



Senate

General Assembly

File No. 401

January Session, 2005

Substitute Senate Bill No. 1205

Senate, April 19, 2005

The Committee on Public Health reported through SEN. MURPHY of the 16th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING APPEALS OF DENIALS OR DETERMINATIONS BY MANAGED CARE ORGANIZATIONS.

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

1 Section 1. Subdivision (1) of subsection (b) of section 38a-478n of the
2 general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective October 1, 2005*):

4 (b) (1) To appeal a denial or determination pursuant to this section
5 an enrollee or any provider acting on behalf of an enrollee shall, not
6 later than thirty days after receiving final written notice of the denial
7 or determination from the enrollee's managed care organization or
8 utilization review company, file a written request with the
9 commissioner. The appeal shall be on forms prescribed by the
10 commissioner and shall include the filing fee set forth in subdivision
11 (2) of this subsection and a general release executed by the enrollee for
12 all medical records pertinent to the appeal. The managed care
13 organization or utilization review company named in the appeal shall

14 also pay to the commissioner the filing fee set forth in subdivision (2)
15 of this subsection. If the Insurance Commissioner receives three or
16 more appeals of denials or determinations by the same managed care
17 organization or utilization review company with respect to the same
18 procedural or diagnostic coding, the Insurance Commissioner may, on
19 said commissioner's own motion, issue an order specifying how such
20 managed care organization or utilization review company shall make
21 determinations about such procedural or diagnostic coding.

22 Sec. 2. Subsection (e) of section 17b-427 of the general statutes is
23 repealed and the following is substituted in lieu thereof (*Effective*
24 *October 1, 2005*):

25 (e) Not later than June 1, 2001, and annually thereafter, the
26 Insurance Commissioner, in conjunction with the [Managed Care
27 Ombudsman] Health Care Advocate, shall submit to the Governor and
28 to the joint standing committees of the General Assembly having
29 cognizance of matters relating to human services and insurance and to
30 the select committee of the General Assembly having cognizance of
31 matters relating to aging, a list of those Medicare organizations that
32 have failed to file any data, reports or information requested pursuant
33 to subsection (c) of this section.

34 Sec. 3. Section 38a-47 of the general statutes is repealed and the
35 following is substituted in lieu thereof (*Effective October 1, 2005*):

36 All domestic insurance companies and other domestic entities
37 subject to taxation under chapter 207 shall, in accordance with section
38 38a-48, as amended by this act, annually pay to the Insurance
39 Commissioner, for deposit in the Insurance Fund established under
40 section 38a-52a, an amount equal to the actual expenditures made by
41 the Insurance Department during each fiscal year, and the actual
42 expenditures made by the Office of the [Managed Care Ombudsman]
43 Health Care Advocate, including the cost of fringe benefits for
44 department and office personnel as estimated by the Comptroller, plus
45 the expenditures made on behalf of the department and the office from
46 the Capital Equipment Purchase Fund pursuant to section 4a-9 for

47 such year, but excluding expenditures paid for by fraternal benefit
48 societies, foreign and alien insurance companies and other foreign and
49 alien entities under sections 38a-49 and 38a-50. Payments shall be
50 made by assessment of all such domestic insurance companies and
51 other domestic entities calculated and collected in accordance with the
52 provisions of section 38a-48, as amended by this act. Any such
53 domestic insurance company or other domestic entity aggrieved
54 because of any assessment levied under this section may appeal
55 therefrom in accordance with the provisions of section 38a-52.

56 Sec. 4. Section 38a-48 of the general statutes is repealed and the
57 following is substituted in lieu thereof (*Effective October 1, 2005*):

58 (a) On or before June thirtieth, annually, the Commissioner of
59 Revenue Services shall render to the Insurance Commissioner a
60 statement certifying the amount of taxes or charges imposed on each
61 domestic insurance company or other domestic entity under chapter
62 207 on business done in this state during the preceding calendar year;
63 the statement for local domestic insurance companies shall set forth the
64 amount of taxes and charges before any tax credits allowed as
65 provided in section 12-202.

