



House of Representatives

General Assembly

File No. 50

January Session, 2003

Substitute House Bill No. 6455

House of Representatives, March 20, 2003

The Committee on Public Health reported through REP. FELTMAN of the 6th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING PATIENT RIGHTS AND MANAGED CARE SUBCONTRACTORS.

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

1 Section 1. (NEW) (*Effective October 1, 2003*) (a) Any managed care
2 organization, as defined in section 38a-478 of the general statutes, that
3 contracts with a utilization review company, as defined in section 38a-
4 226 of the general statutes, to provide services on behalf of the
5 managed care organization, shall be liable for decisions made by such
6 utilization review company. All rights of appeal or causes of action
7 provided to an enrollee by a managed care organization shall also be
8 available to an enrollee aggrieved by actions of a utilization review
9 company that provides services on behalf of such managed care
10 organization, and an enrollee may proceed directly against the
11 managed care organization to contest the actions of such utilization
12 review company.

13 (b) No utilization review company may establish any terms,

14 conditions or requirements for access, diagnosis or treatment that are
15 different from the terms, conditions or requirements for access,
16 diagnosis or treatment in the managed care organization's plan.

17 Sec. 2. Section 38a-815 of the general statutes is repealed and the
18 following is substituted in lieu thereof (*Effective October 1, 2003*):

19 No person shall engage in this state in any trade practice which is
20 defined in section 38a-816 as, or determined pursuant to sections 38a-
21 817 and 38a-818 to be, an unfair method of competition or an unfair or
22 deceptive act or practice in the business of insurance, nor shall any
23 domestic insurance company engage outside of this state in any act or
24 practice defined in subsections (1) to (12), inclusive, of section 38a-816.
25 The commissioner [shall have power to] may examine the affairs of
26 every person engaged in the business of insurance in this state in order
27 to determine whether such person has been or is engaged in any unfair
28 method of competition or in any unfair or deceptive act or practice
29 prohibited by sections 38a-815 to 38a-819, inclusive. When used in said
30 sections, (1) "person" means any individual, corporation, limited
31 liability company, association, partnership, reciprocal exchange,
32 interinsurer, Lloyd's insurer, fraternal benefit society and any other
33 legal entity engaged in the business of insurance, including producers
34 and adjusters, (2) "the business of insurance" includes, but is not
35 limited to, business conducted by a utilization review company, and
36 (3) "utilization review company" has the same meaning as set forth in
37 section 38a-226.

38 Sec. 3. (NEW) (*Effective October 1, 2003*) The Insurance
39 Commissioner shall adopt regulations, in accordance with chapter 54
40 of the general statutes, to establish minimum capital and minimum
41 surplus requirements for any utilization review company, as defined
42 in section 38a-226 of the general statutes, that assumes from an insurer
43 or health care center some or all of the risk to pay health insurance
44 claims with respect to certain enrollees. Such requirements shall be
45 similar to the requirements for insurers as set out in section 38a-72 of
46 the general statutes.

47 Sec. 4. (NEW) (*Effective October 1, 2003*) (a) Every managed care
48 organization, as defined in section 38a-478 of the general statutes, that
49 contracts with a utilization review company, as defined in section 38a-
50 226 of the general statutes, shall include in its contracts and
51 agreements with such utilization review company, a provision that the
52 utilization review company will include in all contracts between the
53 utilization review company and participating health care providers, a
54 provision transferring and assigning contracts between the utilization
55 review company and participating health care providers to the
56 managed care organization for the provision of future services by
57 participating health care providers to enrollees, at the discretion of the
58 managed care organization, in the event the utilization review
59 company fails to make payments previously authorized by such
60 utilization review company, or becomes insolvent.

61 (b) Whenever the commissioner determines that (1) (A) a utilization
62 review company has violated subdivision (15) of section 38a-816 of the
63 general statutes, (B) the time period set forth in said subdivision (15)
64 has elapsed, and (C) there has been a further thirty-day period of a
65 pattern of nonpayment by the utilization review company of
66 authorized claims, or (2) the utilization review company is insolvent,
67 the commissioner, without notice and before applying to the court for
68 any order, forthwith shall take possession of the capital reserves and
69 any letters of credit or performance bonds of such utilization review
70 company. The commissioner shall transfer such capital reserves, letters
71 of credit and performance bonds to the managed care organization
72 that contracted with the utilization review company to provide
73 services on behalf of the managed care organization. The managed
74 care organization shall make payments previously authorized by the
75 utilization review company out of such reserves, letters of credit and
76 performance bonds, and shall be liable for any such payments that
77 exceed the amount of such reserves, letters of credit and bonds.

