



General Assembly

January Session, 2003

Amendment

LCO No. 6498

SB0091706498SD0

Offered by:

SEN. CRISCO, 17th Dist.

REP. OREFICE, 37th Dist.

REP. FELTMAN, 6th Dist.

To: Subst. Senate Bill No. 917

File No. 208

Cal. No. 166

"AN ACT CONCERNING PREFERRED PROVIDER NETWORKS."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 38a-479aa of the general statutes is repealed and
4 the following is substituted in lieu thereof (*Effective October 1, 2003*):

5 (a) As used in this section, sections 2 to 7, inclusive, of this act, and
6 subsection (b) of section 20-138b:

7 (1) "Covered benefits" means health care services to which an
8 enrollee is entitled under the terms of a managed care plan;

9 (2) "Enrollee" means an individual who is eligible to receive health
10 care services through a preferred provider network;

11 ~~[(1)]~~ (3) "Health care services" means health care related services or
12 products rendered or sold by a provider within the scope of the

13 provider's license or legal authorization, and includes hospital,
14 medical, surgical, dental, vision and pharmaceutical services or
15 products;

16 (4) "Managed care organization" means (A) a managed care
17 organization, as defined in section 38a-478, as amended by this act, (B)
18 any other health insurer, or (C) a reinsurer with respect to health
19 insurance;

20 (5) "Managed care plan" means a managed care plan, as defined in
21 section 38a-478, as amended by this act;

22 [(2)] (6) "Person" means an individual, agency, political subdivision,
23 partnership, corporation, limited liability company, association or any
24 other entity;

25 [(3)] (7) "Preferred provider network" means [an arrangement in
26 which agreements relating to the health care services to be rendered by
27 providers, including the amounts to be paid to the providers for such
28 services, are entered into between such providers and a person who
29 establishes, operates, maintains or underwrites the arrangement, in
30 whole or in part, and includes any provider-sponsored preferred
31 provider network or independent practice association that offers
32 network services, but] a person, which is not a managed care
33 organization, but which pays claims for the delivery of health care
34 services, accepts financial risk for the delivery of health care services
35 and establishes, operates or maintains an arrangement or contract with
36 providers relating to (A) the health care services rendered by the
37 providers, and (B) the amounts to be paid to the providers for such
38 services. "Preferred provider network" does not include a workers'
39 compensation preferred provider organization established pursuant to
40 section 31-279-10 of the regulations of Connecticut state [or an
41 arrangement relating only to health care services offered by providers
42 to individuals covered under self-insured Employee Welfare Benefit
43 Plans established pursuant to the federal Employee Retirement Income
44 Security Act of 1974, as from time to time amended] agencies or an

45 independent practice association or physician hospital organization
46 whose primary function is to contract with insurers and provide
47 services to providers;

48 [(4)] (8) "Provider" means an individual or entity duly licensed or
49 legally authorized to provide health care services; and

50 [(5)] (9) "Commissioner" means the Insurance Commissioner.

51 [(b) All preferred provider networks shall file with the
52 commissioner prior to the start of enrollment and shall annually
53 update such filing by July first of each year thereafter.]

54 (b) On and after May 1, 2004, no preferred provider network may
55 enter into or renew a contractual relationship with a managed care
56 organization unless the preferred provider network is licensed by the
57 commissioner. On and after May 1, 2005, no preferred provider
58 network may conduct business in this state unless it is licensed by the
59 commissioner. Any person seeking to obtain or renew a license shall
60 submit an application to the commissioner, on such form as the
61 commissioner may prescribe, and shall include the filing described in
62 this subsection, except that a person seeking to renew a license may
63 submit only the information necessary to update its previous filing.
64 Applications shall be submitted by March first of each year in order to
65 qualify for the May first license issue or renewal date. The filing
66 required [by] from such preferred provider network shall include the
67 following information: (1) The identity of the preferred provider
68 network and any company or organization controlling the operation of
69 the preferred provider network, including the name, business address,
70 contact person, a description of [such] the controlling company or
71 organization and, where applicable, the following: (A) A certificate
72 from the Secretary of the State regarding the preferred provider
73 network's and the controlling company's or organization's good
74 standing to do business in the state; (B) a copy of the preferred
75 provider network's and the controlling company's or organization's
76 [balance sheet at] financial statement completed in accordance with

77 sections 38a-53 and 38a-54, as applicable, for the end of its most
78 recently concluded fiscal year, along with the name and address of any
79 public accounting firm or internal accountant which prepared or
80 assisted in the preparation of such [balance sheet] financial statement;
81 (C) a list of the names, official positions and occupations of members
82 of the preferred provider network's and the controlling company's or
83 organization's board of directors or other policy-making body and of
84 those executive officers who are responsible for the preferred provider
85 network's and controlling company's or organization's activities with
86 respect to the [medical care] health care services network; (D) a list of
87 the preferred provider network's and the controlling company's or
88 organization's principal owners; (E) in the case of an out-of-state
89 preferred provider network, controlling company or organization, a
90 certificate that such preferred provider network, company or
91 organization is in good standing in its state of organization; (F) in the
92 case of a Connecticut or out-of-state preferred provider network,
93 controlling company or organization, a report of the details of any
94 suspension, sanction or other disciplinary action relating to such
95 preferred provider network, or controlling company or organization in
96 this state or in any other state; and (G) the identity, address and
97 current relationship of any related or predecessor controlling company
98 or organization. For purposes of this subparagraph, "related" means
99 that a substantial number of the board or policy-making body
100 members, executive officers or principal owners of both companies are
101 the same; (2) a general description of the preferred provider network
102 and participation in the preferred provider network, including: (A)
103 The geographical service area of and the names of the hospitals
104 included in the preferred provider network; [and] (B) the primary care
105 physicians, the specialty physicians, any other contracting [health care]
106 providers and the number and percentage of each group's capacity to
107 accept new patients; (C) a list of all entities on whose behalf the
108 preferred provider network has contracts or agreements to provide
109 health care services; (D) a table listing all major categories of health
110 care services provided by the preferred provider network; (E) an
111 approximate number of total enrollees served in all of the preferred

112 provider network's contracts or agreements; (F) a list of subcontractors
113 of the preferred provider network, not including individual
114 participating providers, that assume financial risk from the preferred
115 provider network and to what extent each subcontractor assumes
116 financial risk; (G) a contingency plan describing how contracted health
117 care services will be provided in the event of insolvency; and (H) any
118 other information requested by the commissioner; and (3) the name
119 and address of the person to whom applications may be made for
120 participation.

