



General Assembly

January Session, 2001

Amendment

LCO No. 5905

Offered by:
REP. EBERLE, 15th Dist.

To: Subst. House Bill No. 6572 File No. 461 Cal. No. 329

**"AN ACT MAKING TECHNICAL AND OTHER CHANGES TO
CERTAIN PUBLIC HEALTH STATUTES."**

1 Strike out lines 168 to 175, inclusive, in their entirety and insert the
2 following in lieu thereof:

3 "Sec. 9. (NEW) (a) As used in this section and subsection (b) of
4 section 20-138b of the general statutes, as amended by this act:

5 (1) "Health care services" means health care related services or
6 products rendered or sold by a provider within the scope of the
7 provider's license or legal authorization, and includes hospital,
8 medical, surgical, dental, vision and pharmaceutical services or
9 products;

10 (2) "Person" means an individual, agency, political subdivision,
11 partnership, corporation, limited liability company, association or any
12 other entity;

13 (3) "Preferred provider network" means an arrangement in which

14 agreements relating to the health care services to be rendered by
15 providers, including the amounts to be paid to the providers for such
16 services, are entered into between such providers and a person who
17 establishes, operates, maintains or underwrites the arrangement, in
18 whole or in part, and includes any provider-sponsored preferred
19 provider network or independent practice association that offers
20 network services, but does not include a workers' compensation
21 preferred provider organization established pursuant to section 31-
22 279-10 of the regulations of Connecticut state agencies or an
23 arrangement relating only to health care services offered by providers
24 to individuals covered under self-insured Employee Welfare Benefit
25 Plans established pursuant to the federal Employee Retirement Income
26 Security Act of 1974, as from time to time amended;

27 (4) "Provider" means an individual or entity duly licensed or legally
28 authorized to provide health care services; and

29 (5) "Commissioner" means the Insurance Commissioner.

30 (b) All preferred provider networks shall file with the commissioner
31 prior to the start of enrollment and shall annually update such filing
32 by July first of each year thereafter. The filing required by such
33 preferred provider network shall include the following information:
34 (1) The identity of any company or organization controlling the
35 operation of the preferred provider network, a description of such
36 company or organization and, where applicable, the following: (A) A
37 certificate from the Secretary of the State regarding the company's or
38 organization's good standing to do business in the state; (B) a copy of
39 the company's or organization's balance sheet at the end of its most
40 recently concluded fiscal year, along with the name and address of any
41 public accounting firm or internal accountant which prepared or
42 assisted in the preparation of such balance sheet; (C) a list of the
43 names, official positions and occupations of members of the company's
44 or organization's board of directors or other policy-making body and
45 of those executive officers who are responsible for the company's or
46 organization's activities with respect to the medical care network; (D) a

47 list of the company's or organization's principal owners; (E) in the case
48 of an out-of-state company or organization, a certificate that such
49 company or organization is in good standing in its state of
50 organization; (F) in the case of a Connecticut or out-of-state company
51 or organization, a report of the details of any suspension, sanction or
52 other disciplinary action relating to such company or organization in
53 this state or in any other state; and (G) the identity, address and
54 current relationship of any related or predecessor company or
55 organization. For purposes of this subparagraph, "related" means that
56 a substantial number of the board or policy-making body members,
57 executive officers or principal owners of both companies are the same;
58 (2) a general description of the preferred provider network and
59 participation in the preferred provider network, including: (A) The
60 geographical service area of and the names of the hospitals included in
61 the preferred provider network; and (B) the primary care physicians,
62 the specialty physicians, any other contracting health care providers
63 and the number and percentage of each group's capacity to accept new
64 patients; and (3) the name and address of the person to whom
65 applications may be made for participation.

