STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN No. HC- 98
June 27, 2014

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: Connecticut Public Act No. 14-40 – Changes to Utilization Review, Grievance and Appeals

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Connecticut Public Act No. 14-40 (the "2014 Act"), effective May 28, 2014, amended two provisions of the Connecticut utilization review, grievance and appeal statutes. This bulletin will identify the new provisions and compliance requirements resulting from these revisions.

NEW STATUTORY REQUIREMENTS

I. Clinical Peer Definition

Last year, Connecticut Public Act No. 13-3 (the "2013 Act ") amended the definition of clinical peer and required clinical peers be used for all pre-authorizations or concurrent reviews, reviews of adverse determinations and external review determinations. The 2013 Act further required that 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 2013 Act required that each carrier have procedures to ensure that the appropriate or required clinical peers were designated to conduct utilization reviews.

Section 1 of the 2014 Act amended section 38a-591a of the 2014 supplement to the general statutes to redefine a clinical peer. The amended definition of clinical peer means a physician or other health care professional who (A) holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and (B) for an urgent care review concerning (i) a child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or (ii) an adult substance use disorder or an adult mental disorder, holds (I) a national board certification in psychiatry, or (II) a

doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

II. Utilization Review

Section 2 of the 2014 Act eliminated the requirement that health carriers contract with clinical peers to conduct utilization reviews. The requirements as set forth in the amended section 38a-591c of the 2014 supplement to the general statutes now require that utilization review be conducted by the appropriate or required **individual or individuals** who have been designated to conduct utilization reviews. The term "individual" has not been defined, but the Insurance Department ("Department") is providing guidance that adverse determinations should only be issued by clinical peers.

III. Notice Requirements

Section 38a-591d of the 2014 supplement to the general statutes requires that a carrier must notify an insured and, if applicable, his or her authorized representative, of an adverse determination. Section 3 of the 2014 Act amended section 38a-591d of the 2014 supplement to the general statutes to eliminate the requirement that a notice of an adverse determination state that the insured or representative may benefit from free assistance from the Insurance Department's Division of Consumer Affairs for filing a grievance pursuant to 42 USC 300gg-93. The bill retains parallel notice requirements regarding the Office of the Healthcare Advocate ("OHA").

The OHA was the recipient of a Patient Protection and Affordable Care Act, Pub.L.111-48, as amended by the Health Care and Education Reconciliation Act of 2010, Pub.L.111-152 (collectively "ACA") grant to provide consumer services related to the ACA. 42 U.S.C. 300gg–93, the statute that authorizes the consumer assistance grant, provides that any grant recipients are required to coordinate with state insurance regulators.[1] 42 USC 300gg-93 does **not** (1) designate OHA as the singular consumer assistance entity by virtue of receiving the ACA grant, (2) preempt the state insurance

[1] 42 U.S.C. 300gg–93 provides:
''(a) IN GENERAL.—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—
''(1) offices of health insurance consumer assistance; or
''(2) health insurance ombudsman programs.
''(b) ELIGIBILITY.—
''(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, **that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.**
''(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.
''(c) DUTIES.—The office of health insurance consumer assistance or health insurance ombudsman shall—
''(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;
''(2) collect, track, and quantify problems and inquiries encountered by consumers;
''(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;
''(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral,and assistance; and
''(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

regulator's consumer assistance authority, (3) transfer regulatory authority for consumer assistance to OHA, or, (4) give OHA any regulatory authority; on the contrary, the ACA and grant award statute mandates cooperation with a state regulatory authority. Therefore, while the 2014 Act eliminated the statutory requirement that insurers include references for free assistance available from the Insurance Department's Consumer Affairs Division in connection with assistance received pursuant to the 42 USC 300gg-93 grant, the statute does not prohibit insurers from continuing to include these references on a voluntary basis or in regards to assistance not funded by the OHA's ACA grant. The Department encourages insurers to do so to enable maximum cooperation between the OHA and the Insurance Department as required by 42 USC 300gg-93.

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