121 (c) Any person developing a preferred provider network, or
122 expanding a preferred provider network into a new county, pursuant
123 to this section and subsection (b) of section 20-138b, shall publish a
124 notice, in at least one newspaper having a substantial circulation in the
125 service area in which the preferred provider network operates or will
126 operate, indicating such planned development or expansion. Such
127 notice shall include the medical specialties included in the preferred
128 provider network, the name and address of the person to whom
129 applications may be made for participation and a time frame for
130 making application. The preferred provider network shall provide the
131 applicant with written acknowledgment of receipt of the application.
132 Each complete application shall be considered by the preferred
133 provider network in a timely manner.

134 (d) (1) Each preferred provider network shall file with the
135 commissioner and make available upon request from a provider [,] the
136 general criteria for its selection or termination of providers. Disclosure
137 shall not be required of criteria deemed by the preferred provider
138 network to be of a proprietary or competitive nature that would hurt
139 the preferred provider network's ability to compete or to manage
140 health care services. For purposes of this section, [disclosure of] criteria
141 is of a proprietary or [anticompetitive] competitive nature if it has the
142 tendency to cause [health care] providers to alter their practice pattern
143 in a manner that would circumvent efforts to contain health care costs
144 and criteria is of a proprietary nature if revealing the criteria would

145 cause the preferred provider network's competitors to obtain valuable
146 business information.

147 (2) If a preferred provider network uses criteria that have not been
148 filed pursuant to subdivision (1) of this subsection to judge the quality
149 and cost-effectiveness of a provider's practice under any specific
150 program within the preferred provider network, the preferred
151 provider network may not reject or terminate the provider
152 participating in that program based upon such criteria until the
153 provider has been informed of the criteria that the provider's practice
154 fails to meet.

155 (e) [A] Each preferred provider network [which has a limited
156 network and which does not provide any reimbursement when an
157 enrollee obtains service outside that limited network shall inform each
158 applicant of that fact prior to enrolling the applicant for coverage] shall
159 permit the Insurance Commissioner to inspect its books and records.

160 (f) Each preferred provider network shall permit the commissioner
161 to examine, under oath, any officer or agent of the preferred provider
162 network or controlling company or organization with respect to the
163 use of the funds of the preferred provider network, company or
164 organization, and compliance with (1) the provisions of this part and
165 sections 2 to 7, inclusive, of this act, and (2) the terms and conditions of
166 its contracts to provide health care services.

167 (g) Each preferred provider network shall file with the
168 commissioner a notice of any material modification of any matter or
169 document furnished pursuant to this part, or sections 2 to 7, inclusive,
170 of this act, and shall include such supporting documents as are
171 necessary to explain the modification.

172 (h) Each preferred provider network shall maintain a minimum net
173 worth of either (1) the greater of (A) two hundred fifty thousand
174 dollars, or (B) an amount equal to eight per cent of its annual
175 expenditures as reported on its most recent financial statement
176 completed and filed with the commissioner in accordance with

177 sections 38a-53 and 38a-54, as applicable, or (2) another amount
178 determined by the commissioner.

179 (i) Each preferred provider network shall maintain or arrange for a
180 letter of credit, bond, surety, reinsurance, reserve or other financial
181 security acceptable to the commissioner for the exclusive use of paying
182 any outstanding amounts owed participating providers in the event of
183 insolvency or nonpayment except that any remaining security may be
184 used for the purpose of reimbursing managed care organizations in
185 accordance with subsection (b) of section 2 of this act. Such
186 outstanding amount shall be at least an amount equal to the greater of
187 (1) an amount calculated on the basis of the two quarters within the
188 past year with the greatest amounts owed by the preferred provider
189 network to participating providers, (2) the actual outstanding amount
190 owed by the preferred provider network to participating providers, or
191 (3) another amount determined by the commissioner. Such amount
192 may be credited against the preferred provider network's minimum
193 net worth requirements set forth in subsection (h) of this section. The
194 commissioner shall review such security amount and calculation on a
195 quarterly basis.

196 (j) Each preferred provider network shall pay the applicable license
197 or renewal fee specified in section 38a-11, as amended by this act. The
198 commissioner shall use the amount of such fees solely for the purpose
199 of regulating preferred provider networks.

200 (k) In no event, including, but not limited to, nonpayment by the
201 managed care organization, insolvency of the managed care
202 organization, or breach of contract between the managed care
203 organization and the preferred provider network, shall a preferred
204 provider network bill, charge, collect a deposit from, seek
205 compensation, remuneration or reimbursement from, or have any
206 recourse against an enrollee or an enrollee's designee, other than the
207 managed care organization, for covered benefits provided, except that
208 the preferred provider network may collect any copayments,
209 deductibles or other out-of-pocket expenses that the enrollee is

210 required to pay pursuant to the managed care plan.

211 (l) Each contract or agreement between a preferred provider
212 network and a participating provider shall contain a provision that if
213 the preferred provider network fails to pay for health care services as
214 set forth in the contract, the enrollee shall not be liable to the
215 participating provider for any sums owed by the preferred provider
216 network or any sums owed by the managed care organization because
217 of nonpayment by the managed care organization, insolvency of the
218 managed care organization or breach of contract between the managed
219 care organization and the preferred provider network.

220 (m) Each utilization review determination made by or on behalf of a
221 preferred provider network shall be made in accordance with sections
222 38a-226 to 38a-226d, inclusive, except that any initial appeal of a
223 determination not to certify an admission, service, procedure or
224 extension of stay shall be conducted in accordance with subdivision (7)
225 of subsection (a) of section 38a-226c, and any subsequent appeal shall
226 be referred to the managed care organization on whose behalf the
227 preferred provider network provides services. The managed care
228 organization shall conduct the subsequent appeal in accordance with
229 said subdivision.

230 Sec. 2. (NEW) (*Effective May 1, 2004*) (a) On and after May 1, 2004, no
231 managed care organization may enter into or renew a contractual
232 relationship with a preferred provider network that is not licensed in
233 accordance with section 38a-479aa of the general statutes, as amended
234 by this act. On and after May 1, 2005, no managed care organization
235 may continue or maintain a contractual relationship with a preferred
236 provider network that is not licensed in accordance with section 38a-
237 479aa of the general statutes, as amended by this act.