66 (c) Any person developing a preferred provider network, or
67 expanding a preferred provider network into a new county, pursuant
68 to this section and subsection (b) of section 20-138b of the general
69 statutes, as amended by this act, shall publish a notice, in at least one
70 newspaper having a substantial circulation in the service area in which
71 the preferred provider network operates or will operate, indicating
72 such planned development or expansion. Such notice shall include the
73 medical specialties included in the preferred provider network, the
74 name and address of the person to whom applications may be made
75 for participation and a time frame for making application. The
76 preferred provider network shall provide the applicant with written
77 acknowledgment of receipt of the application. Each complete
78 application shall be considered by the preferred provider network in a
79 timely manner.

80 (d) (1) Each preferred provider network shall file with the

81 commissioner and make available upon request from a provider, the
82 general criteria for its selection or termination of providers. Disclosure
83 shall not be required of criteria deemed by the preferred provider
84 network to be of a proprietary or competitive nature that would hurt
85 the preferred provider network's ability to compete or to manage
86 health services. For purposes of this section, disclosure of criteria is
87 proprietary or anticompetitive if it has the tendency to cause health
88 care providers to alter their practice pattern in a manner that would
89 circumvent efforts to contain health care costs and is proprietary if
90 revealing criteria would cause the preferred provider network's
91 competitors to obtain valuable business information.

92 (2) If a preferred provider network uses criteria that have not been
93 filed pursuant to subdivision (1) of this subsection to judge the quality
94 and cost-effectiveness of a provider's practice under any specific
95 program within the preferred provider network, the preferred
96 provider network may not reject or terminate the provider
97 participating in that program based upon such criteria until the
98 provider has been informed of the criteria that the provider's practice
99 fails to meet.

100 (e) A preferred provider network which has a limited network and
101 which does not provide any reimbursement when an enrollee obtains
102 service outside that limited network shall inform each applicant of that
103 fact prior to enrolling the applicant for coverage.

104 Sec. 10. Subsection (b) of section 20-138b of the general statutes is
105 repealed and the following is substituted in lieu thereof:

106 (b) If any health care center, as defined in section 38a-175 or
107 preferred provider network, as defined in section [19a-647b] 9 of this
108 act, offers health care benefits which provide ophthalmologic care for
109 any person, partnership, corporation, association or [any] group,
110 however organized, such health care center or preferred provider
111 network shall provide optometric care. If the ophthalmologic care
112 provided may be lawfully rendered by an optometrist, such health

113 care center or preferred provider network shall provide the identical
114 eye care coverage and benefits for its members when such care is
115 rendered by an optometrist under contract with such health care center
116 or preferred provider network. Such health care center or preferred
117 provider network shall (1) contract with ophthalmologists and
118 optometrists in a manner which will provide fair and sufficient
119 representation of such providers in relation to the benefits provided by
120 the health care center plan or preferred provider network, and (2)
121 equally inform its members of the availability of ophthalmologic and
122 optometric services.

123 Sec. 11. Section 38a-478a of the general statutes is repealed and the
124 following is substituted in lieu thereof:

125 On March 1, 1999, and annually thereafter, the Insurance
126 Commissioner shall submit a report, to the Governor and to the joint
127 standing committees of the General Assembly having cognizance of
128 matters relating to public health and relating to insurance, concerning
129 the commissioner's responsibilities under the provisions of sections
130 [19a-647,] 38a-226 to 38a-226d, inclusive, 38a-478 to 38a-478u, inclusive,
131 [and] 38a-993 and section 9 of this act. The report shall include: (1) A
132 summary of the quality assurance plans submitted by managed care
133 organizations pursuant to section 38a-478c along with suggested
134 changes to improve such plans; (2) suggested modifications to the
135 consumer report card developed under the provisions of section 38a-
136 478l; (3) a summary of the commissioner's procedures and activities in
137 conducting market conduct examinations of utilization review
138 companies, including, but not limited to: (A) The number of desk and
139 field audits completed during the previous calendar year; (B) a
140 summary of findings of the desk and field audits, including any
141 recommendations made for improvements or modifications; (C) a
142 description of complaints concerning managed care companies,
143 including a summary and analysis of any trends or similarities found
144 in the managed care complaints filed by enrollees; (4) a summary of
145 the complaints received by the Insurance Department's Consumer
146 Affairs Division and the commissioner under section 38a-478n,

