



House of Representatives

General Assembly

File No. 280

January Session, 2001

Substitute House Bill No. 6987

House of Representatives, April 12, 2001

The Committee on Insurance and Real Estate reported through REP. JARJURA of the 74th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE CLAIMS AND PAYMENT RECOVERY.

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

1 Section 1. Subdivision (15) of section 38a-816 of the general statutes
2 is repealed and the following is substituted in lieu thereof:

3 (15) (A) Failure to pay accident and health claims, including, but not
4 limited to, claims for payment or reimbursement to health care
5 providers, within the time periods set forth in subparagraph (B) of this
6 subdivision, unless the Insurance Commissioner determines that a
7 legitimate dispute exists as to coverage, liability or damages or that the
8 claimant has fraudulently caused or contributed to the loss. Any
9 insurer who fails to pay such a claim or request within the time
10 periods set forth in subparagraph (B) of this subdivision shall pay the
11 claimant or health care provider the amount of such claim plus interest
12 at the rate of fifteen per cent per annum, in addition to any other
13 penalties which may be imposed pursuant to sections 38a-11, 38a-25,

14 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,
15 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
16 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
17 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-
18 819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
19 inclusive. Whenever the interest due a claimant or health care provider
20 pursuant to this section is less than one dollar, the insurer shall deposit
21 such amount in a separate interest-bearing account in which all such
22 amounts shall be deposited. At the end of each calendar year each such
23 insurer shall donate such amount to The University of Connecticut
24 Health Center.

25 (B) Each insurer shall pay claims not later than forty-five days after
26 [receipt by the insurer of] the insurer receives the claimant's proof of
27 loss form or the health care provider's request for payment filed in
28 accordance with the insurer's practices or procedures, except that
29 when there is a deficiency in the information needed for processing a
30 claim, the insurer shall (i) send written notice to the claimant or health
31 care provider, as the case may be, of all alleged deficiencies in
32 information needed for processing a claim not later than thirty days
33 after the insurer receives a claim for payment or reimbursement under
34 the contract, and (ii) pay claims for payment or reimbursement under
35 the contract not later than thirty days after the insurer receives the
36 requested information. [requested.]

37 (C) After a claim is paid, no insurer may seek to recover payment
38 unless (i) the insurer gives written notice to the claimant or health care
39 provider, as the case may be, (ii) the notice indicates the insurer's
40 intent to recover payment and identifies the claim, and (iii) the notice
41 is sent not later than one hundred twenty days after the date the
42 insurer paid the claim.

43 Sec. 2. Subdivision (1) of section 38a-226 of the general statutes is
44 repealed and the following is substituted in lieu thereof:

45 (1) "Utilization review" means the prospective, [or] concurrent or
46 retrospective assessment of the necessity and appropriateness of the
47 allocation of health care resources and services given or proposed to be
48 given to an individual within this state. Such assessment may include,
49 but is not limited to, matters relating to coverage, medical necessity,
50 medical appropriateness, health care setting, level of care, medical
51 efficacy and technical compliance with the practices and procedures
52 set forth in a policy, contract or plan. Utilization review shall not
53 include elective requests for clarification of coverage.

54 Sec. 3. Section 38a-226c of the general statutes is repealed and the
55 following is substituted in lieu thereof:

56 (a) All utilization review companies shall meet the following
57 minimum standards:

58 (1) Each utilization review company shall maintain and make
59 available procedures for providing notification of its determinations
60 regarding certification in accordance with the following:

61 (A) Notification of any prospective determination by the utilization
62 review company shall be mailed or otherwise communicated to the
63 provider of record or the enrollee or other appropriate individual
64 within two business days of the receipt of all information necessary to
65 complete the review, provided any determination not to certify an
66 admission, service, procedure or extension of stay shall be in writing.
67 When there is a deficiency in the information necessary for completing
68 the review, the utilization review company shall (i) provide written
69 notice to the appropriate individual of all alleged deficiencies in
70 information needed for completing the review not later than five
71 business days after the utilization review company receives a request
72 for review, and (ii) complete the review not later than five business
73 days after the utilization review company receives the information
74 requested. After a prospective determination that authorizes an
75 admission, service, procedure or extension of stay has been

76 communicated to the appropriate individual, based on accurate
77 information from the provider, the utilization review company may
78 not reverse such determination if such admission, service, procedure
79 or extension of stay has taken place in reliance on such determination.