238 (b) Each managed care organization that contracts with a preferred
239 provider network shall (1) post and maintain or require the preferred
240 provider network to post and maintain a letter of credit, bond, surety,
241 reinsurance, reserve or other financial security acceptable to the

242 Insurance Commissioner, in order to satisfy the risk accepted by the
243 preferred provider network pursuant to the contract, in an amount
244 calculated in accordance with subsection (i) of section 38a-479aa of the
245 general statutes, as amended by this act, and (2) determine who posts
246 and maintains the security required under subdivision (1) of this
247 subsection. In the event of insolvency or nonpayment such security
248 shall be used by the preferred provider network, or other entity
249 designated by the commissioner, solely for the purpose of paying any
250 outstanding amounts owed participating providers, except that any
251 remaining security may be used for the purpose of reimbursing the
252 managed care organization for any payments made by the managed
253 care organization to participating providers on behalf of the preferred
254 provider network.

255 (c) Each managed care organization that contracts with a preferred
256 provider network shall provide to the preferred provider network at
257 the time the contract is entered into and annually thereafter:

258 (1) Information, as determined by the managed care organization,
259 regarding the amount and method of remuneration to be paid to the
260 preferred provider network;

261 (2) Information, as determined by the managed care organization, to
262 assist the preferred provider network in being informed regarding any
263 financial risk assumed under the contract or agreement, including, but
264 not limited to, enrollment data, primary care provider to covered
265 person ratios, provider to covered person ratios by specialty, a table of
266 the services that the preferred provider network is responsible for,
267 expected or projected utilization rates, and all factors used to adjust
268 payments or risk-sharing targets;

269 (3) The National Associations of Insurance Commissioners annual
270 statement for the managed care organization; and

271 (4) Any other information the commissioner may require.

272 (d) Each managed care organization shall ensure that any contract it

273 has with a preferred provider network includes:

274 (1) A provision that requires the preferred provider network to
275 provide to the managed care organization at the time a contract is
276 entered into, annually, and upon request of the managed care
277 organization, (A) the financial statement completed in accordance with
278 sections 38a-53 and 38a-54 of the general statutes, as applicable, and
279 section 38a-479aa of the general statutes, as amended by this act; (B)
280 documentation that satisfies the managed care organization that the
281 preferred provider network has sufficient ability to accept financial
282 risk; (C) documentation that satisfies the managed care organization
283 that the preferred provider network has appropriate management
284 expertise and infrastructure; (D) documentation that satisfies the
285 managed care organization that the preferred provider network has an
286 adequate provider network taking into account the geographic
287 distribution of enrollees and participating providers and whether
288 participating providers are accepting new patients; (E) an accurate list
289 of participating providers; and (F) documentation that satisfies the
290 managed care organization that the preferred provider network has
291 the ability to ensure the delivery of health care services as set forth in
292 the contract.

293 (2) A provision that requires the preferred provider network to
294 provide to the managed care organization a quarterly status report that
295 includes (A) information updating the financial statement completed
296 in accordance with sections 38a-53 and 38a-54 of the general statutes,
297 as applicable, and section 38a-479aa of the general statutes, as
298 amended by this act; (B) a report showing amounts paid to those
299 providers who provide health care services on behalf of the managed
300 care organization; (C) an estimate of payments due providers but not
301 yet reported by providers; (D) amounts owed to providers for that
302 quarter; and (E) the number of utilization review determinations not to
303 certify an admission, service, procedure or extension of stay made by
304 or on behalf of the preferred provider network and the outcome of
305 such determination on appeal;

306 (3) A provision that requires the preferred provider network to
307 provide notice to the managed care organization not later than five
308 business days after (A) any change involving the ownership structure
309 of the preferred provider network; (B) financial or operational
310 concerns arise regarding the financial viability of the preferred
311 provider network; or (C) the preferred provider network's loss of a
312 license in this or any other state;

313 (4) A provision that if the managed care organization fails to pay for
314 health care services as set forth in the contract, the enrollee will not be
315 liable to the provider or preferred provider network for any sums
316 owed by the managed care organization or preferred provider
317 network;

318 (5) A provision that the preferred provider network shall include in
319 all contracts between the preferred provider network and participating
320 providers a provision that if the preferred provider network fails to
321 pay for health care services as set forth in the contract, for any reason,
322 the enrollee shall not be liable to the participating provider or
323 preferred provider network for any sums owed by the preferred
324 provider network or any sums owed by the managed care
325 organization because of nonpayment by the managed care
326 organization, insolvency of the managed care organization or breach of
327 contract between the managed care organization and the preferred
328 provider network;

329 (6) A provision requiring the preferred provider network to provide
330 information to the managed care organization, satisfactory to the
331 managed care organization, regarding the preferred provider
332 network's reserves for financial risk;

333 (7) A provision that (A) the preferred provider network or managed
334 care organization shall post and maintain a letter of credit, bond,
335 surety, reinsurance, reserve or other financial security acceptable to the
336 commissioner, in order to satisfy the risk accepted by the preferred
337 provider network pursuant to the contract, in an amount calculated in

338 accordance with subsection (i) of section 38a-479aa of the general
339 statutes, as amended by this act, (B) the managed care organization
340 shall determine who posts and maintains the security required under
341 subparagraph (A) of this subdivision, and (C) in the event of
342 insolvency or nonpayment, such security shall be used by the
343 preferred provider network, or other entity designated by the
344 commissioner, solely for the purpose of paying any outstanding
345 amounts owed participating providers, except that any remaining
346 security may be used for the purpose of reimbursing the managed care
347 organization for any payments made by the managed care
348 organization to participating providers on behalf of the preferred
349 provider network;

350 (8) A provision under which the managed care organization is
351 permitted, at the discretion of the managed care organization, to pay
352 participating providers directly and in lieu of the preferred provider
353 network in the event of insolvency or mismanagement by the
354 preferred provider network and that payments made pursuant to this
355 subdivision may be made or reimbursed from the security posted
356 pursuant to subsection (b) of this section;