147 including a summary and analysis of any trends or similarities found
148 in the complaints received; (5) a summary of any violations the
149 commissioner has found against any managed care organization; and
150 (6) a summary of the issues discussed related to health care or
151 managed care organizations at the Insurance Department's quarterly
152 forums throughout the state.

153 Sec. 12. Section 38a-478b of the general statutes is repealed and the
154 following is substituted in lieu thereof:

155 (a) Each managed care organization, as defined in section 38a-478,
156 that fails to file the data, reports or information required by sections
157 [19a-647,] 38a-226 to 38a-226d, inclusive, 38a-478 to 38a-478u, inclusive,
158 [and] 38a-993 and section 9 of this act, shall pay a late fee of one
159 hundred dollars per day for each day from the due date of such data,
160 reports or information to the date of filing. Each managed care
161 organization that files incomplete data, reports or information shall be
162 so informed by the commissioner, shall be given a date by which to
163 remedy such incomplete filing and shall pay said late fee commencing
164 from the new due date.

165 (b) On June 1, 1998, and annually thereafter, the commissioner shall
166 submit, to the Governor and to the joint standing committees of the
167 General Assembly having cognizance of matters relating to public
168 health and matters relating to insurance, a list of those managed care
169 organizations that have failed to file any data, report or information
170 required by sections [19a-647,] 38a-226 to 38a-226d, inclusive, 38a-478
171 to 38a-478u, inclusive, [and] 38a-993 and section 9 of this act.

172 Sec. 13. Section 38a-478t of the general statutes is repealed and the
173 following is substituted in lieu thereof:

174 The Commissioner of Public Health may request and shall receive
175 any data, report or information filed with the Insurance Commissioner
176 pursuant to the provisions of sections [19a-647,] 38a-226 to 38a-226d,
177 inclusive, 38a-478 to 38a-478u, inclusive, [and] 38a-993 and section 9 of
178 this act.

179 Sec. 14. Section 38a-478u of the general statutes is repealed and the
180 following is substituted in lieu thereof:

181 The Insurance Commissioner shall adopt regulations in accordance
182 with the provisions of chapter 54 to implement the provisions of
183 sections [19a-647,] 38a-226 to 38a-226d, inclusive, 38a-478 to 38a-478u,
184 inclusive, [and] 38a-993 and section 9 of this act.

185 Sec. 15. Subsection (a) of section 46b-22 of the general statutes is
186 repealed and the following is substituted in lieu thereof:

187 (a) All judges and retired judges, either elected or appointed and
188 including federal judges and judges of other states who may legally
189 join persons in marriage in their jurisdictions, family support
190 magistrates, state referees and justices of the peace may join persons in
191 marriage in any town in the state and all ordained or licensed
192 clergymen, belonging to this state or any other state, so long as they
193 continue in the work of the ministry may join persons in marriage. All
194 marriages solemnized according to the forms and usages of any
195 religious denomination in this state, including marriages witnessed by
196 a duly constituted Spiritual Assembly of the Baha'is, are valid. All
197 marriages attempted to be celebrated by any other person are void.

198 Sec. 16. Section 19a-647 of the general statutes is repealed.

199 Sec. 17. This act shall take effect from its passage, except that
200 sections 3 to 5, inclusive, sections 9 to 14, inclusive, and section 16 shall
201 take effect October 1, 2001, and section 2 shall take effect the later of its
202 passage or on the date notice is published by the Commissioner of
203 Public Health in the Connecticut Law Journal indicating that the
204 licensing of athletic trainers and physical therapist assistants is being
205 implemented by the commissioner."