



General Assembly

February Session, 2004

Amendment

LCO No. 4363

SB0010804363SD0

Offered by:
SEN. CRISCO, 17th Dist.

To: Subst. Senate Bill No. 108

File No. 78

Cal. No. 109

**"AN ACT CONCERNING APPEALS OF HEALTH CARE
DETERMINATIONS MADE TO THE INSURANCE COMMISSIONER."**

1 Strike lines 67 to 86, inclusive, in their entirety and substitute the
2 following in lieu thereof:

3 "(d) (1) Not later than five business days after receiving a written
4 request from the commissioner, enrollee or any provider acting on
5 behalf of an enrollee with the enrollee's consent, a managed care
6 organization whose enrollee is the subject of an appeal shall provide to
7 the commissioner, enrollee or any provider acting on behalf of an
8 enrollee with the enrollee's consent, written verification of whether the
9 enrollee's managed care plan is fully insured, self-funded, or otherwise
10 funded. If the plan is a fully insured plan or a self-insured
11 governmental plan, the managed care organization shall send: (A)
12 Written certification to the commissioner or reviewing entity, as
13 determined by the commissioner, that the benefit or service subject to
14 the appeal is a covered benefit or service; (B) a copy of the entire policy
15 or contract between the enrollee and the managed care organization,

16 except that with respect to a self-insured governmental plan, (i) the
17 managed care organization shall notify the plan sponsor, and (ii) the
18 plan sponsor shall send, or require the managed care organization to
19 send, such copy; or (C) written certification that the policy or contract
20 is accessible to the review entity electronically and clear and simple
21 instructions on how to electronically access the policy.

22 (2) Failure of the managed care organization to provide information
23 or notify the plan sponsor in accordance with subdivision (1) of this
24 subsection within said five-business-day period or before the
25 expiration of the thirty-day period for appeals set forth in subdivision
26 (1) of subsection (b) of this section, whichever is later as determined by
27 the commissioner, shall (A) create a presumption on the review entity,
28 solely for purposes of accepting an appeal and conducting the review
29 pursuant to subdivision (4) of subsection (b) of this section, that the
30 benefit or service is a covered benefit under the applicable policy or
31 contract, except that such presumption shall not be construed as
32 creating or authorizing benefits or services in excess of those that are
33 provided for in the enrollee's policy or contract, and (B) entitle the
34 commissioner to require the managed care organization from whom
35 the enrollee is appealing a medical necessity determination to
36 reimburse the department for the expenses related to the appeal,
37 including, but not limited to, expenses incurred by the review entity."