66 (b) On or before July thirty-first, annually, the Insurance
67 Commissioner and the Office of the [Managed Care Ombudsman]
68 Health Care Advocate shall render to each domestic insurance
69 company or other domestic entity liable for payment under section
70 38a-47, as amended by this act, (1) a statement which includes the
71 amount appropriated to the Insurance Department and the Office of
72 the [Managed Care Ombudsman] Health Care Advocate for the fiscal
73 year beginning July first of the same year, the cost of fringe benefits for
74 department and office personnel for such year, as estimated by the
75 Comptroller, and the estimated expenditures on behalf of the
76 department and the office from the Capital Equipment Purchase Fund
77 pursuant to section 4a-9 for such year, (2) a statement of the total taxes
78 imposed on all domestic insurance companies and domestic insurance
79 entities under chapter 207 on business done in this state during the

80 preceding calendar year, and (3) the proposed assessment against that
81 company or entity, calculated in accordance with the provisions of
82 subsection (c) of this section, provided that for the purposes of this
83 calculation the amount appropriated to the Insurance Department and
84 the Office of the [Managed Care Ombudsman] Health Care Advocate
85 plus the cost of fringe benefits for department and office personnel and
86 the estimated expenditures on behalf of the department and the office
87 from the Capital Equipment Purchase Fund pursuant to section 4a-9
88 shall be deemed to be the actual expenditures of the department and
89 the office.

90 (c) (1) The proposed assessments for each domestic insurance
91 company or other domestic entity shall be calculated by (A) allocating
92 twenty per cent of the amount to be paid under section 38a-47, as
93 amended by this act, among the domestic entities organized under
94 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,
95 in proportion to their respective shares of the total taxes and charges
96 imposed under chapter 207 on such entities on business done in this
97 state during the preceding calendar year, and (B) allocating eighty per
98 cent of the amount to be paid under section 38a-47, as amended by this
99 act, among all domestic insurance companies and domestic entities
100 other than those organized under sections 38a-199 to 38a-209,
101 inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their
102 respective shares of the total taxes and charges imposed under chapter
103 207 on such domestic insurance companies and domestic entities on
104 business done in this state during the preceding calendar year,
105 provided if there are no domestic entities organized under sections
106 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the
107 time of assessment, one hundred per cent of the amount to be paid
108 under section 38a-47, as amended by this act, shall be allocated among
109 such domestic insurance companies and domestic entities. (2) When
110 the amount any such company or entity is assessed pursuant to this
111 section exceeds twenty-five per cent of the actual expenditures of the
112 Insurance Department and the Office of the [Managed Care
113 Ombudsman] Health Care Advocate, such excess amount shall not be
114 paid by such company or entity but rather shall be assessed against

115 and paid by all other such companies and entities in proportion to
116 their respective shares of the total taxes and charges imposed under
117 chapter 207 on business done in this state during the preceding
118 calendar year. The provisions of this subdivision shall not be
119 applicable to any corporation which has converted to a domestic
120 mutual insurance company pursuant to section 38a-155 upon the
121 effective date of any public act which amends said section to modify or
122 remove any restriction on the business such a company may engage in,
123 for purposes of any assessment due from such company on and after
124 such effective date.

125 (d) For purposes of calculating the amount of payment under
126 section 38a-47, as amended by this act, as well as the amount of the
127 assessments under this section, the "total taxes imposed on all
128 domestic insurance companies and other domestic entities under
129 chapter 207" shall be based upon the amounts shown as payable to the
130 state for the calendar year on the returns filed with the Commissioner
131 of Revenue Services pursuant to chapter 207; with respect to
132 calculating the amount of payment and assessment for local domestic
133 insurance companies, the amount used shall be the taxes and charges
134 imposed before any tax credits allowed as provided in section 12-202.