357 (9) A provision transferring and assigning contracts between the
358 preferred provider network and participating providers to the
359 managed care organization for the provision of future services by
360 participating providers to enrollees, at the discretion of the managed
361 care organization, in the event the preferred provider network (A)
362 becomes insolvent, (B) otherwise ceases to conduct business, as
363 determined by the commissioner, or (C) demonstrates a pattern of
364 nonpayment of authorized claims, as determined by the commissioner,
365 for a period in excess of ninety days;

366 (10) A provision that each contract or agreement between the
367 preferred provider network and participating providers shall include a
368 provision transferring and assigning contracts between the preferred
369 provider network and participating providers to the managed care
370 organization for the provision of future health care services by

371 participating providers to enrollees, at the discretion of the managed
372 care organization, in the event the preferred provider network (A)
373 becomes insolvent, (B) otherwise ceases to conduct business, as
374 determined by the commissioner, or (C) demonstrates a pattern of
375 nonpayment of authorized claims, as determined by the commissioner,
376 for a period in excess of ninety days; and

377 (11) A provision that the preferred provider network shall pay for
378 the delivery of health care services and operate or maintain
379 arrangements or contracts with providers in a manner consistent with
380 the provisions of law that apply to the managed care organization's
381 contracts with enrollees and providers.

382 (12) A provision that the preferred provider network shall ensure
383 that utilization review determinations are made in accordance with
384 sections 38a-226 to 38a-226d, inclusive, of the general statutes, except
385 that any initial appeal of a determination not to certify an admission,
386 service, procedure or extension of stay shall be made in accordance
387 with subdivision (7) of subsection (a) of section 38a-226c of the general
388 statutes. In cases where an appeal to reverse a determination not to
389 certify is unsuccessful, the preferred provider network shall refer the
390 case to the managed care organization which shall conduct the
391 subsequent appeal, if any, in accordance with said subdivision.

392 (e) Each managed care organization that contracts with a preferred
393 provider network shall have adequate procedures in place to notify the
394 commissioner that a preferred provider network has experienced an
395 event that may threaten the preferred provider network's ability to
396 materially perform under its contract with the managed care
397 organization. The managed care organization shall provide such notice
398 to the commissioner not later than five days after it discovers that the
399 preferred provider network has experienced such an event.

400 (f) Each managed care organization that contracts with a preferred
401 provider network shall monitor and maintain systems and controls for
402 monitoring the financial health of the preferred provider networks

403 with which it contracts.

404 (g) Each managed care organization that contracts with a preferred
405 provider network shall provide to the commissioner, and update on an
406 annual basis, a contingency plan, satisfactory to the commissioner,
407 describing how health care services will be provided to enrollees if the
408 preferred provider network becomes insolvent or is mismanaged. The
409 contingency plan shall include a description of what contractual and
410 financial steps have been taken to ensure continuity of care to enrollees
411 if the preferred provider network becomes insolvent or is
412 mismanaged.

413 (h) Notwithstanding any agreement to the contrary, each managed
414 care organization shall retain full responsibility to its enrollees for
415 providing coverage for health care services pursuant to any applicable
416 managed care plan and any applicable state or federal law. Each
417 managed care organization shall exercise due diligence in its selection
418 and oversight of a preferred provider network.

419 (i) Notwithstanding any agreement to the contrary, each managed
420 care organization shall be able to demonstrate to the satisfaction of the
421 commissioner that the managed care organization can fulfill its
422 nontransferable obligations to provide coverage for the provision of
423 health care services to enrollees in the event of the failure, for any
424 reason, of a preferred provider network.

425 (j) Each managed care organization that contracts with a preferred
426 provider network shall provide that in the event of the failure, for any
427 reason, of a preferred provider network, the managed care
428 organization shall provide coverage for the enrollee to continue
429 covered treatment with the provider who treated the enrollee under
430 the preferred provider network contract regardless of whether the
431 provider participates in any plan operated by the managed care
432 organization. In the event of such failure, the managed care
433 organization shall continue coverage until the earlier of (1) the date the
434 enrollee's treatment is completed under a treatment plan that was

435 authorized and in effect on the date of the failure, or (2) the date the
436 contract between the enrollee and the managed care organization
437 terminates. The managed care organization shall compensate a
438 provider for such continued treatment at the rate due the provider
439 under the provider's contract with the failed preferred provider
440 network.

441 (k) Each managed care organization that contracts with a preferred
442 provider network shall confirm the information in the quarterly status
443 report submitted by the preferred provider network pursuant to
444 subdivision (2) of subsection (d) of this section and shall submit such
445 information to the commissioner, on such form as the commissioner
446 prescribes, not later than ten days after receiving a request from the
447 commissioner for such information.

448 (l) (1) Each managed care organization that contracts with a
449 preferred provider network shall certify annually to the commissioner,
450 on such form and in such manner as the commissioner prescribes, that
451 the managed care organization has reviewed the documentation
452 submitted by the preferred provider network pursuant to subdivision
453 (l) of subsection (d) of this section and has determined that the
454 preferred provider network maintains a provider network that is
455 adequate to ensure the delivery of health care services as set forth in
456 the contract. If the commissioner finds that the certification was not
457 submitted in good faith, the commissioner may deem the managed
458 care organization to have not complied with this subsection and may
459 take action pursuant to section 5 of this act.

460 (2) If the managed care organization determines that the preferred
461 provider network's provider network is not adequate and must be
462 increased, the managed care organization shall provide written notice
463 of the determination to the commissioner. Such notice shall describe
464 (1) any plan in place for the preferred provider network to increase its
465 provider network, and (2) the managed care organization's
466 contingency plan in the event the preferred provider network does not
467 satisfactorily increase its provider network.

468 (m) Nothing in section 38a-479aa of the general statutes, as
469 amended by this act, sections 2 to 7, inclusive, of this act, or part 1a of
470 chapter 700c of the general statutes, as amended by this act, shall be
471 construed to require a preferred provider network to share proprietary
472 information with a managed care organization concerning contracts or
473 financial arrangements with providers who are not included in that
474 managed care organization's network, or other preferred provider
475 networks or managed care organizations.

