



General Assembly

January Session, 2005

**Raised Bill No. 1002**

LCO No. 3025

\* SB01002INS\_\_032205\_\_ \*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

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

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

1 Section 1. Subdivision (1) of subsection (a) of section 38a-226c of the  
2 general statutes is repealed and the following is substituted in lieu  
3 thereof (*Effective July 1, 2005*):

4 (1) Each utilization review company shall maintain and make  
5 available procedures for providing notification of its determinations  
6 regarding certification in accordance with the following:

7 (A) Notification of any prospective determination by the utilization  
8 review company shall be mailed or otherwise communicated to the  
9 provider of record or the enrollee or other appropriate individual  
10 within two business days of the receipt of all information necessary to  
11 complete the review, provided any determination not to certify an  
12 admission, service, procedure or extension of stay shall be in writing.  
13 After a prospective determination that authorizes an admission,  
14 service, procedure or extension of stay has been communicated to the  
15 appropriate individual, based on accurate information from the

16 provider, the utilization review company may not reverse such  
17 determination if such admission, service, procedure or extension of  
18 stay has taken place in reliance on such determination.

19 (B) Notification of a concurrent determination shall be mailed or  
20 otherwise communicated to the provider of record within two business  
21 days of receipt of all information necessary to complete the review or,  
22 provided all information necessary to perform the review has been  
23 received, prior to the end of the current certified period and provided  
24 any determination not to certify an admission, service, procedure or  
25 extension of stay shall be in writing.

26 (C) The utilization review company shall not make a determination  
27 not to certify based on incomplete information unless it has clearly  
28 indicated, in writing, to the provider of record or the enrollee all the  
29 information that is needed to make such determination.

30 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this  
31 subdivision, the utilization review company may give authorization  
32 orally, electronically or communicated other than in writing. If the  
33 determination is an approval for a request, the company shall provide  
34 a confirmation number corresponding to the authorization.

35 (E) [Any] Except as provided in subparagraph (F) of this  
36 subdivision with respect to a final notice, each notice of a  
37 determination not to certify an admission, service, procedure or  
38 extension of stay shall include in writing (i) the principal reasons for  
39 the determination, (ii) the procedures to initiate an appeal of the  
40 determination or the name and telephone number of the person to  
41 contact with regard to an appeal pursuant to the provisions of this  
42 section, and (iii) the procedure to appeal to the commissioner pursuant  
43 to section 38a-478n, as amended by this act.

44 (F) Each notice of a final determination not to certify an admission,  
45 service, procedure or extension of stay shall include in writing (i) the  
46 principal reasons for the determination, (ii) a statement that all internal

47 appeal mechanisms have been exhausted, and (iii) a copy of the  
48 application and procedures prescribed by the commissioner for filing  
49 an appeal to the commissioner pursuant to section 38a-478n, as  
50 amended by this act.

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

53 (a) Each managed care organization or health insurer, as defined in  
54 section 38a-478n, as amended by this act, shall establish and maintain  
55 an internal grievance procedure to assure that enrollees, as defined in  
56 section 38a-478n, as amended by this act, may seek a review of any  
57 grievance that may arise from a managed care organization's or health  
58 insurer's action or inaction, other than action or inaction based on  
59 utilization review, and obtain a timely resolution of any such  
60 grievance. Such grievance procedure shall comply with the following  
61 requirements:

62 (1) Enrollees shall be informed of the grievance procedure at the  
63 time of initial enrollment and at not less than annual intervals  
64 thereafter, which notification may be met by inclusion in an enrollment  
65 agreement or update. Enrollees shall also be informed of the grievance  
66 procedure when a decision has been made not to certify an admission,  
67 service or extension of stay.

68 (2) Notices to enrollees describing the grievance procedure shall  
69 explain: (A) The process for filing a grievance with the managed care  
70 organization or health insurer, which may be communicated orally,  
71 electronically or in writing; (B) that the enrollee, or a person acting on  
72 behalf of an enrollee, including the enrollee's health care provider, may  
73 make a request for review of a grievance; and (C) the time periods  
74 within which the managed care organization or health insurer must  
75 resolve the grievance.

76 (3) Each managed care organization and health insurer shall notify  
77 its enrollee in writing in cases where an appeal to reverse a denial of a

78 claim based on medical necessity is unsuccessful. Each notice of a final  
79 denial of a claim based on medical necessity shall include (A) a written  
80 statement that all internal appeal mechanisms have been exhausted,  
81 and (B) a copy of the application and procedures prescribed by the  
82 commissioner for filing an appeal to the commissioner pursuant to  
83 section 38a-478n, as amended by this act.

