
81 The most recent guidelines of the American Academy of Child and
82 Adolescent Psychiatry's Child and Adolescent Service Intensity
83 Instrument; or (B) clinical review criteria that the health carrier
84 demonstrates to the Insurance Department is consistent with the most
85 recent guidelines of the American Academy of Child and Adolescent
86 Psychiatry's Child and Adolescent Service Intensity Instrument, except
87 that nothing in this subdivision shall prohibit a health carrier from
88 developing its own clinical review criteria or purchasing or licensing
89 additional clinical review criteria from qualified vendors approved by
90 the commissioner, to address advancements in technology or types of
91 care for the treatment of a child or adolescent mental disorder, that are
92 not covered in the most recent guidelines of the American Academy of
93 Child and Adolescent Psychiatry's Child and Adolescent Service
94 Intensity Instrument. Any such clinical review criteria developed by a
95 health carrier or purchased or licensed from a qualified vendor shall
96 conform to the requirements of subparagraph (A) of subdivision (2) of
97 this subsection.

98 (5) For any utilization review for the treatment of an adult mental
99 disorder, the clinical review criteria used shall be: (A) The most recent
100 guidelines of the American Psychiatric Association or the most recent
101 Standards and Guidelines of the Association for Ambulatory Behavioral
102 Healthcare; or (B) clinical review criteria that the health carrier
103 demonstrates to the Insurance Department is consistent with the most
104 recent guidelines of the American Psychiatric Association or the most
105 recent Standards and Guidelines of the Association for Ambulatory
106 Behavioral Healthcare, except that nothing in this subdivision shall
107 prohibit a health carrier from developing its own clinical review criteria
108 or purchasing or licensing additional clinical review criteria from
109 qualified vendors approved by the commissioner, to address
110 advancements in technology or types of care for the treatment of an
111 adult mental disorder, that are not covered in the most recent guidelines

112 of the American Psychiatric Association or the most recent Standards
113 and Guidelines of the Association for Ambulatory Behavioral
114 Healthcare. Any such clinical review criteria developed by a health
115 carrier or purchased or licensed from a qualified vendor shall conform
116 to the requirements of subparagraph (A) of subdivision (2) of this
117 subsection.

118 Sec. 3. Subsection (a) of section 38a-591d of the 2024 supplement to
119 the general statutes is repealed and the following is substituted in lieu
120 thereof (*Effective January 1, 2025*):

121 (a) (1) Each health carrier shall maintain written procedures for (A)
122 utilization review and benefit determinations, (B) expedited utilization
123 review and benefit determinations with respect to prospective urgent
124 care requests and concurrent review urgent care requests, and (C)
125 notifying covered persons or covered persons' authorized
126 representatives of such review and benefit determinations. Each health
127 carrier shall make such review and benefit determinations within the
128 specified time periods under this section.

129 (2) In determining whether a benefit request shall be considered an
130 urgent care request, an individual acting on behalf of a health carrier
131 shall apply the judgment of a prudent layperson who possesses an
132 average knowledge of health and medicine, except that any benefit
133 request (A) determined to be an urgent care request by a health care
134 professional with knowledge of the covered person's medical condition,
135 or (B) specified under subparagraph (B) or (C) of subdivision (38) of
136 section 38a-591a shall be deemed an urgent care request.

137 (3) (A) At the time a health carrier notifies a covered person, a covered
138 person's authorized representative or a covered person's health care
139 professional of an initial adverse determination that was based, in whole
140 or in part, on medical necessity, of a concurrent or prospective
141 utilization review or of a benefit request, the health carrier shall notify
142 the covered person's health care professional (i) of the opportunity for a
143 conference as provided in subparagraph (B) of this subdivision, and (ii)
144 that such conference shall not be considered a grievance of such initial

145 adverse determination as long as a grievance has not been filed as set
146 forth in subparagraph (B) of this subdivision.

147 (B) After a health carrier notifies a covered person, a covered person's
148 authorized representative or a covered person's health care professional
149 of an initial adverse determination that was based, in whole or in part,
150 on medical necessity, of a concurrent or prospective utilization review
151 or of a benefit request, the health carrier shall offer a covered person's
152 health care professional the opportunity to confer, at the request of the
153 covered person's health care professional, with a clinical peer of such
154 health carrier, provided such covered person, covered person's
155 authorized representative or covered person's health care professional
156 has not filed a grievance of such initial adverse determination prior to
157 such conference. Such conference shall not be considered a grievance of
158 such initial adverse determination. Such health carrier shall grant such
159 clinical peer the authority to reverse such initial adverse determination.

160 Sec. 4. Subsection (c) of section 38a-591e of the general statutes is
161 repealed and the following is substituted in lieu thereof (*Effective January*
162 *1, 2025*):

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

167 (B) If the adverse determination involves utilization review, the
168 health carrier shall designate an appropriate clinical peer or peers to
169 review such adverse determination. Such clinical peer or peers shall not
170 have been involved in the initial adverse determination.

171 (C) (i) For each review of an adverse determination under this section,
172 there shall be a rebuttable presumption that each health care service
173 under review is medically necessary if such health care service was
174 ordered by a health care professional acting within the scope of the
175 health care professional's practice. The health carrier may rebut such
176 presumption by reasonably substantiating to the clinical peer or peers

177 conducting the review under this section that such health care service is
178 not medically necessary.