78 Sec. 5. (NEW) (*Effective October 1, 2003*) (a) Complaints regarding
79 acts or practices of a utilization review company may be made by an
80 enrollee, subscriber or provider to the Insurance Commissioner, the

81 Office of the Managed Care Ombudsman or to the Attorney General.
82 Such commissioner, office and Attorney General shall each compile a
83 list of complaints received and, on a monthly basis, send each list to
84 the other two entities, except the names of complainants shall not be
85 disclosed if such disclosure would violate the provisions of section 4-
86 61dd or 38a-1045 of the general statutes.

87 (b) If such lists of complaints indicate that a utilization review
88 company may have engaged in a pattern or practice that may be in
89 violation of sections 38a-226 to 38a-226d, inclusive, of the general
90 statutes, or sections 38a-815 to 38a-819, inclusive, of the general
91 statutes, as amended by this act, the Attorney General may investigate
92 and compel discovery for the purposes of such investigation regarding
93 such utilization review company. The Attorney General may refer the
94 results of such investigation to the Insurance Commissioner for
95 appropriate administrative remedies, or may bring an action in the
96 superior court for the judicial district of Hartford to enjoin any such act
97 or practice and to recover a civil penalty as provided in subsection (c)
98 of this section.

99 (c) Any person found, pursuant to an action brought by the
100 Attorney General pursuant to subsection (b) of this section, to have
101 violated any provision of sections 38a-226 to 38a-226d, inclusive, of the
102 general statutes, or to have engaged in an unfair method of
103 competition or an unfair or deceptive act or practice in the business of
104 insurance shall be liable for one or both of the following: (1) Payment
105 of a monetary penalty of not more than one thousand dollars for each
106 and every act or violation, but not to exceed an aggregate penalty of
107 ten thousand dollars unless the person knew or reasonably should
108 have known that the person was in violation of section 38a-815 of the
109 general statutes, as amended by this act, or section 38a-816 of the
110 general statutes, in which case the penalty shall be not more than five
111 thousand dollars for each and every act or violation, but not to exceed
112 an aggregate penalty of fifty thousand dollars in any six-month period;
113 and (2) restitution of any sums shown to have been obtained in
114 violation of any of the provisions of sections 38a-226 to 38a-226d,

115 inclusive, of the general statutes, sections 38a-815 to 38a-819, inclusive,
 116 of the general statutes, as amended by this act, or any regulation
 117 implementing the provisions of said sections.

118 (d) Any enrollee, subscriber or provider who is aggrieved by any
 119 utilization review company that has been engaged or is engaging in
 120 any practice or act defined in section 38a-816 of the general statutes as
 121 an unfair method of competition or an unfair or deceptive act or
 122 practice in the business of insurance in violation of sections 38a-815 to
 123 38a-819, inclusive, of the general statutes, as amended by this act, may
 124 bring an action in the superior court, and the court may, in its
 125 discretion, award restitution of any sums shown to have been obtained
 126 in violation of any of the provisions of said sections or any regulation
 127 adopted pursuant to said sections, costs and reasonable attorneys' fees,
 128 damages and, in addition to damages or in lieu of damages, injunctive
 129 or other equitable relief.

130 Sec. 6. (NEW) (*Effective October 1, 2003*) No health insurer, health
 131 care center or utilization review company, as defined in section 38a-
 132 226 of the general statutes, shall take or threaten to take any health
 133 insurance or personnel action against any enrollee, provider or
 134 employee in retaliation for such enrollee, provider or employee (1)
 135 disclosing information to the Insurance Commissioner or Attorney
 136 General concerning any practice defined in section 38a-816 of the
 137 general statutes as an unfair method of competition or an unfair and
 138 deceptive act or practice in the business of insurance, (2) filing a
 139 complaint with the Office of the Managed Care Ombudsman, or (3)
 140 filing an action under subsection (d) of section 5 of this act. Any
 141 enrollee, provider or employee who is aggrieved by a violation of this
 142 section may bring a civil action in the superior court to recover
 143 damages and attorneys' fees and costs.

