



Senate

General Assembly

January Session, 2005

File No. 245

Senate Bill No. 1297

Senate, April 11, 2005

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING MANAGED CARE GRIEVANCE PROCEDURES.

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

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 Section 38a-478m of the general statutes is repealed and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

3 (a) Each managed care organization shall establish and maintain an
4 internal grievance procedure to assure that enrollees may seek a
5 review of any grievance that may arise from a managed care
6 organization's action or inaction, other than action or inaction based on
7 utilization review, and obtain a timely resolution of any such
8 grievance. Such grievance procedure shall comply with the following
9 requirements:

10 (1) Enrollees shall be informed of the grievance procedure at the
11 time of initial enrollment and at not less than annual intervals
12 thereafter, which notification may be met by inclusion in an enrollment

13 agreement or update. [Enrollees] Each enrollee and the enrollee's
 14 provider shall also be informed of the grievance procedure when a
 15 decision has been made not to certify an admission, service or
 16 extension of stay ordered by the provider.

17 (2) Notices to enrollees and providers describing the grievance
 18 procedure shall explain: (A) The process for filing a grievance with the
 19 managed care organization, which may be communicated orally,
 20 electronically or in writing; (B) that the enrollee, or a person acting on
 21 behalf of an enrollee, including the enrollee's health care provider, may
 22 make a request for review of a grievance; and (C) the time periods
 23 within which the managed care organization must resolve the
 24 grievance.

25 (b) All reviews conducted under this section shall be resolved not
 26 later than sixty days from the date the enrollee or person acting on
 27 behalf of the enrollee commences the complaint, unless an extension is
 28 requested by the enrollee or person acting on behalf of the enrollee.

29 (c) A managed care organization that fails to provide notice of the
 30 resolution of a complaint within the time provided in subsection (b) of
 31 this section shall be fined twenty-five dollars for each failure to
 32 provide notice. Any fines collected under this section shall be paid to
 33 the Insurance Commissioner and deposited in the Insurance Fund
 34 established in section 38a-52a. The amount of such fines shall be
 35 allocated to the Office of Managed Care Ombudsman for the purposes
 36 set forth in section 38a-1041.

37 Sec. 2. Section 38a-816 of the general statutes is amended by adding
 38 subdivision (22) as follows (*Effective October 1, 2005*):

39 (NEW) (22) Any violation of section 38a-478m, as amended by this
 40 act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2005	38a-478m

Sec. 2	<i>October 1, 2005</i>	38a-816
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INS *Joint Favorable*

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.	Various - Revenue Gain	Potential Minimal	Potential Minimal

Municipal Impact: None

Explanation

The bill makes violating certain grievance requirements an unfair and deceptive insurance practice. Under the Connecticut Unfair Insurance Practices Act (CUIPA) a person in violation of one of its provisions is subject to various monetary penalties. Therefore, this could result in a minimal revenue gain to the state.

The bill also requires a managed care organization (MCO) to pay a \$25 fine for each time it does not resolve a grievance within a certain time frame. Under the bill, this fine is to be deposited into the Insurance Fund. This could also result in a minimal revenue gain to the state.

OLR Bill Analysis

SB 1297

AN ACT CONCERNING MANAGED CARE GRIEVANCE PROCEDURES**SUMMARY:**

By law, a managed care organization (MCO) must maintain a grievance process for enrollees to appeal the MCO's actions or inactions that meets specified requirements. This bill makes violating the grievance requirements an unfair and deceptive insurance practice, subject to a fine up to \$1,000 for each violation, to a maximum of \$10,000. If a person knew or should have known his action was a violation, the penalty is (1) a fine up to \$5,000 for each violation, to a maximum of \$50,000 in any six-month period; (2) license suspension or revocation; and (3) restitution of any amounts obtained through the violation.

By law, a grievance must be resolved within 60 days after it is initiated, unless the enrollee requests an extension. The bill permits a person acting on the enrollee's behalf to also request an extension. It requires an MCO to pay a \$25 fine for each time it does not resolve a grievance within the required timeframe. The fines are payable to the insurance commissioner for deposit into the Insurance Fund and must be allocated to the managed care ombudsman's office.

The bill requires the MCO to notify the enrollee and his provider of the grievance process when it denies a service, admission, or stay extension ordered by the provider. Current law requires it to notify just the enrollee of the grievance process when it denies any service, admission, or stay extension, regardless of whom requested it. The notification must explain (1) how to submit a grievance, which can be done orally, electronically, or in writing; (2) that the enrollee or a person acting on his behalf, including his provider, can submit a grievance; and (3) the insurer's timeframe to resolve a grievance.

EFFECTIVE DATE: October 1, 2005

BACKGROUND

Managed Care Ombudsman

The managed care ombudsman's office assists managed care consumers with plan selection, grievance and appeal filing, and understanding their rights and responsibilities under managed care plans. It also publishes a list of consumer complaints against managed care companies in conjunction with the insurance department and pursues administrative remedies on behalf of the consumers.

Related Bills

SB 1002 extends the grievance procedure requirements to health insurers, requires a final denial notice to include instructions on how to appeal to the insurance commissioner, and limits the information an MCO must provide about a self-insured government plan that is the subject of an appeal.

HB 6863 expands the information an MCO must provide about a self-insured government plan that is the subject of an appeal.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Report

Yea 11 Nay 5