476 Sec. 3. (NEW) (*Effective October 1, 2003*) (a) Whenever a preferred
477 provider network is providing services pursuant to a contract with a
478 managed care organization, the preferred provider network may not
479 establish any terms, conditions or requirements for access, diagnosis or
480 treatment that are different than the terms, conditions or requirements
481 for access, diagnosis or treatment in the managed care organization's
482 plan, except that no preferred provider network shall be required to
483 provide an enrollee access to a provider who does not participate in
484 the preferred provider network unless the preferred provider network
485 is required to provide such access under its contract with the managed
486 care organization.

487 (b) Whenever a preferred provider network is providing services
488 pursuant to a contract with a managed care organization, the preferred
489 provider network shall pay for the delivery of health care services and
490 operate and maintain arrangements or contracts with providers in a
491 manner consistent with the provisions of law that apply to the
492 managed care organization's contracts with enrollees and providers.

493 Sec. 4. (NEW) (*Effective October 1, 2003*) Each preferred provider
494 network shall examine its outstanding amounts in each quarter and if
495 the preferred provider network determines that the outstanding
496 amounts in a quarter will exceed ninety-five per cent of the security
497 posted pursuant to subsection (i) of section 38a-479aa of the general
498 statutes, as amended by this act, the preferred provider network shall
499 mail a notice to each of its participating providers concerning the
500 status of incurred claims and shall send notice to each managed care

501 organization with which it contracts and the Insurance Commissioner
502 on such form as the commissioner prescribes. The commissioner shall
503 meet with the applicable managed care organization and preferred
504 provider network to ensure continued services to enrollees and
505 payment to providers.

506 Sec. 5. (NEW) (*Effective October 1, 2003*) (a) If the Insurance
507 Commissioner determines that a preferred provider network or
508 managed care organization, or both, has not complied with any
509 applicable provision of section 38a-479aa of the general statutes, as
510 amended by this act, sections 38a-226 to 38a-226d, inclusive, of the
511 general statutes, sections 38a-815 to 38a-819, inclusive, of the general
512 statutes or sections 2 to 7, inclusive, of this act, the commissioner may
513 (1) order the preferred provider network or managed care
514 organization, or both if both have not complied, to cease and desist all
515 operations in violation of said sections; (2) terminate or suspend the
516 preferred provider network's license; (3) institute a corrective action
517 against the preferred provider network or managed care organization,
518 or both if both have not complied; (4) order the payment of a civil
519 penalty by the preferred provider network or managed care
520 organization, or both if both have not complied, of not more than one
521 thousand dollars for each and every act or violation; (5) order the
522 payment of such reasonable expenses as may be necessary to
523 compensate the commissioner in conjunction with any proceedings
524 held to investigate or enforce violations of section 38a-479aa of the
525 general statutes, as amended by this act, sections 38a-226 to 38a-226d,
526 inclusive, of the general statutes, sections 38a-815 to 38a-819, inclusive,
527 of the general statutes or sections 2 to 7, inclusive, of this act; and (6)
528 use any of the commissioner's other enforcement powers to obtain
529 compliance with section 38a-479aa of the general statutes, as amended
530 by this act, sections 38a-226 to 38a-226d, inclusive, of the general
531 statutes, sections 38a-815 to 38a-819, inclusive, of the general statutes
532 or sections 2 to 7, inclusive, of this act. The commissioner may hold a
533 hearing concerning any matter governed by section 38a-479aa of the
534 general statutes, as amended by this act, sections 38a-226 to 38a-226d,

535 inclusive, of the general statutes, sections 38a-815 to 38a-819, inclusive,
536 of the general statutes or sections 2 to 7, inclusive, of this act, in
537 accordance with section 38a-16 of the general statutes. Subject to the
538 same confidentiality and liability protections set forth in subsections
539 (c) and (k) of section 38a-14 of the general statutes, the commissioner
540 may engage the services of attorneys, appraisers, independent
541 actuaries, independent certified public accountants or other
542 professionals and specialists to assist the commissioner in conducting
543 an investigation under this section, the cost of which shall be borne by
544 the managed care organization or preferred provider network, or both,
545 that is the subject of the investigation.

546 (b) If a preferred provider network fails to comply with any
547 applicable provision of section 38a-479aa of the general statutes, as
548 amended by this act, sections 38a-226 to 38a-226d, inclusive, of the
549 general statutes, sections 38a-815 to 38a-819, inclusive, of the general
550 statutes or sections 2 to 7, inclusive, of this act, the commissioner may
551 assign or require the preferred provider network to assign its rights
552 and obligations under any contract with participating providers in
553 order to ensure that covered benefits are provided.

554 (c) The commissioner shall receive and investigate (1) any grievance
555 filed against a preferred provider network or managed care
556 organization, or both, by an enrollee or an enrollee's designee
557 concerning matters governed by section 38a-479aa of the general
558 statutes, as amended by this act, sections 38a-226 to 38a-226d,
559 inclusive, of the general statutes, sections 38a-815 to 38a-819, inclusive,
560 of the general statutes or sections 2 to 7, inclusive, of this act, or (2) any
561 referral from the Office of Managed Care Ombudsman pursuant to
562 section 38a-1041 of the general statutes, as amended by this act. The
563 commissioner shall code, track and review such grievances and
564 referrals. The preferred provider network or managed care
565 organization, or both, shall provide the commissioner with all
566 information necessary for the commissioner to investigate such
567 grievances and referrals. The information collected by the
568 commissioner pursuant to this section shall be maintained as

569 confidential and shall not be disclosed to any person except (A) to the
570 extent necessary to carry out the purposes of section 38a-479aa of the
571 general statutes, as amended by this act, sections 38a-226 to 38a-226d,
572 inclusive, of the general statutes, sections 38a-815 to 38a-819, inclusive,
573 of the general statutes and sections 2 to 7, inclusive, of this act, (B) as
574 allowed under title 38a of the general statutes, (C) to the Managed
575 Care Ombudsman and (D) information concerning the nature of any
576 grievance or referral and the commissioner's final determination shall
577 be a public record, as defined in section 1-200 of the general statutes,
578 provided no personal information, as defined in section 38a-975 of the
579 general statutes, shall be disclosed. The commissioner shall report to
580 the Managed Care Ombudsman on the resolution of any matter
581 referred to the commissioner by the Managed Care Ombudsman.