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>October 1, 2003</i>
Sec. 3	<i>October 1, 2003</i>

Sec. 4	<i>October 1, 2003</i>
Sec. 5	<i>October 1, 2003</i>
Sec. 6	<i>October 1, 2003</i>

PH *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:

Agency Affected	Fund-Type	FY 04 \$	FY 05 \$
Insurance Dept.	Utilization Review Fund - Cost	50,000 - 75,000	50,000 - 75,000
Attorney General; Insurance Dept.	GF & IF - Revenue Gain	less than 50,000	less than 50,000
Office of Managed Care Ombudsman	GF - None	None	None
St. Employees Health Serv. Cost	Various - None	None	None

Note: GF=General Fund; IF =Insurance Fund

Municipal Impact: None

Explanation

The bill would result in: 1) an estimated cost of \$50,000 - \$75,000 to the Utilization Review Fund (URF) associated with the need to hire outside consultants, 2) a potential revenue gain of less than \$50,000 to the General Fund and Insurance Fund associated with the collection of penalties and 3) no fiscal impact on state employee health benefit accounts or the Office of the Managed Care Ombudsman.

Regulatory Costs

The bill requires the Department of Insurance (DOI) to further regulate utilization review companies. Currently these companies (about 120 in number) are licensed and reviewed by DOI at a cost of about \$270,000 for three staff and associated expenses. These costs are paid from the URF, which is a separate account within the Insurance Fund.

The URF is funded exclusively through the \$2,500 annual licensing fee charged to these companies and generates about \$320,000 per year.

The current balance in the fund is \$1.4 million. It is anticipated that the bill would require the need for contractual staff to assist the existing URF staff. The cost of these consultants could range from \$50,000 to \$75,000.

There is no cost to the Attorney General (AG) associated with investigating utilization review companies since he is already engaged in these activities. In addition, there is no cost to the AG, DOI or the Office of the Managed Care Ombudsman associated with maintaining and sharing a list of complaints against utilization review companies.

Penalty Collections

The bill permits DOI and the AG to penalize utilization review companies if they violate utilization review laws or the unfair and deceptive insurance practices act. The DOI and the AG may seek to recover up to \$50,000 per violation in penalties. Revenue from these penalties would be deposited into the General Fund or the Insurance Fund depending on the source of the action.

OLR Bill Analysis

sHB 6455

AN ACT CONCERNING PATIENT RIGHTS AND MANAGED CARE SUBCONTRACTORS**SUMMARY:**

This bill addresses the relationship between managed care companies (MCOs) and utilization companies ("subcontractors") that they contract with to provide services to their enrollees.

It:

1. makes MCOs liable for decisions of their subcontractors;
2. ensures that MCO enrollees have appeal and lawsuit rights concerning subcontractors' actions;
3. prohibits a subcontractor from establishing terms and conditions for access and treatment different from those of the MCO;
4. subjects subcontractors to the Connecticut Unfair Insurance Practices Act;
5. requires the insurance commissioner to adopt regulations on financial requirements for subcontractors;
6. requires contractual provisions addressing the MCO's responsibilities in the event a subcontractor fails to pay providers or becomes insolvent;
7. gives the insurance commissioner the authority to take the subcontractor's capital reserves, letters of credit, or performance bonds and transfer them to the MCO in the event of nonpayment or insolvency;
8. allows enrollees and providers to complain about a subcontractor's practices to the insurance commissioner, managed care ombudsman, or attorney general;
9. authorizes the attorney general to investigate complaints and establishes monetary penalties and restitution in the case of violations of the law;
10. allows enrollees and providers to sue in court concerning subcontractors' actions; and
11. prohibits retaliation against enrollees, providers, or employees disclosing information about unfair practices, filing complaints, or suing in court.

EFFECTIVE DATE: October 1, 2003

LIABILITY FOR DECISIONS, APPEAL RIGHTS, TERMS AND CONDITIONS FOR TREATMENT

The bill makes a managed care organization (MCO) liable for the decisions made by a utilization company that it contracts with (a "subcontractor" for purposes of the bill) to provide services on behalf of the MCO. Under the bill, all appeal rights and rights to sue that a MCO enrollee has must also be available to an enrollee aggrieved by the subcontractor's actions. The bill provides that an enrollee can proceed directly against the MCO to contest the subcontractor's actions.

The bill prohibits the subcontractor from establishing any terms, conditions; or requirements for access, diagnosis, and treatment different from those of the MCO.