135 (e) On or before September thirtieth, annually, for each fiscal year
136 ending prior to July 1, 1990, the Insurance Commissioner and the
137 [Managed Care Ombudsman] Health Care Advocate, after receiving
138 any objections to the proposed assessments and making such
139 adjustments as in their opinion may be indicated, shall assess each
140 such domestic insurance company or other domestic entity an amount
141 equal to its proposed assessment as so adjusted. Each domestic
142 insurance company or other domestic entity shall pay to the Insurance
143 Commissioner on or before October thirty-first an amount equal to
144 fifty per cent of its assessment adjusted to reflect any credit or amount
145 due from the preceding fiscal year as determined by the commissioner
146 under subsection (g) of this section. Each domestic insurance company
147 or other domestic entity shall pay to the Insurance Commissioner on or
148 before the following April thirtieth, the remaining fifty per cent of its

149 assessment.

150 (f) On or before September first, annually, for each fiscal year
151 ending after July 1, 1990, the Insurance Commissioner and the
152 [Managed Care Ombudsman] Health Care Advocate, after receiving
153 any objections to the proposed assessments and making such
154 adjustments as in their opinion may be indicated, shall assess each
155 such domestic insurance company or other domestic entity an amount
156 equal to its proposed assessment as so adjusted. Each domestic
157 insurance company or other domestic entity shall pay to the Insurance
158 Commissioner (1) on or before June 30, 1990, and on or before June
159 thirtieth annually thereafter, an estimated payment against its
160 assessment for the following year equal to twenty-five per cent of its
161 assessment for the fiscal year ending such June thirtieth, (2) on or
162 before September thirtieth, annually, twenty-five per cent of its
163 assessment adjusted to reflect any credit or amount due from the
164 preceding fiscal year as determined by the commissioner under
165 subsection (g) of this section, and (3) on or before the following
166 December thirty-first and March thirty-first, annually, each domestic
167 insurance company or other domestic entity shall pay to the Insurance
168 Commissioner the remaining fifty per cent of its proposed assessment
169 to the department in two equal installments.

170 (g) Immediately following the close of the fiscal year, the Insurance
171 Commissioner and the [Managed Care Ombudsman] Health Care
172 Advocate shall recalculate the proposed assessment for each domestic
173 insurance company or other domestic entity in accordance with
174 subsection (c) of this section using the actual expenditures made by the
175 Insurance Department and the Office of the [Managed Care
176 Ombudsman] Health Care Advocate during that fiscal year and the
177 actual expenditures made on behalf of the department and the office
178 from the Capital Equipment Purchase Fund pursuant to section 4a-9.
179 On or before July thirty-first, the Insurance Commissioner and the
180 [Managed Care Ombudsman] Health Care Advocate shall render to
181 each such domestic insurance company and other domestic entity a
182 statement showing the difference between their respective recalculated

183 assessments and the amount they have previously paid. On or before
184 August thirty-first, the Insurance Commissioner and the [Managed
185 Care Ombudsman] Health Care Advocate, after receiving any
186 objections to such statements, shall make such adjustments which in
187 their opinion may be indicated, and shall render an adjusted
188 assessment, if any, to the affected companies.

189 (h) If any assessment is not paid when due, a penalty of ten dollars
190 shall be added thereto, and interest at the rate of six per cent per
191 annum shall be paid thereafter on such assessment and penalty.

192 (i) The commissioner shall deposit all payments made under this
193 section with the State Treasurer. On and after June 6, 1991, the moneys
194 so deposited shall be credited to the Insurance Fund established under
195 section 38a-52a and shall be accounted for as expenses recovered from
196 insurance companies.

