



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC- 92

June 19, 2013

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT; ALL UTILIZATION REVIEW ENTITIES LICENSED IN CONNECTICUT

RE: Sections 70-78 of Connecticut Public Act No. 13-3 – Behavioral Health Changes to Utilization Review, Grievance and Appeals

Sections 70-78 of Connecticut Public Act No. 13-3 (the “Act”), effective October 1, 2013, amended multiple provisions of the Connecticut utilization review, grievance and appeal statutes as well as the Consumer Report Card statute relating to behavioral health. This bulletin will identify the new provisions and compliance requirements resulting from these revisions.

NEW STATUTORY REQUIREMENTS

The Act has revised the utilization review, grievance and appeals statutes as follows with respect to behavioral health and substance abuse disorders:

- Section 72 amends section 38a-591c of the Connecticut General Statutes and requires that for any utilization review or benefit determination for treating a substance use disorder, the default criteria are those in the most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria. For any utilization review or benefit determination for treating a mental disorder in a child or adolescent, the default criteria are the most recent guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument. For any utilization review or benefit determination for treating a mental disorder in an adult, the default criteria are the most recent (1) guidelines of the American Psychiatric Association or (2) standards and guidelines of the Association of Ambulatory Behavioral Healthcare.

In each case, the carrier can use other criteria that it demonstrates are consistent with the default criteria. But if the carrier does this, it must create and maintain a document on an easily accessible location on its website that compares each aspect of its criteria with the default criteria and provides citations to (a) peer-reviewed medical literature generally recognized by the relevant medical community or (b) professional society guidelines that justify each deviation from the default criteria.

- Sections 71 (Conn. Gen. Stat. §38a-591a) and 73 (Conn. Gen. Stat. §38a-591d) require insurance carriers and health care centers to make a determination on a

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pre-authorization or concurrent request for specified behavioral health services within 24 hours after receiving the urgent request unless the covered person or his /her representative fails to provide the required information needed to make a determination. The specified behavioral health services that require 24 hour urgent care determinations have been defined as those for a service or treatment for (1) substance use disorder or co-occurring mental disorder and (2) inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental disorder.

- The prior law has required that each carrier must promptly notify a covered person and, if applicable, his or her authorized representative, of an adverse determination. The Act additionally requires the notice to list, upon request, any clinical review criteria (including professional criteria) and medical or scientific evidence used to reach a denial. The notice must also describe the carrier's internal grievance procedures. The Act requires the notice to include a statement that, if the covered person or his or her representative choose to grieve an adverse determination, that (1) such appeals sometimes succeed; (2) the covered person or his or her representative may benefit from free assistance from the department's consumer affairs division or the Office of Healthcare Advocate ("OHA"), which can help with a grievance; (3) the covered person or representative is entitled and encouraged to submit supporting documentation for the carrier to consider during the review of an adverse determination, including their narratives and letters and treatment notes from the covered person's health care professional; and, (4) the covered person or representative has the right to ask his or her health care professional for these letters and treatment notes.

If an adverse determination is based on a carrier's internal rule or other similar criterion, the notice must provide the criterion and related information or a statement that a specific criterion was relied upon to make the adverse determination and the criterion is available free of charge upon request. The Act additionally requires the notice to provide the links to the criterion on the carrier's web site. If the adverse determination involves treating a substance use or a mental disorder, the Act requires the notice to also include a link to the carrier's applicable clinical review criteria, as described above, on its website.

- The Act allows 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 provision applies 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 based, at least in part, on medical necessity and if the covered person, representative, or health care professional has not already filed a grievance of the initial adverse determination.

The peer to peer conference is not considered a grievance of the initial adverse determination.

- The Act requires if a non-urgent grievance appeal is a concurrent review request, the treatment must be continued without liability to the covered person during the pendency of the grievance of an adverse determination or a final adverse determination of the concurrent review. The law already provides that in the case

of grievance appeals filed for urgent requests, treatment must be continued without liability to the covered person during the review.

- Sections 74 (Conn. Gen. Stat. §38a-591e) and 76 (Conn. Gen. Stat. §38a-591g) deal with expedited reviews. By classifying requests for the identified services and treatments as urgent, the amended law entitles the covered person to an expedited review of an adverse determination or an expedited external review and requires that decisions for expedited reviews of requests for services and treatment for the mental and substance use disorders within 24 hours.
- Section 75 (Conn. Gen. Stat. §38a-591f) adds additional requirements to the notice of a decision upholding an adverse determination not based on medical necessity. The Act requires that the notice of the decision must include a statement advising of the covered person's right to contact the Insurance Commissioner's ("Commissioner") office or the OHA at any time; that the covered person may benefit from free assistance from the Insurance Department's ("Department") Consumer Affairs Division or OHA, which can help him or her file a grievance; and the contact information for the offices.
- The Act provides a new definition of clinical peer and requires clinical peers be used for all pre-authorizations or concurrent reviews, reviews of adverse determinations and external review determinations. The Act requires certain clinical peers to have additional qualifications. Under current law, clinical peers are health care professionals who hold a non-restricted license in any state in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. For a review or benefit determination concerning a substance use or mental disorder in a child or adolescent, the clinical peer must (1) hold a national board certification in child and adolescent psychiatry or child and adolescent psychology and (2) have training or clinical experience in treating child and adolescent substance use or mental disorder, as applicable. For a review or benefit determination concerning substance use disorder or mental disorder in an adult, the clinical peer must (1) hold a national board certification in psychiatry or psychology, and (2) have training or clinical experience in the treatment of adult substance use or mental disorders, as applicable. The Act requires that each carrier have procedures to ensure that the appropriate or required clinical peers are designated to conduct utilization reviews. (See Conn. Gen. Stat. §§38a-591a, 591c, and 38a-591e)