80 (B) Notification of a concurrent determination shall be mailed or
81 otherwise communicated to the provider of record within two business
82 days of receipt of all information necessary to complete the review or,
83 provided all information necessary to perform the review has been
84 received, prior to the end of the current certified period and provided
85 any determination not to certify an admission, service, procedure or
86 extension of stay shall be in writing.

87 (C) The utilization review company shall not make a determination
88 not to certify based on incomplete information unless it has clearly
89 indicated, in writing, to the provider of record or the enrollee all the
90 information that is needed to make such determination.

91 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this
92 subdivision, the utilization review company may give authorization
93 orally, electronically or communicated other than in writing. If the
94 determination is an approval for a request, the company shall provide
95 a confirmation number corresponding to the authorization.

96 (E) Any notice of a determination not to certify an admission,
97 service, procedure or extension of stay shall include in writing (i) the
98 principal reasons for the determination, (ii) the procedures to initiate
99 an appeal of the determination or the name and telephone number of
100 the person to contact with regard to an appeal pursuant to the
101 provisions of this section, and (iii) the procedure to appeal to the
102 commissioner pursuant to section 38a-478n.

103 (2) Each utilization review company shall maintain and make
104 available a written description of the appeal procedure by which either
105 the enrollee or the provider of record may seek review of

106 determinations not to certify an admission, service, procedure or
107 extension of stay. The procedures for appeals shall include the
108 following:

109 (A) Each utilization review company shall notify in writing the
110 enrollee and provider of record of its determination on the appeal as
111 soon as practical, but in no case later than thirty days after receiving
112 the required documentation on the appeal.

113 (B) On appeal, all determinations not to certify an admission,
114 service, procedure or extension of stay shall be made by a licensed
115 practitioner of the medical arts.

116 (3) The process established by each utilization review company may
117 include a reasonable period within which an appeal must be filed to be
118 considered.

119 (4) Each utilization review company shall also provide for an
120 expedited appeals process for emergency or life threatening situations.
121 Each utilization review company shall complete the adjudication of
122 such expedited appeals within two business days of the date the
123 appeal is filed and all information necessary to complete the appeal is
124 received by the utilization review company.

125 (5) Each utilization review company shall utilize written clinical
126 criteria and review procedures which are established and periodically
127 evaluated and updated with appropriate involvement from
128 practitioners.

129 (6) Nurses, practitioners and other licensed health professionals
130 making utilization review decisions shall have current licenses from a
131 state licensing agency in the United States or appropriate certification
132 from a recognized accreditation agency in the United States.

133 (7) In cases where an appeal to reverse a determination not to certify
134 is unsuccessful, each utilization review company shall assure that a

135 practitioner in a specialty related to the condition is reasonably
136 available to review the case. When the reason for the determination not
137 to certify is based on medical necessity, including whether a treatment
138 is experimental or investigational, each utilization review company
139 shall have the case reviewed by a physician who is a specialist in the
140 field related to the condition that is the subject of the appeal. The
141 review shall be completed within thirty days of the request for review.
142 The utilization review company shall be financially responsible for the
143 review and shall maintain, for the commissioner's verification,
144 documentation of the review, including the name of the reviewing
145 physician.

146 (8) Except as provided in subsection (e) of this section, each
147 utilization review company shall make review staff available by toll-
148 free telephone, at least forty hours per week during normal business
149 hours.

150 (9) Each utilization review company shall comply with all
151 applicable federal and state laws to protect the confidentiality of
152 individual medical records. Summary and aggregate data shall not be
153 considered confidential if it does not provide sufficient information to
154 allow identification of individual patients.

155 (10) Each utilization review company shall allow a minimum of
156 twenty-four hours following an emergency admission, service or
157 procedure for an enrollee or [his] the enrollee's representative to notify
158 the utilization review company and request certification or continuing
159 treatment for that condition.

160 (11) No utilization review company may give an employee any
161 financial incentive based on the number of denials of certification such
162 employee makes.

163 (12) Each utilization review company shall annually file with the
164 commissioner (A) the names of all managed care organizations, as

165 defined in section 38a-478, that the utilization review company
166 services in Connecticut, (B) any utilization review services for which
167 the utilization review company has contracted out for services and the
168 name of such company providing the services, and (C) the number of
169 utilization review determinations not to certify an admission, service,
170 procedure or extension of stay and the outcome of such determination
171 upon appeal within the utilization review company.

172 (13) Any utilization review decision to initially deny services shall
173 be made by a licensed health professional.

