



General Assembly

Raised Bill No. 5467

February Session, 2004

LCO No. 1752

* _____HB05467INS__030904_____*

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

**AN ACT CONCERNING DISCLOSURE OF PARTICIPATING AND
NONPARTICIPATING PROVIDER REIMBURSEMENT UNDER
MANAGED CARE PLANS.**

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

1 Section 1. Section 38a-478g of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective October 1, 2004*):

3 (a) Each managed care contract delivered, issued for delivery,
4 renewed, amended or continued in this state on or after October 1,
5 1997, shall be in writing and a copy thereof furnished to the group
6 contract holder or individual contract holder, as appropriate. Each
7 such contract shall contain the following provisions: (1) Name and
8 address of the managed care organization; (2) eligibility requirements;
9 (3) a statement of copayments, deductibles or other out-of-pocket
10 expenses the enrollee must pay; (4) a statement of the nature of the
11 health care services, benefits or coverages to be furnished and the
12 period during which they will be furnished and, if there are any
13 services, benefits or coverages to be excepted, a detailed statement of
14 such exceptions; (5) a statement of terms and conditions upon which
15 the contract may be cancelled or otherwise terminated at the option of

16 either party; (6) claims procedures; (7) enrollee grievance procedures;
17 (8) continuation of coverage; (9) conversion; (10) extension of benefits,
18 if any; (11) subrogation, if any; (12) description of the service area, and
19 out-of-area benefits and services, if any; (13) a statement of the amount
20 the enrollee or others on his behalf must pay to the managed care
21 organization and the manner in which such amount is payable; (14) a
22 statement that the contract includes the endorsement thereon and
23 attached papers, if any, and contains the entire contract; (15) a
24 statement that no statement by the enrollee in his application for a
25 contract shall void the contract or be used in any legal proceeding
26 thereunder, unless such application or an exact copy thereof is
27 included in or attached to such contract; and (16) a statement of the
28 grace period for making any payment due under the contract, which
29 shall not be less than ten days. The commissioner may waive the
30 requirements of this subsection for any managed care organization
31 subject to the provisions of section 38a-182.

32 (b) Each managed care organization shall provide [every] each
33 enrollee with a plan description. The plan description shall be in plain
34 language as commonly used by the enrollees and consistent with
35 chapter 699a. The plan description shall also be made available to each
36 enrollee and potential enrollee prior to the enrollee's entering into the
37 contract and during any open enrollment period. The plan description
38 shall not contain provisions or statements that are inconsistent with the
39 plan's medical protocols. The plan description shall contain:

40 (1) A clear summary of the provisions set forth in subdivisions (1) to
41 (12), inclusive, of subsection (a) of this section, subdivision (3) of
42 subsection (a) of section 38a-478c, as amended, and sections 38a-478j to
43 38a-478l, inclusive;

44 (2) A statement of the number of managed care organization's
45 utilization review determinations not to certify an admission, service,
46 procedure or extension of stay, and the denials upheld and reversed on
47 appeal within the managed care organization's utilization review

48 procedure;

49 (3) A description of emergency services, the appropriate use of
50 emergency services, including to the use of E 9-1-1 telephone systems,
51 any cost sharing applicable to emergency services and the location of
52 emergency departments and other settings in which participating
53 physicians and hospitals provide emergency services and post
54 stabilization care;

55 (4) Coverage of the plans, including exclusions of specific
56 conditions, ailments or disorders;

57 (5) The use of drug formularies or any limits on the availability of
58 prescription drugs and the procedure for obtaining information on the
59 availability of specific drugs covered;

60 (6) The number, types and specialties and geographic distribution of
61 direct health care providers;

62 (7) Participating and nonparticipating provider reimbursement
63 [procedure] procedures, including, but not limited to, the information
64 and procedures used in calculating and adjusting provider
65 reimbursement;

66 (8) Preauthorization and utilization review requirements and
67 procedures, internal grievance procedures and internal and external
68 complaint procedures;

69 (9) The medical loss ratio, or percentage of total premium revenue
70 spent on medical care compared to administrative costs and plan
71 marketing;

72 (10) The plan's for-profit, nonprofit incorporation and ownership
73 status;

74 (11) Telephone numbers for obtaining further information,
75 including the procedure for enrollees to contact the organization

76 concerning coverage and benefits, claims grievance and complaint
77 procedures after normal business hours;

78 (12) How notification is provided to an enrollee when the plan is no
79 longer contracting with an enrollee's primary care provider;

80 (13) The procedures for obtaining referrals to specialists or for
81 consulting a physician other than the primary care physician;

82 (14) The status of the National Committee for Quality Assurance
83 (NCQA) accreditation;

84 (15) Enrollee satisfaction information; and

85 (16) Procedures for protecting the confidentiality of medical records
86 and other patient information.

This act shall take effect as follows:	
Section 1	<i>October 1, 2004</i>

INS *Joint Favorable*