582 Sec. 6. (NEW) (*Effective October 1, 2003*) No health insurer, health
583 care center, utilization review company, as defined in section 38a-226
584 of the general statutes, or preferred provider network, as defined in
585 section 38a-479aa of the general statutes, as amended by this act, shall
586 take or threaten to take any adverse personnel or coverage-related
587 action against any enrollee, provider or employee in retaliation for
588 such enrollee, provider or employee (1) filing a complaint with the
589 Insurance Commissioner or the Office of Managed Care Ombudsman,
590 or (2) disclosing information to the Insurance Commissioner
591 concerning any violation of section 38a-479aa of the general statutes, as
592 amended by this act, sections 38a-226 to 38a-226d, inclusive, of the
593 general statutes, sections 38a-815 to 38a-819, inclusive, of the general
594 statutes or sections 2 to 7, inclusive, of this act, unless such disclosure
595 violates the provisions of chapter 705 of the general statutes or the
596 privacy provisions of the federal Health Insurance Portability and
597 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from
598 time to time, or regulations adopted thereunder. Any enrollee,
599 provider or employee who is aggrieved by a violation of this section
600 may bring a civil action in the superior court to recover damages and
601 attorneys' fees and costs.

602 Sec. 7. (NEW) (*Effective October 1, 2003*) The Insurance

603 Commissioner may adopt regulations, in accordance with chapter 54
604 of the general statutes, to implement the provisions of section 38a-
605 479aa of the general statutes, as amended by this act, and sections 2 to
606 6, inclusive, of this act.

607 Sec. 8. Section 38a-1041 of the general statutes is repealed and the
608 following is substituted in lieu thereof (*Effective October 1, 2003*):

609 (a) There is established an Office of Managed Care Ombudsman
610 which shall be within the Insurance Department for administrative
611 purposes only.

612 (b) The Office of Managed Care Ombudsman may:

613 (1) Assist health insurance consumers with managed care plan
614 selection by providing information, referral and assistance to
615 individuals about means of obtaining health insurance coverage and
616 services;

617 (2) Assist health insurance consumers to understand their rights and
618 responsibilities under managed care plans;

619 (3) Provide information to the public, agencies, legislators and
620 others regarding problems and concerns of health insurance
621 consumers and make recommendations for resolving those problems
622 and concerns;

623 (4) Assist consumers with the filing of complaints and appeals,
624 including filing appeals with a managed care organization's internal
625 appeal or grievance process and the external appeal process
626 established under section 38a-478n;

627 (5) Analyze and monitor the development and implementation of
628 federal, state and local laws, regulations and policies relating to health
629 insurance consumers and recommend changes it deems necessary;

630 (6) Facilitate public comment on laws, regulations and policies,
631 including policies and actions of health insurers;

632 (7) Ensure that health insurance consumers have timely access to the
633 services provided by the office;

634 (8) Review the health insurance records of a consumer who has
635 provided written consent for such review;

636 (9) Create and make available to employers a notice, suitable for
637 posting in the workplace, concerning the services that the Managed
638 Care Ombudsman provides;

639 (10) Establish a toll-free number, or any other free calling option, to
640 allow customer access to the services provided by the Managed Care
641 Ombudsman;

642 (11) Pursue administrative remedies on behalf of and with the
643 consent of any health insurance consumers;

644 (12) Adopt regulations, pursuant to chapter 54, to carry out the
645 provisions of sections 38a-1040 to 38a-1050, inclusive; and

646 (13) Take any other actions necessary to fulfill the purposes of
647 sections 38a-1040 to 38a-1050, inclusive.

648 (c) The Office of Managed Care Ombudsman shall make a referral
649 to the Insurance Commissioner if the Managed Care Ombudsman
650 finds that a preferred provider network may have engaged in a pattern
651 or practice that may be in violation of section 38a-479aa, as amended
652 by this act, sections 38a-226 to 38a-226d, inclusive, sections 38a-815 to
653 38a-819, inclusive, or sections 2 to 7, inclusive, of this act.

654 (d) The Managed Care Ombudsman and the Insurance
655 Commissioner shall jointly compile a list of complaints received
656 against managed care organizations and preferred provider networks
657 and the commissioner shall maintain the list, except the names of
658 complainants shall not be disclosed if such disclosure would violate
659 the provisions of section 4-61dd or 38a-1045.

660 Sec. 9. Subsection (a) of section 38a-11 of the general statutes is

661 repealed and the following is substituted in lieu thereof (*Effective*
662 *October 1, 2003*):

663 (a) The commissioner shall demand and receive the following fees:
664 (1) For the annual fee for each license issued to a domestic insurance
665 company, one hundred dollars; (2) for receiving and filing annual
666 reports of domestic insurance companies, twenty-five dollars; (3) for
667 filing all documents prerequisite to the issuance of a license to an
668 insurance company, one hundred seventy-five dollars, except that the
669 fee for such filings by any health care center, as defined in section 38a-
670 175, shall be one thousand one hundred dollars; (4) for filing any
671 additional paper required by law, fifteen dollars; (5) for each certificate
672 of valuation, organization, reciprocity or compliance, twenty dollars;
673 (6) for each certified copy of a license to a company, twenty dollars; (7)
674 for each certified copy of a report or certificate of condition of a
675 company to be filed in any other state, twenty dollars; (8) for
676 amending a certificate of authority, one hundred dollars; (9) for each
677 license issued to a rating organization, one hundred dollars. In
678 addition, insurance companies shall pay any fees imposed under
679 section 12-211; (10) a filing fee of twenty-five dollars for each initial
680 application for a license made pursuant to section 38a-769; (11) with
681 respect to insurance agents appointments: (A) A filing fee of twenty-
682 five dollars for each request for any agent appointment; (B) a fee of
683 forty dollars for each appointment issued to an agent of a domestic
684 insurance company or for each appointment continued; and (C) a fee
685 of twenty dollars for each appointment issued to an agent of any other
686 insurance company or for each appointment continued, except that no
687 fee shall be payable for an appointment issued to an agent of an
688 insurance company domiciled in a state or foreign country which does
689 not require any fee for an appointment issued to an agent of a
690 Connecticut insurance company; (12) with respect to insurance
691 producers: (A) An examination fee of seven dollars for each
692 examination taken, except when a testing service is used, the testing
693 service shall pay a fee of seven dollars to the commissioner for each
694 examination taken by an applicant; (B) a fee of forty dollars for each