197 Sec. 5. Subsection (f) of section 38a-478n of the general statutes is
198 repealed and the following is substituted in lieu thereof (*Effective*
199 *October 1, 2005*):

200 (f) Not later than January 1, 2000, the Insurance Commissioner shall
201 develop a comprehensive public education outreach program to
202 educate health insurance consumers of the existence of the appeals
203 procedure established in this section. The program shall maximize
204 public information concerning the appeals procedure and shall
205 include, but not be limited to: (1) The dissemination of information
206 through mass media, interactive approaches and written materials; (2)
207 involvement of community-based organizations in developing
208 messages and in devising and implementing education strategies; and
209 (3) periodic evaluations of the effectiveness of educational efforts. The
210 [Managed Care Ombudsman] Health Care Advocate shall coordinate
211 the outreach program and oversee the education process.

212 Sec. 6. Section 38a-479ee of the general statutes is repealed and the
213 following is substituted in lieu thereof (*Effective October 1, 2005*):

214 (a) If the Insurance Commissioner determines that a preferred
215 provider network or managed care organization, or both, has not
216 complied with any applicable provision of this part, sections 38a-226 to
217 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, the
218 commissioner may (1) order the preferred provider network or
219 managed care organization, or both if both have not complied, to cease
220 and desist all operations in violation of this part or said sections; (2)
221 terminate or suspend the preferred provider network's license; (3)
222 institute a corrective action against the preferred provider network or
223 managed care organization, or both if both have not complied; (4)
224 order the payment of a civil penalty by the preferred provider network
225 or managed care organization, or both if both have not complied, of
226 not more than one thousand dollars for each and every act or violation;
227 (5) order the payment of such reasonable expenses as may be necessary
228 to compensate the commissioner in conjunction with any proceedings
229 held to investigate or enforce violations of this part, sections 38a-226 to
230 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive; and (6)
231 use any of the commissioner's other enforcement powers to obtain
232 compliance with this part, sections 38a-226 to 38a-226d, inclusive, or
233 sections 38a-815 to 38a-819, inclusive. The commissioner may hold a
234 hearing concerning any matter governed by this part, sections 38a-226
235 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, in
236 accordance with section 38a-16. Subject to the same confidentiality and
237 liability protections set forth in subsections (c) and (k) of section 38a-
238 14, the commissioner may engage the services of attorneys, appraisers,
239 independent actuaries, independent certified public accountants or
240 other professionals and specialists to assist the commissioner in
241 conducting an investigation under this section, the cost of which shall
242 be borne by the managed care organization or preferred provider
243 network, or both, that is the subject of the investigation.

244 (b) If a preferred provider network fails to comply with any
245 applicable provision of this part, sections 38a-226 to 38a-226d,
246 inclusive, or sections 38a-815 to 38a-819, inclusive, the commissioner
247 may assign or require the preferred provider network to assign its
248 rights and obligations under any contract with participating providers

249 in order to ensure that covered benefits are provided.

250 (c) The commissioner shall receive and investigate (1) any grievance
251 filed against a preferred provider network or managed care
252 organization, or both, by an enrollee or an enrollee's designee
253 concerning matters governed by this part, sections 38a-226 to 38a-226d,
254 inclusive, or sections 38a-815 to 38a-819, inclusive, or (2) any referral
255 from the Office of [Managed Care Ombudsman] the Health Care
256 Advocate pursuant to section 38a-1041, as amended by this act. The
257 commissioner shall code, track and review such grievances and
258 referrals. The preferred provider network or managed care
259 organization, or both, shall provide the commissioner with all
260 information necessary for the commissioner to investigate such
261 grievances and referrals. The information collected by the
262 commissioner pursuant to this section shall be maintained as
263 confidential and shall not be disclosed to any person except (A) to the
264 extent necessary to carry out the purposes of this part, sections 38a-226
265 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, (B) as
266 allowed under this title, (C) to the [Managed Care Ombudsman]
267 Health Care Advocate and (D) information concerning the nature of
268 any grievance or referral and the commissioner's final determination
269 shall be a public record, as defined in section 1-200, provided no
270 personal information, as defined in section 38a-975, shall be disclosed.
271 The commissioner shall report to the [Managed Care Ombudsman]
272 Health Care Advocate on the resolution of any matter referred to the
273 commissioner by the [Managed Care Ombudsman] Health Care
274 Advocate.