84 (b) All reviews conducted under this section shall be resolved not  
85 later than sixty days from the date the enrollee commences the  
86 complaint, unless an extension is requested by the enrollee.

87 Sec. 3. Section 38a-478n of the general statutes is repealed and the  
88 following is substituted in lieu thereof (*Effective July 1, 2005*):

89 (a) Any enrollee, or any provider acting on behalf of an enrollee  
90 with the enrollee's consent, who has exhausted the internal  
91 mechanisms provided by a managed care organization, health insurer  
92 or utilization review company to appeal the denial of a claim based on  
93 medical necessity or a determination not to certify an admission,  
94 service, procedure or extension of stay, regardless of whether such  
95 determination was made before, during or after the admission, service,  
96 procedure or extension of stay, may appeal such denial or  
97 determination to the commissioner. As used in this section and section  
98 38a-478m, as amended by this act, "health insurer" means any entity,  
99 other than a managed care organization, which delivers, issues for  
100 delivery, renews or amends an individual or group health plan in this  
101 state, "health plan" means a plan of health insurance providing  
102 coverage of the type specified in subdivision (1), (2), (4), (10), (11), (12)  
103 and (13) of section 38a-469, but does not include a managed care plan  
104 offered by a managed care organization, and "enrollee" means a person  
105 who has contracted for or who participates in a managed care plan or  
106 health plan for himself or his eligible dependents.

107 (b) (1) To appeal a denial or determination pursuant to this section  
108 an enrollee or any provider acting on behalf of an enrollee shall, not  
109 later than thirty days after receiving final written notice of the denial

110 or determination from the enrollee's managed care organization,  
111 health insurer or utilization review company, file a written request  
112 with the commissioner. The appeal shall be on forms prescribed by the  
113 commissioner and shall include the filing fee set forth in subdivision  
114 (2) of this subsection and a general release executed by the enrollee for  
115 all medical records pertinent to the appeal. The managed care  
116 organization, health insurer or utilization review company named in  
117 the appeal shall also pay to the commissioner the filing fee set forth in  
118 subdivision (2) of this subsection.

119 (2) The filing fee shall be twenty-five dollars and shall be deposited  
120 in the Insurance Fund established in section 38a-52a. If the  
121 commissioner finds that an enrollee is indigent or unable to pay the  
122 fee, the commissioner shall waive the enrollee's fee. The commissioner  
123 shall refund any paid filing fee to (A) the managed care organization,  
124 health insurer or utilization review company if the appeal is not  
125 accepted for full review, or (B) the prevailing party upon completion of  
126 a full review pursuant to this section.

127 (3) Upon receipt of the appeal together with the executed release  
128 and appropriate fee, the commissioner shall assign the appeal for  
129 review to an entity as defined in subsection (c) of this section.

130 (4) Upon receipt of the request for appeal from the commissioner,  
131 the entity conducting the appeal shall conduct a preliminary review of  
132 the appeal and accept the appeal if such entity determines: (A) The  
133 individual was or is an enrollee of the managed care organization or  
134 health insurer; (B) the benefit or service that is the subject of the  
135 complaint or appeal reasonably appears to be a covered service, benefit  
136 or service under the agreement provided by contract to the enrollee;  
137 (C) the enrollee has exhausted all internal appeal mechanisms  
138 provided; (D) the enrollee has provided all information required by the  
139 commissioner to make a preliminary determination including the  
140 appeal form, a copy of the final decision of denial and a fully-executed  
141 release to obtain any necessary medical records from the managed care

142 organization or health insurer and any other relevant provider.

143 (5) Upon completion of the preliminary review, the entity  
144 conducting such review shall immediately notify the member or  
145 provider, as applicable, in writing as to whether the appeal has been  
146 accepted for full review and, if not so accepted, the reasons why the  
147 appeal was not accepted for full review.

148 (6) If accepted for full review, the entity shall conduct such review  
149 in accordance with the regulations adopted by the commissioner, after  
150 consultation with the Commissioner of Public Health, in accordance  
151 with the provisions of chapter 54.

152 (c) To provide for such appeal the Insurance Commissioner, after  
153 consultation with the Commissioner of Public Health, shall engage  
154 impartial health entities to provide for medical review under the  
155 provisions of this section. Such review entities shall include (1) medical  
156 peer review organizations, (2) independent utilization review  
157 companies, provided any such organizations or companies are not  
158 related to or associated with any managed care organization or health  
159 insurer, and (3) nationally recognized health experts or institutions  
160 approved by the commissioner.