695 license issued; and (C) a fee of forty dollars for each license renewed;
696 (13) with respect to public adjusters: (A) An examination fee of seven
697 dollars for each examination taken, except when a testing service is
698 used, the testing service shall pay a fee of seven dollars to the
699 commissioner for each examination taken by an applicant; and (B) a fee
700 of one hundred twenty-five dollars for each license issued or renewed;
701 (14) with respect to casualty adjusters: (A) An examination fee of ten
702 dollars for each examination taken, except when a testing service is
703 used, the testing service shall pay a fee of ten dollars to the
704 commissioner for each examination taken by an applicant; (B) a fee of
705 forty dollars for each license issued or renewed; and (C) the expense of
706 any examination administered outside the state shall be the
707 responsibility of the entity making the request and such entity shall
708 pay to the commissioner one hundred dollars for such examination
709 and the actual traveling expenses of the examination administrator to
710 administer such examination; (15) with respect to motor vehicle
711 physical damage appraisers: (A) An examination fee of forty dollars
712 for each examination taken, except when a testing service is used, the
713 testing service shall pay a fee of forty dollars to the commissioner for
714 each examination taken by an applicant; (B) a fee of forty dollars for
715 each license issued or renewed; and (C) the expense of any
716 examination administered outside the state shall be the responsibility
717 of the entity making the request and such entity shall pay to the
718 commissioner one hundred dollars for such examination and the
719 actual traveling expenses of the examination administrator to
720 administer such examination; (16) with respect to certified insurance
721 consultants: (A) An examination fee of thirteen dollars for each
722 examination taken, except when a testing service is used, the testing
723 service shall pay a fee of thirteen dollars to the commissioner for each
724 examination taken by an applicant; (B) a fee of two hundred dollars for
725 each license issued; and (C) a fee of one hundred twenty-five dollars
726 for each license renewed; (17) with respect to surplus lines brokers: (A)
727 An examination fee of ten dollars for each examination taken, except
728 when a testing service is used, the testing service shall pay a fee of ten
729 dollars to the commissioner for each examination taken by an

730 applicant; and (B) a fee of five hundred dollars for each license issued
731 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
732 for each license issued or renewed; (19) a fee of thirteen dollars for
733 each license certificate requested, whether or not a license has been
734 issued; (20) with respect to domestic and foreign benefit societies shall
735 pay: (A) For service of process, twenty-five dollars for each person or
736 insurer to be served; (B) for filing a certified copy of its charter or
737 articles of association, five dollars; (C) for filing the annual report, ten
738 dollars; and (D) for filing any additional paper required by law, three
739 dollars; (21) with respect to foreign benefit societies: (A) For each
740 certificate of organization or compliance, four dollars; (B) for each
741 certified copy of permit, two dollars; and (C) for each copy of a report
742 or certificate of condition of a society to be filed in any other state, four
743 dollars; (22) with respect to reinsurance intermediaries: A fee of five
744 hundred dollars for each license issued or renewed; (23) with respect
745 to viatical settlement providers: (A) A filing fee of thirteen dollars for
746 each initial application for a license made pursuant to section 38a-465a;
747 and (B) a fee of twenty dollars for each license issued or renewed; (24)
748 with respect to viatical settlement brokers: (A) A filing fee of thirteen
749 dollars for each initial application for a license made pursuant to
750 section 38a-465a; and (B) a fee of twenty dollars for each license issued
751 or renewed; (25) with respect to preferred provider networks, a fee of
752 two thousand five hundred dollars for each license issued or renewed;
753 (26) with respect to rental companies, as defined in section 38a-799, a
754 fee of forty dollars for each permit issued or renewed; and [(26)] (27)
755 with respect to each duplicate license issued a fee of twenty-five
756 dollars for each license issued.

757 Sec. 10. Section 38a-478 of the general statutes is repealed and the
758 following is substituted in lieu thereof (*Effective October 1, 2003*):

759 As used in sections 38a-478 to 38a-478o, inclusive, and subsection (a)
760 of section 38a-478s:

761 (1) "Commissioner" means the Insurance Commissioner.

762 (2) "Managed care organization" means an insurer, health care
763 center, hospital or medical service corporation or other organization
764 delivering, issuing for delivery, renewing or amending any individual
765 or group health managed care plan in this state.

766 (3) "Managed care plan" means a product offered by a managed care
767 organization that provides for the financing or delivery of health care
768 services to persons enrolled in the plan through: (A) Arrangements
769 with selected providers to furnish health care services; (B) explicit
770 standards for the selection of participating providers; (C) financial
771 incentives for enrollees to use the participating providers and
772 procedures provided for by the plan; or (D) arrangements that share
773 risks with providers, provided the organization offering a plan
774 described under subparagraph (A), (B), (C) or (D) of this subdivision is
775 licensed by the Insurance Department pursuant to chapter 698, 698a or
776 700 and that the plan includes utilization review pursuant to sections
777 38a-226 to 38a-226d, inclusive.

778 (4) "Provider" means a person licensed to provide health care
779 services under chapters 370 to 373, inclusive, 375 to 383b, inclusive,
780 384a to 384c, inclusive, or chapter 400j.

781 (5) "Enrollee" means a person who has contracted for or who
782 participates in a managed care plan for himself or his eligible
783 dependents.

784 (6) "Preferred provider network" means a preferred provider
785 network, as defined in section 38a-479aa, as amended by this act.

786 (7) "Utilization review" means utilization review, as defined in
787 section 38a-226.

788 (8) "Utilization review company" means a utilization review
789 company, as defined in section 38a-226.