275 Sec. 7. Section 38a-479ff of the general statutes is repealed and the
276 following is substituted in lieu thereof (*Effective October 1, 2005*):

277 No health insurer, health care center, utilization review company, as
278 defined in section 38a-226, or preferred provider network, as defined
279 in section 38a-479aa, shall take or threaten to take any adverse
280 personnel or coverage-related action against any enrollee, provider or
281 employee in retaliation for such enrollee, provider or employee (1)

282 filing a complaint with the Insurance Commissioner or the Office of
283 [Managed Care Ombudsman] the Health Care Advocate, or (2)
284 disclosing information to the Insurance Commissioner concerning any
285 violation of this part, sections 38a-226 to 38a-226d, inclusive, or
286 sections 38a-815 to 38a-819, inclusive, unless such disclosure violates
287 the provisions of chapter 705 or the privacy provisions of the federal
288 Health Insurance Portability and Accountability Act of 1996 (P.L. 104-
289 191) (HIPAA), as amended from time to time, or regulations adopted
290 thereunder. Any enrollee, provider or employee who is aggrieved by a
291 violation of this section may bring a civil action in the Superior Court
292 to recover damages and attorneys' fees and costs.

293 Sec. 8. Section 38a-1041 of the general statutes is repealed and the
294 following is substituted in lieu thereof (*Effective October 1, 2005*):

295 (a) There is established an Office of [Managed Care Ombudsman]
296 the Health Care Advocate which shall be within the Insurance
297 Department for administrative purposes only.

298 (b) The Office of [Managed Care Ombudsman] the Health Care
299 Advocate may:

300 (1) Assist health insurance consumers with managed care plan
301 selection by providing information, referral and assistance to
302 individuals about means of obtaining health insurance coverage and
303 services;

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

306 (3) Provide information to the public, agencies, legislators and
307 others regarding problems and concerns of health insurance
308 consumers and make recommendations for resolving those problems
309 and concerns;

310 (4) Assist consumers with the filing of complaints and appeals,
311 including filing appeals with a managed care organization's internal
312 appeal or grievance process and the external appeal process

313 established under section 38a-478n, as amended by this act;

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

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

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

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

323 (9) Create and make available to employers a notice, suitable for
324 posting in the workplace, concerning the services that the [Managed
325 Care Ombudsman] Health Care Advocate provides;

326 (10) Establish a toll-free number, or any other free calling option, to
327 allow customer access to the services provided by the [Managed Care
328 Ombudsman] Health Care Advocate;

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

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

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

335 (c) The Office of [Managed Care Ombudsman] the Health Care
336 Advocate shall make a referral to the Insurance Commissioner if the
337 [Managed Care Ombudsman] Health Care Advocate finds that a
338 preferred provider network may have engaged in a pattern or practice
339 that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-
340 479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

341 (d) The [Managed Care Ombudsman] Health Care Advocate and
342 the Insurance Commissioner shall jointly compile a list of complaints
343 received against managed care organizations and preferred provider
344 networks and the commissioner shall maintain the list, except the
345 names of complainants shall not be disclosed if such disclosure would
346 violate the provisions of section 4-61dd or 38a-1045, as amended by
347 this act.

348 Sec. 9. Section 38a-1042 of the general statutes is repealed and the
349 following is substituted in lieu thereof (*Effective October 1, 2005*):

350 (a) The Office of [Managed Care Ombudsman] the Health Care
351 Advocate shall be under the direction of the [Managed Care
352 Ombudsman] Health Care Advocate who shall be appointed by the
353 Governor, with the approval of the General Assembly. The [Managed
354 Care Ombudsman] Health Care Advocate shall be an elector of the
355 state with expertise and experience in the fields of health care, health
356 insurance and advocacy for the rights of consumers, provided the
357 [ombudsman] Health Care Advocate shall not have served as a
358 director or officer of a managed care organization within two years of
359 appointment. In addition to the [Managed Care Ombudsman] Health
360 Care Advocate, the Office of [Managed Care Ombudsman] the Health
361 Care Advocate shall consist of a staff of not more than three persons,
362 which staff may be increased as the requirements and resources of the
363 office permit.