161 (d) (1) Not later than five business days after receiving a written  
162 request from the commissioner, enrollee or any provider acting on  
163 behalf of an enrollee with the enrollee's consent, a managed care  
164 organization or health insurer whose enrollee is the subject of an  
165 appeal shall provide to the commissioner, enrollee or any provider  
166 acting on behalf of an enrollee with the enrollee's consent, written  
167 verification of whether the enrollee's [managed care] plan is fully  
168 insured, self-funded, or otherwise funded. If the plan is a fully insured  
169 plan [or a self-insured governmental plan,] the managed care  
170 organization or health insurer shall send: (A) Written certification to  
171 the commissioner or reviewing entity, as determined by the  
172 commissioner, that the benefit or service subject to the appeal is a  
173 covered benefit or service; (B) a copy of the entire policy or contract

174 between the enrollee and the managed care organization or health  
175 insurer; [, except that with respect to a self-insured governmental plan,  
176 (i) the managed care organization shall notify the plan sponsor, and (ii)  
177 the plan sponsor shall send, or require the managed care organization  
178 to send, such copy;] or (C) written certification that the policy or  
179 contract is accessible to the review entity electronically and clear and  
180 simple instructions on how to electronically access the policy or  
181 contract.

182 (2) Failure of the managed care organization or health insurer to  
183 provide information [or notify the plan sponsor] in accordance with  
184 subdivision (1) of this subsection within said five-business-day period  
185 or before the expiration of the thirty-day period for appeals set forth in  
186 subdivision (1) of subsection (b) of this section, whichever is later as  
187 determined by the commissioner, shall (A) create a presumption on the  
188 review entity, solely for purposes of accepting an appeal and  
189 conducting the review pursuant to subdivision (4) of subsection (b) of  
190 this section, that the benefit or service is a covered benefit under the  
191 applicable policy or contract, except that such presumption shall not be  
192 construed as creating or authorizing benefits or services in excess of  
193 those that are provided for in the enrollee's policy or contract, and (B)  
194 entitle the commissioner to require the managed care organization or  
195 health insurer from whom the enrollee is appealing a medical necessity  
196 determination to reimburse the department for the expenses related to  
197 the appeal, including, but not limited to, expenses incurred by the  
198 review entity.

199 (e) The commissioner shall accept the decision of the review entity  
200 and the decision of the commissioner shall be binding.

201 (f) Not later than January 1, 2000, the Insurance Commissioner shall  
202 develop a comprehensive public education outreach program to  
203 educate health insurance consumers of the existence of the appeals  
204 procedure established in this section. The program shall maximize  
205 public information concerning the appeals procedure and shall

206 include, but not be limited to: (1) The dissemination of information  
207 through mass media, interactive approaches and written materials; (2)  
208 involvement of community-based organizations in developing  
209 messages and in devising and implementing education strategies; and  
210 (3) periodic evaluations of the effectiveness of educational efforts. The  
211 Managed Care Ombudsman shall coordinate the outreach program  
212 and oversee the education process.

213 Sec. 4. Section 38a-478s of the general statutes is repealed and the  
214 following is substituted in lieu thereof (*Effective July 1, 2005*):

215 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended  
216 by this act, shall be construed to apply to the arrangements [of  
217 managed care organizations] offered to individuals covered under self-  
218 insured [employee welfare benefit plans established pursuant to the  
219 federal Employee Retirement Income Security Act of 1974] health  
220 plans.

221 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, as  
222 amended by this act, shall not apply to any plan that provides for the  
223 financing or delivery of health care services solely for the purposes of  
224 workers' compensation benefits pursuant to chapter 568.

225 Sec. 5. Subdivision (5) of section 38a-478 of the general statutes is  
226 repealed and the following is substituted in lieu thereof (*Effective July*  
227 *1, 2005*):

228 (5) ["Enrollee"] Except as provided in sections 38a-478m and 38a-  
229 478n, as amended by this act, "enrollee" means a person who has  
230 contracted for or who participates in a managed care plan for himself  
231 or his eligible dependents.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2005</i>	38a-226c(a)(1)
Sec. 2	<i>July 1, 2005</i>	38a-478m

Sec. 3	<i>July 1, 2005</i>	38a-478n
Sec. 4	<i>July 1, 2005</i>	38a-478s
Sec. 5	<i>July 1, 2005</i>	38a-478(5)

**INS**      *Joint Favorable*