174 (b) Unless there is a contrary written agreement between the
175 utilization review company and the hospital, all hospitals in this state
176 shall permit each licensed utilization review company to conduct
177 reviews on the premises. Each utilization review company shall
178 conduct its telephone, on-site information gathering reviews and
179 hospital communications during the hospitals' and practitioners'
180 reasonable and normal business hours, unless other arrangements are
181 mutually agreed upon. Each utilization review company's staff shall
182 identify themselves by name and by the name of their organization
183 and, for on-site reviews, shall carry photographic identification and the
184 utilization review company's company identification card.

185 (c) The provider of record shall provide to each utilization review
186 company, within a reasonable period of time, all relevant information
187 necessary for the utilization review company to certify the admission,
188 procedure, treatment or length of stay. Failure of the provider to
189 provide such documentation for review shall be grounds for a denial
190 of certification in accordance with the policy of the utilization review
191 company or the health benefit plan.

192 (d) No provider, enrollee or agent thereof may provide to any
193 utilization review company information which is fraudulent or
194 misleading. If fraudulent or misleading statements have occurred, the
195 commissioner shall provide notice of the alleged violation and

196 opportunity to request a hearing in accordance with chapter 54 to said
197 provider, enrollee or agent thereof. If a hearing is not requested or if
198 after a hearing the commissioner finds that a violation has in fact
199 occurred, the commissioner may impose a civil penalty (1) of not more
200 than five thousand dollars, or (2) commensurate with the value of
201 services provided which were certified as a result of said fraudulent or
202 misleading information. In addition, any allegation or denial made
203 without reasonable cause and found untrue shall subject the party
204 pleading the same to the payment of such reasonable expenses as may
205 be necessary to compensate the department for expenses incurred due
206 to such untrue pleading. All such payments to the department shall be
207 dedicated exclusively to the regulation of utilization review.

208 (e) On or after November 1, 1997, if an enrollee has been admitted to
209 an acute care hospital and the attending physician determines that the
210 enrollee's life will be endangered or other serious injury or illness
211 could occur if the patient is discharged or if treatment is delayed, the
212 attending physician may transmit, pursuant to the standardized
213 process developed pursuant to section 38a-478p, a request for an
214 expedited review to the utilization review company. If such attending
215 physician receives no response, in the standardized process developed
216 pursuant to section 38a-478p, from the utilization review company
217 after three hours have passed since the provider sent the request and
218 all information needed to complete the review, the request shall be
219 deemed approved. Each utilization review company shall make review
220 staff available from 8:00 a.m. to 9:00 p.m. to process requests pursuant
221 to this subsection.

222 (f) The Insurance Commissioner, after consultation with the
223 Commissioner of Public Health, shall adopt regulations, in accordance
224 with chapter 54, as [he] the Insurance Commissioner deems necessary
225 to clarify or supplement the standards set forth in this section. The
226 regulations shall include standards, which may be based on the
227 national standards of the American Accreditation Health Care

228 Commission, concerning the confidentiality of patient medical records.

229 Sec. 4. Section 38a-483b of the general statutes is repealed and the
230 following is substituted in lieu thereof:

231 Except as otherwise provided in [this title] chapter 698a, each
232 insurer, health care center, hospital and medical service corporation or
233 other entity delivering, issuing for delivery, renewing or amending
234 any individual health insurance policy in this state on or after January
235 1, 2000, providing coverage of the type specified in subdivisions (1),
236 (2), (4), (11) and (12) of section 38a-469 shall complete any coverage
237 determination with respect to such policy and notify the insured or the
238 insured's health care provider of its decision not later than forty-five
239 days after a request for such determination is received by the insurer,
240 health care center, hospital and medical service corporation or other
241 entity. If there is a deficiency in the information needed for making a
242 decision, the entity shall (1) send written notice to the insured or
243 provider of all alleged deficiencies in information needed for making a
244 decision not later than thirty days after the entity receives a request for
245 a coverage determination, and (2) notify the insured or provider of its
246 decision not later than thirty days after receiving the information
247 requested. In the case of a denial of coverage, such entity shall notify
248 the insured and the insured's health care provider of the reasons for
249 such denial.