364 (b) The Governor shall make the initial appointment of [Managed
365 Care Ombudsman] the Health Care Advocate from a list of candidates
366 prepared and submitted, not later than June 1, 2000, to the Governor
367 by the advisory committee established pursuant to section 38a-1049, as
368 amended by this act. The Governor shall notify the advisory committee
369 of the pending expiration of the term of an incumbent [ombudsman]
370 Health Care Advocate not less than ninety days prior to the final day
371 of the [ombudsman's] Health Care Advocate's term in office. If a
372 vacancy occurs in the position of [ombudsman] Health Care Advocate,
373 the Governor shall notify the advisory committee immediately of the

374 vacancy. The advisory committee shall meet to consider qualified
375 candidates for the position of [ombudsman] Health Care Advocate and
376 shall submit a list of not more than five candidates to the Governor
377 ranked in order of preference, not more than sixty days after receiving
378 notice from the Governor of the pending expiration of the
379 [ombudsman's] Health Care Advocate's term or the occurrence of a
380 vacancy. The Governor shall designate, not more than sixty days after
381 receipt of the list of candidates from the advisory committee, one
382 candidate from the list for the position of [ombudsman] Health Care
383 Advocate. If, after the list is submitted to the Governor by the advisory
384 committee, any candidate withdraws from consideration, the
385 Governor shall designate a candidate from those remaining on the list.
386 If the Governor fails to designate a candidate within sixty days of
387 receipt of the list from the advisory committee, the advisory committee
388 shall refer the candidate with the highest ranking on the list to the
389 General Assembly for confirmation. If the General Assembly is not in
390 session at the time of the Governor's or advisory committee's
391 designation of a candidate, the candidate shall serve as the acting
392 [ombudsman] Health Care Advocate until the General Assembly
393 meets and confirms the candidate as [ombudsman] Health Care
394 Advocate. A candidate serving as acting [ombudsman] Health Care
395 Advocate is entitled to compensation and has all the powers, duties
396 and privileges of the [ombudsman] Health Care Advocate. [An
397 ombudsman] A Health Care Advocate shall serve a term of four years,
398 not including any time served as acting [ombudsman] Health Care
399 Advocate, and may be reappointed by the Governor or shall remain in
400 the position until a successor is confirmed. Although an incumbent
401 [ombudsman] Health Care Advocate may be reappointed, the
402 Governor shall also consider additional candidates from a list
403 submitted by the advisory committee as provided in this section.

404 (c) Upon a vacancy in the position of the [ombudsman] Health Care
405 Advocate, the most senior attorney in the Office of [Managed Care
406 Ombudsman] the Health Care Advocate shall serve as the acting
407 [ombudsman] Health Care Advocate until the vacancy is filled
408 pursuant to subsection (a) or (b) of this section. The acting

409 [ombudsman] Health Care Advocate has all the powers, duties and
410 privileges of the [ombudsman] Health Care Advocate.

411 Sec. 10. Section 38a-1043 of the general statutes is repealed and the
412 following is substituted in lieu thereof (*Effective October 1, 2005*):

413 (a) Each managed care organization shall, when presented with the
414 written consent of the consumer or the consumer's guardian or legal
415 representative, provide to the Office of [Managed Care Ombudsman]
416 the Health Care Advocate access to records relating to such consumer.

417 (b) Any records provided pursuant to this section to the Office of
418 [Managed Care Ombudsman] the Health Care Advocate shall be
419 exempt from disclosure under the Freedom of Information Act, as
420 defined in section 1-200.

