



General Assembly

February Session, 2004

Amendment

LCO No. 3720

SB0010803720SD0

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: (A) (i) Written certification to the
9 commissioner or reviewing entity, as determined by the commissioner,
10 that the benefit or service subject to the appeal is a covered benefit or
11 service; (ii) a copy of the entire policy or contract between the enrollee
12 and the managed care organization; or (iii) written certification by the
13 managed care organization that the policy or contract is accessible to
14 the review entity electronically and clear and simple instructions on
15 how to electronically access the policy; and (B) written verification of

16 whether the enrollee's managed care plan is fully insured, self-funded
17 or otherwise funded.

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