250 Sec. 5. Section 38a-513a of the general statutes is repealed and the
251 following is substituted in lieu thereof:

252 Except as otherwise provided in [this title] chapter 698a, each
253 insurer, health care center, hospital and medical service corporation or
254 other entity delivering, issuing for delivery, renewing or amending
255 any group health insurance policy in this state on or after January 1,
256 2000, providing coverage of the type specified in subdivisions (1), (2),
257 (4), (11) and (12) of section 38a-469 shall complete any coverage
258 determination with respect to such policy and notify the insured or the

259 insured's health care provider of its decision not later than forty-five
260 days after a request for such determination is received by the insurer,
261 health care center, hospital and medical service corporation or other
262 entity. If there is a deficiency in the information needed for making a
263 decision, the entity shall (1) send written notice to the insured or
264 provider of all alleged deficiencies in information needed for making a
265 decision not later than thirty days after the entity receives a request for
266 a coverage determination, and (2) notify the insured or provider of its
267 decision not later than thirty days after receiving the information
268 requested. In the case of a denial of coverage, such entity shall notify
269 the insured and the insured's health care provider of the reasons for
270 such denial.

271 Sec. 6. This act shall take effect from its passage.

INS JOINT FAVORABLE SUBST.

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: Potential Revenue Gain (Utilization Review Fund), Potential Cost

Affected Agencies: Department of Insurance

Municipal Impact: None

Explanation

State Impact:

The bill specifies that no health insurer may seek to recover a payment after a claim is made until it gives written notice to the claimant or health care provider. The notice may not be sent not more than 120 days after the date the insurer has paid the claim.

The bill authorizes that a Utilization Review Company in its determination of adequate health care may include matters relating to coverage, medical necessity, medical appropriateness, health care setting, level of care, medical efficacy and the technical compliance with the practices and procedures set forth in a policy.

The Department of Insurance would have potential revenue gain in their Utilization Review Fund with the possibility of considering the expanded areas above. The licensing fee for Utilization Review Company is \$2,500. It cannot be determined how many additional review companies may be licensed.

The expansion of utilization review would create the possibility of additional external appeals of utilization review decisions to the Department of Insurance. The cost of an external appeal is \$300 to \$431. This cost is partially offset by a fee of \$25 charged to the individual initiating the external appeal. The number of external appeals cannot be determined.

OLR Bill Analysis

sHB 6987

AN ACT CONCERNING HEALTH INSURANCE CLAIMS AND PAYMENT RECOVERY.**SUMMARY:**

This bill revises several health insurance claim and coverage determination statutes by adding notice and time limit requirements. It also extends utilization review to any retrospective assessment of the medical necessity and appropriateness of using health care services and adds certain factors that may be used in making prospective, concurrent, or retrospective assessments.

EFFECTIVE DATE: Upon Passage

CLAIMS RECOVERY***Unfair Claims Settlement Practice***

The bill prohibits an insurer from seeking to recover payment of a claim after it has been paid and makes it an unfair claims settlement practice unless the (1) insurer gives the claimant or health care provider written notice, (2) notice indicates the insurer's intent to recover payment and identifies the claim, and (3) notice is sent at least 120 days after the date the claim is paid.

UTILIZATION REVIEW

By law, utilization review requires the company or entity conducting the review to maintain and disclose its notification procedures about its decision to approve or deny a requested admission, service, procedure or extension of a stay to plan enrollees and health care providers of record.

Retrospective Determination. The bill extends utilization review to retrospective assessments of the medical necessity of providing health

care services.

Prospective, Concurrent, and Retrospective Assessments. The bill requires prospective, concurrent, and retrospective assessments to include the following factors:

1. matters relating to coverage,
2. medical necessity and appropriateness,
3. health care setting and level of care, and
4. medical efficacy and technical compliance with a policy, plan or contract's practices and procedures.

Prospective Determination. The bill requires utilization review companies to (1) provide written notice to the appropriate person within five days after the review request, of all alleged information deficiencies needed to complete the review, and (2) complete the review within five days after receiving the information requested, when there is a deficiency in information needed to complete a review of a prospective determination.

COVERAGE DETERMINATIONS

When there is a deficiency in information needed to make a coverage decision, the bill requires insurers, HMOs, hospital and medical service corporations and other entities to (1) send written notice to the insured or health care provider within 30 days after receiving a coverage determination request, about all alleged information deficiencies needed to make a coverage decision, and (2) notify the insured or provider of their decision within 30 days after receiving the requested information. The requirement applies to individual and group health insurance policies that (1) pay for (a) basic hospital expenses, (b) basic medical-surgical expenses, (c) major medical expenses, (d) hospital or medical services, and (e) hospital and medical services offered by HMOs to their subscribers and (2) are delivered, issued for delivery, renewed, or amended in the state on and after the bill's effective date.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 10 Nay 8