421 Sec. 11. Section 38a-1044 of the general statutes is repealed and the
422 following is substituted in lieu thereof (*Effective October 1, 2005*):

423 All state agencies shall comply with reasonable requests of the
424 Office of [Managed Care Ombudsman] the Health Care Advocate for
425 information and assistance.

426 Sec. 12. Section 38a-1045 of the general statutes is repealed and the
427 following is substituted in lieu thereof (*Effective October 1, 2005*):

428 In the absence of the written consent of a consumer utilizing the
429 services of the Office of [Managed Care Ombudsman] the Health Care
430 Advocate or such consumer's guardian or legal representative or of a
431 court order, the Office of [Managed Care Ombudsman] the Health
432 Care Advocate, its employees and agents, shall not disclose the
433 identity of the consumer.

434 Sec. 13. Section 38a-1046 of the general statutes is repealed and the
435 following is substituted in lieu thereof (*Effective October 1, 2005*):

436 Each employer, other than a self-insured employer, that provides
437 health insurance benefits to employees shall obtain from the [Managed

438 Care Ombudsman] Health Care Advocate and post, in a conspicuous
439 location, a notice concerning the services that the [Managed Care
440 Ombudsman] Health Care Advocate provides.

441 Sec. 14. Section 38a-1047 of the general statutes is repealed and the
442 following is substituted in lieu thereof (*Effective October 1, 2005*):

443 (a) No [ombudsman] Health Care Advocate or person employed by
444 the Office of [Managed Care Ombudsman] the Health Care Advocate
445 may:

446 (1) Have a direct involvement in the licensing, certification or
447 accreditation of a managed care organization;

448 (2) Have a direct ownership or investment interest in a managed
449 care organization;

450 (3) Be employed by or participate in the management of a managed
451 care organization; or

452 (4) Receive or have the right to receive, directly or indirectly,
453 remuneration under a compensation arrangement with a managed
454 care organization.

455 (b) No [ombudsman] Health Care Advocate or person employed by
456 the Office of [Managed Care Ombudsman] the Health Care Advocate
457 may knowingly accept employment with a managed care organization
458 for a period of one year following termination of that person's services
459 with the Office of [Managed Care Ombudsman] the Health Care
460 Advocate.

461 Sec. 15. Section 38a-1048 of the general statutes is repealed and the
462 following is substituted in lieu thereof (*Effective October 1, 2005*):

463 (a) The Office of [Managed Care Ombudsman] the Health Care
464 Advocate may apply for and accept grants, gifts and bequests of funds
465 from other states, federal and interstate agencies and independent
466 authorities and private firms, individuals and foundations, for the

467 purpose of carrying out its responsibilities.

468 (b) There is established within the General Fund a [managed care
469 ombudsman] Health Care Advocate account that shall be a separate
470 nonlapsing account. Any funds received under this section shall, upon
471 deposit in the General Fund, be credited to said account and may be
472 used by the Office of [Managed Care Ombudsman] the Health Care
473 Advocate in the performance of its duties.

474 Sec. 16. Section 38a-1049 of the general statutes is repealed and the
475 following is substituted in lieu thereof (*Effective October 1, 2005*):

476 (a) There is established an advisory committee to the Office of
477 [Managed Care Ombudsman] Health Care Advocate which shall meet
478 four times a year with the [Managed Care Ombudsman] Health Care
479 Advocate and the staff of the Office of [Managed Care Ombudsman]
480 the Health Care Advocate to review and assess the performance of the
481 Office of [Managed Care Ombudsman] the Health Care Advocate. The
482 advisory committee shall consist of six members appointed one each
483 by the president pro tempore of the Senate, the speaker of the House of
484 Representatives, the majority leader of the Senate, the majority leader
485 of the House of Representatives, the minority leader of the Senate and
486 the minority leader of the House of Representatives. Each member of
487 the advisory committee shall serve a term of five years and may be
488 reappointed at the conclusion of that term. All initial appointments to
489 the advisory committee shall be made not later than March 1, 2000.