UNFAIR AND DECEPTIVE INSURANCE PRACTICES

The bill applies the law on "unfair method of competition or unfair and deceptive act or practice in the business of insurance" to the business of a utilization review company (i.e. a subcontractor). By law, the insurance commissioner may order anyone engaged in an unfair method of competition or an unfair and deceptive act to stop; pay a penalty of \$1,000 to \$5,000 per act up to an aggregate maximum of \$50,000; or surrender his license.

MINIMUM FINANCIAL REQUIREMENTS

The bill requires the insurance commissioner to adopt regulations establishing minimum capital and surplus requirements for any subcontractor that assumes from an insurer some or all of the risk to pay health insurance claims to certain enrollees. These regulatory requirements must be similar to those already established for insurance companies.

CONTRACTUAL REQUIREMENTS, TIMELY PAYMENTS

The bill requires MCOs contracting with a utilization company (subcontractor) to include in its contracts and agreements with the subcontractor a provision that the subcontractor will in turn include in

all contracts between the subcontractor and all participating health care providers. This provision must transfer and assign contracts between the subcontractor and participating providers to the MCO for providing future services to enrollees, "at the MCO's discretion," if the subcontractor fails to make payments it previously authorized or becomes insolvent. (It is unclear what is meant by "at the MCO's discretion.")

The bill gives the insurance commissioner certain authority to act in the event the subcontractor fails to make payments to providers within time established by law, or the subcontractor is insolvent. Specifically, if the subcontractor (1) fails to pay claims within 45 days of receiving a health care provider's request for payment filed according to the company's practices and there is another 30-day period of a pattern of nonpayment by the subcontractor of authorized claims, or (2) the subcontractor is insolvent, the commissioner, without notice and before applying for a court order, can take possession of the subcontractor's capital reserves and any letters of credit or performance bonds. The insurance commissioner must transfer the capital reserves, letters of credit and performance bonds to the MCO that contracted with the subcontractor for services. The bill requires the MCO to make payments previously authorized by the subcontractor out of the reserves, letters of credit, and performance bonds. The MCO is also liable for any payments that exceed the amount of these reserves, letters of credit, and bonds.

COMPLAINTS

The bill allows an enrollee, subscriber, or provider to complain about a subcontractor's acts or practices to the insurance commissioner, managed care ombudsman, or attorney general. Each of these officials must compile a monthly list of complaints and send it to the other two. Complainants' names must not be disclosed if it would violate the law on confidentiality of consumer identification for consumers using the services of the ombudsman (consumers must give their consent to disclosure) or the whistleblower law concerning disclosure of information to the state auditors.

The attorney general may investigate if the list of complaints indicates that the subcontractor may have violated the utilization review laws or the unfair and deceptive insurance practices act. He may compel discovery for investigative purposes and refer the results of his

investigation to the insurance commissioner for appropriate administrative remedies. The Attorney General, under the bill, may sue in Hartford Superior Court to enjoin the acts or practices of subcontractor and to recover a civil penalty.

Under the bill, anyone found by the attorney general to have violated the law or engaged in unfair acts or practices is liable for one or both of the following: (1) a penalty of up to \$1,000 for each act or violation, up to a maximum of \$10,000, unless the person knew or should have known he was in violation of the unfair practices law in which case the penalty is up to \$5,000 for each violation, up to a maximum of \$50,000 in any six-month period, and (2) restitution of sums obtained in violation of the laws on utilization review companies and unfair and deceptive practices.

Under the bill, any enrollee, subscriber, or provider aggrieved by any subcontractor engaging in any unfair practice can sue in Superior Court. The court has discretion to award restitution of any sums obtained in violation of the law, as well as costs and reasonable attorneys' fees, damages, and in addition to or in lieu of damages, injunctive or other equitable relief.

PROHIBITION ON RETALIATION

The bill prohibits a health insurer, health care center (i.e. HMO), or utilization review company from taking or threatening to take any health insurance or personnel action against any enrollee, provider, or employee in retaliation for (1) disclosing information to the insurance commissioner or attorney general concerning any unfair practice, (2) filing a complaint with the managed care ombudsman, or (3) filing a court action concerning an unfair and deceptive act (see above).

Any enrollee, provider, or employee aggrieved by retaliatory action can sue in Superior Court for damages and attorneys' fees and costs.

BACKGROUND

Related Bill

SB 917, "An Act Concerning Preferred Provider Networks," concerns the licensure, contracts, and financial solvency of subcontractors and has had a public hearing by the Insurance Committee.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 16 Nay 1