In addition to the amended utilization review, grievance and appeal laws, Section 78 of the Act also amended Conn. Gen. Stat. §38a-478*l*, the statute dealing with the Consumer Report Card. By law, the Commissioner must prepare an annual Consumer Report Card that, among other things, addresses managed care organizations and mental health services. The Act requires the Commissioner to annually analyze this data for the accuracy of, trends in, and statistically significant differences in, the data among the health care centers and health insurers included in the report card. It allows him to investigate such differences to determine whether he should take further action.

Section 79 of the Act, effective upon passage of the Act, establishes new requirements relating to the oversight of federal and state mental health parity compliance by insurers. The Act requires that by September 15, 2013, the Commissioner must seek input from stakeholders on methods the Department might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities

under its jurisdiction. The stakeholders must at least include the OHA, health insurance companies, health care professionals, and behavioral health advocacy groups. The Department also must post notice of the request for input on its web site and provide for a written public comment period of 30 days following the posting. The posting must include the date the public comment period closes and information on how to submit comments to the department.

Section 79 also requires that by January 1, 2014, the Commissioner must issue a report and provide an educational presentation to the Insurance and Real Estate and Public Health committees. The report and presentation must:

- cover the methodology the Department is using to check for compliance with the interim or final regulations or guidance, whichever is in effect, published by the U. S. Department of Health and Human Services relating to the compliance and oversight requirements of federal law on mental health parity;
- cover the methodology the Department is using to check for compliance with state law on mental health parity; and
- detail the Department's regulatory and educational approaches relating to the financing of mental health services in this state.
- In addition, the report must describe and address any public comments the department received in the comment period described above.

By February 1, 2014, the Insurance and Public Health committees must hold a joint public hearing on the report submitted by the Department.

NEW PROCEDURAL REQUIREMENTS

1. Utilization Review Licensing:

As a result of the Act, filing requirements will change for Utilization Review licenses which are due October 1. All new or renewal applications will need to reflect the revisions identified above both for procedural updates as well as communication materials. The Department will no longer approve national letter templates to be used for review determination notification. Because of the requirements of the Connecticut laws, and the potential for confusion when notification is made on a letter that requires the recipient to determine which state rules apply and ascertain if their plan is fully insured or self-funded, the Department has determined that a Connecticut specific letter, for use only with fully insured plans, will need to be developed by each utilization review company. This letter will need to address all the requirements as provided in the revised statutes. A separate letter can be used for self-funded plans and the self-funded letter is not required to be submitted to the Insurance Department.

Additionally, the applications will need to either state that the entity's review criteria meets the statutory source requirements as provided in the amended Conn. Gen. Stat. §38a-591c for substance abuse and child and adolescent mental health guidelines. If the entity chooses to use alternate criteria, it must provide a link to its webpage where it has posted the document mandated in the amended Conn. Gen. Stat. §38a-591c that compares each aspect of its criteria with the default criteria and

provides citations to (a) peer-reviewed medical literature generally recognized by the relevant medical community or (b) professional society guidelines that justify each deviation from the default criteria.

2. Form Filing Policy

Policy forms affected by the statutory changes will need to be re-filed to reflect the new requirements and definitions.

3. Mental Health Parity Form Filing Certification

Effective immediately, every applicable health insurance policy form filing for use in Connecticut sited health insurance contracts subject to the requirements of 42 U.S.C. § 300gg-26, 45 CFR §146.136 and Conn. Gen. Stat. §§38a-488a and 38a-514 will be required to be submitted with a certification verifying that the form is compliant with state and federal mental health parity requirements. This will be submitted through SERFF using the “Supporting Documentation” field.

The Department is requesting that each insurer/health care center file an initial certification for forms already submitted for policies effective January 1, 2014 or later; thereafter, each applicable policy form filing will be required to be accompanied by the certification.

The following is the required language to be used for the certification:

MENTAL HEALTH CERTIFICATION

The undersigned deposes and says that all policy forms submitted (Date) by (Name of Insurer) for use in Connecticut sited health insurance contracts subject to the requirements of 42 U.S.C. § 300gg-26, 45 CFR §146.136 and Conn. Gen. Stat. §§38a-488a and 38a-514 provide coverage for parity in mental health and substance abuse disorder benefits in accordance with both state and federal laws as applicable. The undersigned certifies that all such policies issued or renewed will provide coverage for the medical treatment of mental illness and substance abuse provided under the same terms and conditions as coverage that is provided for other illnesses and diseases in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.

(Name) certifies that (s)he is the (Title) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

(Date)_____

4. External Review Application and External Review Consumer Guide

The Department will make available an updated Request for External Review Application and External Review Consumer Guide for use by the insurance carriers and health care centers that conforms to all requirements under Public Act 13-3. These documents will be distributed later this summer under separate Bulletin.

Please contact the Insurance Department Life & Health Division at cid.lh@ct.gov with any utilization review licensing or Consumer Report Card questions. Please contact the Insurance Department Consumer Services Division at externalreview@ct.gov with any utilization review, grievance or appeal questions.


Thomas B. Leonardi
Insurance Commissioner