490 (b) The advisory committee shall make an annual evaluation of the
491 effectiveness of the Office of [Managed Care Ombudsman] Health
492 Care Advocate and shall submit the evaluation to the Governor and
493 the joint standing committees of the General Assembly having
494 cognizance of matters relating to public health and insurance not later
495 than February first of each year commencing February 1, 2001.

496 Sec. 17. Section 38a-1050 of the general statutes is repealed and the
497 following is substituted in lieu thereof (*Effective October 1, 2005*):

498 The [Managed Care Ombudsman] Health Care Advocate shall
 499 submit, not later than January first of each year, a report to the
 500 Governor and the joint standing committees of the General Assembly
 501 having cognizance of matters relating to public health and insurance
 502 concerning the activities of the [ombudsman] Health Care Advocate.
 503 The report shall include, but not be limited to, information regarding:
 504 (1) The subject matter, disposition and number of consumer
 505 complaints processed by the [ombudsman] Health Care Advocate; (2)
 506 common problems and concerns discerned by the [ombudsman]
 507 Health Care Advocate from the consumer complaints and other
 508 relevant sources; (3) the need, if any, for administrative, legislative or
 509 executive remedies to assist consumers; and (4) the fiscal accounts of
 510 the Office of [Managed Care Ombudsman] the Health Care Advocate.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2005</i>	38a-478n(b)(1)
Sec. 2	<i>October 1, 2005</i>	17b-427(e)
Sec. 3	<i>October 1, 2005</i>	38a-47
Sec. 4	<i>October 1, 2005</i>	38a-48
Sec. 5	<i>October 1, 2005</i>	38a-478n(f)
Sec. 6	<i>October 1, 2005</i>	38a-479ee
Sec. 7	<i>October 1, 2005</i>	38a-479ff
Sec. 8	<i>October 1, 2005</i>	38a-1041
Sec. 9	<i>October 1, 2005</i>	38a-1042
Sec. 10	<i>October 1, 2005</i>	38a-1043
Sec. 11	<i>October 1, 2005</i>	38a-1044
Sec. 12	<i>October 1, 2005</i>	38a-1045
Sec. 13	<i>October 1, 2005</i>	38a-1046
Sec. 14	<i>October 1, 2005</i>	38a-1047
Sec. 15	<i>October 1, 2005</i>	38a-1048
Sec. 16	<i>October 1, 2005</i>	38a-1049
Sec. 17	<i>October 1, 2005</i>	38a-1050

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-Effect	FY 06 \$	FY 07 \$
Insurance Dept.; Office of Managed Care Ombudsman	IF - None	None	None

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill allows the Insurance Commissioner to issue an order specifying how a managed care organization or utilization review company must make determinations. The bill also changes the name of the Office of Managed Care Ombudsman (OMCO) to the Office of the Health Care Advocate. The bill has no fiscal impact.

OLR Bill Analysis

sSB 1205

AN ACT CONCERNING APPEALS OF DENIALS OR DETERMINATIONS BY MANAGED CARE ORGANIZATIONS**SUMMARY:**

Existing law allows an enrollee, or health care provider acting on an enrollee's behalf with his consent, who has exhausted the internal mechanisms provided by a managed care organization (MCO) or utilization review (UR) company to appeal a claim denial based on medical necessity to the insurance commissioner up to 30 days after receiving written notice of it. It also allows appeals of determinations not to certify an admission, service, procedure, or extension of stay.

The bill allows the insurance commissioner to issue an order specifying how an MCO or UR company must make determinations about procedural or diagnostic coding if she receives three or more appeals of denials or determinations by the same MCO or UR company about the same procedural or diagnostic coding. The commissioner can issue the order on her own motion.

The bill also changes the name of the Office of Managed Care Ombudsman to the Office of Health Care Advocate and makes a number of technical changes to accomplish this throughout the statutes. The duties and responsibilities of the office remain the same.

EFFECTIVE DATE: October 1, 2005

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 26 Nay 0