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

186 (D) Prior to issuing a decision, the health carrier shall provide free of
187 charge, by facsimile, electronic means or any other expeditious method
188 available, to the covered person or the covered person's authorized
189 representative, as applicable, any new or additional documents,
190 communications, information and evidence relied upon and any new or
191 additional scientific or clinical rationale used by the health carrier in
192 connection with the grievance. Such documents, communications,
193 information, evidence and rationale shall be provided sufficiently in
194 advance of the date the health carrier is required to issue a decision to
195 permit the covered person or the covered person's authorized
196 representative, as applicable, a reasonable opportunity to respond prior
197 to such date.

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

204 (3) If the review under subdivision (1) of this subsection is an
205 expedited review of a grievance involving an adverse determination of
206 a concurrent review request, pursuant to 45 CFR 147.136, as amended
207 from time to time, the treatment shall be continued without liability to
208 the covered person until the covered person has been notified of the
209 review decision.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>January 1, 2025</i>	38a-591a(7)
Sec. 2	<i>January 1, 2025</i>	38a-591c(a)
Sec. 3	<i>January 1, 2025</i>	38a-591d(a)
Sec. 4	<i>January 1, 2025</i>	38a-591e(c)

PH *Joint Favorable*

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:

Agency Affected	Fund-Effect	FY 25 \$	FY 26 \$
State Comptroller - Fringe Benefits	GF - Potential Cost	Potential	Potential
UConn Health Ctr.	GF - Potential Clinical Revenue Gain	Potential	Potential

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 25 \$	FY 26 \$
Various Municipalities	Potential Cost	See Below	See Below

Explanation

The bill results in a potential cost to the State Comptroller – Fringe Benefits account for the state employee health plan from the anticipated increase in administrative costs and utilization of medical services. Administrative costs are expected to increase from the redefinition of "clinical peer," which would require carriers to contract specialists at a rate of approximately \$700 per adverse determination. Claims costs are also expected to increase as more medical services are deemed, "medically necessary" resulting from the change in utilization review methodology.

Self and fully insured municipalities as well as those enrolled in the Partnership plan are likely to see an increase in premiums to the extent carriers expect to see higher utilization of services and face higher costs for evaluating adverse determination appeals. Due to federal law, self-

insured health plans are exempt from state health insurance benefit mandates, so potential costs are contingent on the plan electing to adopt the mandate.

To the extent that the bill results in additional medical services provided by the University of Connecticut Health Center, there could be a clinical revenue increase beginning in FY 25. The scope of the revenue increase would be dependent upon the type and number of additional services.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: State Employee Health Plan Provider

OLR Bill Analysis**SB 180*****AN ACT CONCERNING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.*****SUMMARY**

For insurance utilization or adverse determination reviews, this bill establishes a rebuttable presumption that a health care service is medically necessary if it was ordered by a health professional acting within his or her scope of practice (see BACKGROUND). For utilization reviews, the bill imposes on health carriers or utilization review companies the burden of proving a health care service is not medically necessary. For adverse determination reviews, a carrier may rebut the presumption by reasonably substantiating to the clinical peers doing the review that the service is not medically necessary. (Utilization and adverse determination reviews are steps in determining whether a specific service is covered and reimbursed.)

The bill generally increases the requirements to qualify as a “clinical peer” for adverse determination reviews, by requiring the person to be licensed in the same specialty, rather than a similar one, as the professional under review. (It does not change existing, generally comparable requirements that apply in cases involving the urgent treatment of substance use or mental disorders.)

The bill also requires health carriers to authorize clinical peers to reverse initial adverse determinations that were based on medical necessity. This applies when the carrier, as required by law, offers a covered person’s health care professional the opportunity to confer with a clinical peer of the carrier following the adverse determination (see BACKGROUND).

EFFECTIVE DATE: January 1, 2025

§ 1 — CLINICAL PEER QUALIFICATIONS

Under current law, clinical peers doing adverse determination reviews generally must have a nonrestricted license (in any U.S. state) in the same or similar specialty that typically manages the medical condition, procedures, or treatment under review. The bill instead generally requires these clinical peers to have a nonrestricted license in the same specialty as the treating physician or other health care professional under review.

By law, unchanged by the bill, for urgent care requests of substance use or mental health disorders under certain circumstances, the clinical peer must be a (1) psychologist with relevant training and clinical experience or (2) psychiatrist.

BACKGROUND

Utilization and Adverse Determination Reviews

Generally, reviews have up to three steps: (1) an initial utilization review to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is done when a covered person exhausts a health carrier's internal process and appeals the carrier's adverse determination to the Insurance Department. External reviews, also called final adverse determination reviews, are done by an independent review organization assigned by the department.

Medically Necessary

State law specifies the definition of "medically necessary" that health policies must include. In general, a health care service is medically necessary if it would be provided by a physician exercising prudent clinical judgment for the purposes of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and it is:

1. in keeping with generally accepted medical standards;
2. clinically appropriate and considered effective for the illness, injury, or disease;
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. not more costly than therapeutically equivalent alternative treatments (CGS §§ 38a-482a and 38a-513c).

Conference With Clinical Peer Following Adverse Determination

The law requires a carrier to offer a covered person's health care professional an opportunity to confer with a clinical peer of the carrier under certain circumstances. This applies:

1. after a covered person or his or her representative or health care professional is notified of an initial adverse determination of a concurrent or prospective utilization review, or of a benefit request, that was at least partially based on medical necessity and
2. as long as the covered person, representative, or health care professional has not already filed a grievance of the initial adverse determination.

COMMITTEE ACTION

Public Health Committee

Joint Favorable

Yea 30 Nay 7 (03/04/2024)