790 Sec. 11. Section 38a-478a of the general statutes is repealed and the
791 following is substituted in lieu thereof (*Effective October 1, 2003*):

792 On March 1, 1999, and annually thereafter, the Insurance
793 Commissioner shall submit a report, to the Governor and to the joint
794 standing committees of the General Assembly having cognizance of
795 matters relating to public health and relating to insurance, concerning
796 the commissioner's responsibilities under the provisions of sections
797 38a-226 to 38a-226d, inclusive, 38a-478 to 38a-478u, inclusive, as
798 amended by this act, 38a-479aa, as amended by this act, and 38a-993.
799 The report shall include: (1) A summary of the quality assurance plans
800 submitted by managed care organizations pursuant to section 38a-
801 478c, as amended by this act, along with suggested changes to improve
802 such plans; (2) suggested modifications to the consumer report card
803 developed under the provisions of section 38a-478l; (3) a summary of
804 the commissioner's procedures and activities in conducting market
805 conduct examinations of utilization review companies and preferred
806 provider networks, including, but not limited to: (A) The number of
807 desk and field audits completed during the previous calendar year; (B)
808 a summary of findings of the desk and field audits, including any
809 recommendations made for improvements or modifications; (C) a
810 description of complaints concerning managed care companies, and
811 any preferred provider network that provides services to enrollees on
812 behalf of the managed care organization, including a summary and
813 analysis of any trends or similarities found in the managed care
814 complaints filed by enrollees; (4) a summary of the complaints
815 received by the Insurance Department's Consumer Affairs Division
816 and the commissioner under section 38a-478n, including a summary
817 and analysis of any trends or similarities found in the complaints
818 received; (5) a summary of any violations the commissioner has found
819 against any managed care organization or any preferred provider
820 network that provides services to enrollees on behalf of the managed
821 care organization; and (6) a summary of the issues discussed related to
822 health care or managed care organizations at the Insurance
823 Department's quarterly forums throughout the state.

824 Sec. 12. Section 38a-478c of the general statutes is repealed and the
825 following is substituted in lieu thereof (*Effective October 1, 2003*):

826 (a) On or before May 1, 1998, and annually thereafter, each managed
827 care organization shall submit to the commissioner:

828 (1) A report on its quality assurance plan that includes, but is not
829 limited to, information on complaints related to providers and quality
830 of care, on decisions related to patient requests for coverage and on
831 prior authorization statistics. Statistical information shall be submitted
832 in a manner permitting comparison across plans and shall include, but
833 not be limited to: (A) The ratio of the number of complaints received to
834 the number of enrollees; (B) a summary of the complaints received
835 related to providers and delivery of care or services and the action
836 taken on the complaint; (C) the ratio of the number of prior
837 authorizations denied to the number of prior authorizations requested;
838 (D) the number of [managed care organization's] utilization review
839 determinations made by or on behalf of a managed care organization
840 not to certify an admission, service, procedure or extension of stay, and
841 the denials upheld and reversed on appeal within the managed care
842 organization's utilization review procedure; (E) the percentage of those
843 employers or groups that renew their contracts within the previous
844 twelve months; and (F) notwithstanding the provisions of this
845 subsection, on or before July 1, 1998, and annually thereafter, all data
846 required by the National Committee for Quality Assurance (NCQA)
847 for its Health Plan Employer Data and Information Set (HEDIS). If an
848 organization does not provide information for the National Committee
849 for Quality Assurance for its Health Plan Employer Data and
850 Information Set, then it shall provide such other equivalent data as the
851 commissioner may require by regulations adopted in accordance with
852 the provisions of chapter 54. The commissioner shall find that the
853 requirements of this subdivision have been met if the managed care
854 plan has received a one-year or higher level of accreditation by the
855 National Committee for Quality Assurance and has submitted the
856 Health Plan Employee Data Information Set data required by
857 subparagraph (F) of this subdivision.

858 (2) A model contract that contains the provisions currently in force
859 in contracts between the managed care organization and preferred

860 provider networks in this state, and the managed care organization
861 and participating providers in this state and, upon the commissioner's
862 request, a copy of any individual contracts between such parties,
863 provided the contract may withhold or redact proprietary fee schedule
864 information.

865 (3) A written statement of the types of financial arrangements or
866 contractual provisions that the managed care organization has with
867 hospitals, utilization review companies, physicians, preferred provider
868 networks and any other health care providers including, but not
869 limited to, compensation based on a fee-for-service arrangement, a
870 risk-sharing arrangement or a capitated risk arrangement.

871 (4) Such information as the commissioner deems necessary to
872 complete the consumer report card [he is] required [to develop and
873 distribute] pursuant to section 38a-478l. Such information may include,
874 but need not be limited to: (A) The organization's characteristics,
875 including its model, its profit or nonprofit status, its address and
876 telephone number, the length of time it has been licensed in this and
877 any other state, its number of enrollees and whether it has received
878 any national or regional accreditation; (B) a summary of the
879 information required by subdivision (3) of this section, including any
880 change in a plan's rates over the prior three years, its medical loss ratio
881 or percentage of the total premium revenues spent on medical care
882 compared to administrative costs and plan marketing, how it
883 compensates health care providers and its premium level; (C) a
884 description of services, the number of primary care physicians and
885 specialists, the number and nature of participating preferred provider
886 networks and the distribution and [the] number of hospitals, by
887 county; (D) utilization review information, including the name or
888 source of any established medical protocols and the utilization review
889 standards; (E) medical management information, including the
890 provider-to-patient ratio by primary care provider and speciality care
891 provider, the percentage of primary and speciality care providers who
892 are board certified, and how the medical protocols incorporate input as

893 required in section 38a-478e; (F) the quality assurance information
 894 required to be submitted under the provisions of subdivision (1) of
 895 subsection (a) of this section; (G) the status of the organization's
 896 compliance with the reporting requirements of this section; (H)
 897 whether the organization markets to individuals and Medicare
 898 recipients; (I) the number of hospital days per thousand enrollees; and
 899 (J) the average length of hospital stays for specific procedures, as may
 900 be requested by the commissioner.

901 (5) A summary of the procedures used by managed care
 902 organizations to credential providers.

903 (b) The information required pursuant to subsection (a) of this
 904 section shall be consistent with the data required by the National
 905 Committee for Quality Assurance (NCQA) for its Health Plan
 906 Employer Data and Information Set (HEDIS).

907 (c) The commissioner may accept electronic filing for any of the
 908 requirements under this section.

909 (d) No managed care organization shall be liable for a claim arising
 910 out of the submission of any information concerning complaints
 911 concerning providers, provided the managed care organization
 912 submitted the information in good faith."

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>May 1, 2004</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>
Sec. 7	<i>October 1, 2003</i>
Sec. 8	<i>October 1, 2003</i>
Sec. 9	<i>October 1, 2003</i>
Sec. 10	<i>October 1, 2003</i>
Sec. 11	<i>October 1, 2003</i>

Sec. 12	October 1, 2003
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