



General Assembly

January Session, 2007

Raised Bill No. 7055

LCO No. 3631

03631_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ENSURING REAL ACCESS TO HEALTH INSURANCE.

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

1 Section 1. (NEW) (*Effective from passage*) (a) For purposes of this
2 section:

3 (1) "Insurer" has the same meaning as provided in section 38a-1 of
4 the general statutes; and

5 (2) "Postclaims underwriting" means the rescinding, canceling or
6 limiting of a policy or certificate due to the insurer's failure to complete
7 medical underwriting and resolve all reasonable questions arising
8 from written information submitted on or with an application before
9 issuing the policy or certificate.

10 (b) No insurer that delivers, issues for delivery, renews or continues
11 any policy of insurance providing coverage of the type specified in
12 subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 of the
13 general statutes shall engage in the practice of postclaims
14 underwriting.

15 (c) No insurer shall rescind, cancel or limit a policy or certificate

16 based on written information submitted on or with an application
17 unless it proves to the Insurance Commissioner that such information
18 is false, material to the disposition of a pending claim or claims and
19 was provided by the insured with an intent to deceive the insurer.

20 Sec. 2. (NEW) (*Effective July 1, 2007*) (a) As used in a managed care
21 contract, the term "medical necessity" or "medically necessary" means
22 any health intervention that is recommended by the treating physician
23 or treating licensed health care provider and is (1) for the purpose of
24 treating a medical condition or mental health or nervous condition; (2)
25 the most appropriate delivery or level of service considering potential
26 benefits and harms to the patient; (3) known to be effective in
27 improving health outcomes, provided: (A) Effectiveness is determined
28 first by scientific evidence; (B) if no scientific evidence exists, then by
29 professional standards of care; and (C) if no professional standards of
30 care exist or if such standards exist but are outdated or contradictory,
31 then by expert opinion; and (4) cost-effective for the medical condition
32 being treated compared to alternative health interventions, including
33 no intervention. For the purposes of this subsection, cost-effective shall
34 not necessarily mean lowest price.

35 (b) The definition of medically necessary in subsection (a) of this
36 section shall not apply to the HUSKY Plan, Part A and Part B.

37 Sec. 3. Subsection (a) of section 38a-226c of the general statutes is
38 repealed and the following is substituted in lieu thereof (*Effective July*
39 *1, 2007*):

40 (a) All utilization review companies shall meet the following
41 minimum standards:

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

45 (A) Notification of any prospective determination by the utilization

46 review company shall be mailed or otherwise communicated to the
47 provider of record or the enrollee or other appropriate individual
48 within two business days of the receipt of all information necessary to
49 complete the review, provided any determination not to certify an
50 admission, service, procedure or extension of stay shall be in writing.
51 After a prospective determination that authorizes an admission,
52 service, procedure or extension of stay has been communicated to the
53 appropriate individual, based on accurate information from the
54 provider, the utilization review company may not reverse such
55 determination if such admission, service, procedure or extension of
56 stay has taken place in reliance on such determination.

57 (B) Notification of a concurrent determination shall be mailed or
58 otherwise communicated to the provider of record within two business
59 days of receipt of all information necessary to complete the review or,
60 provided all information necessary to perform the review has been
61 received, prior to the end of the current certified period and provided
62 any determination not to certify an admission, service, procedure or
63 extension of stay shall be in writing.

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

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

73 (E) Except as provided in subparagraph (F) of this subdivision with
74 respect to a final notice, each notice of a determination not to certify an
75 admission, service, procedure or extension of stay shall include in
76 writing (i) the principal reasons for the determination and, if the
77 reason not to certify is based on medical necessity, the notice shall

78 include an explanation of why the admission, service, procedure or
79 extension of stay is not medically necessary, (ii) the procedures to
80 initiate an appeal of the determination or the name and telephone
81 number of the person to contact with regard to an appeal pursuant to
82 the provisions of this section, and (iii) the procedure to appeal to the
83 commissioner pursuant to section 38a-478n.

84 (F) For all determinations, there shall be a presumption that an
85 admission, service, procedure or extension of stay is medically
86 necessary if it is ordered by a licensed participating provider and is
87 within the provider's scope of practice. The utilization review
88 company shall have the burden of proving that the admission, service,
89 procedure or extension of stay is not medically necessary.

90 [(F)] (G) Each notice of a final determination not to certify an
91 admission, service, procedure or extension of stay shall include in
92 writing (i) the principal reasons for the determination, (ii) a statement
93 that all internal appeal mechanisms have been exhausted, and (iii) a
94 copy of the application and procedures prescribed by the
95 commissioner for filing an appeal to the commissioner pursuant to
96 section 38a-478n.

97 (2) Each utilization review company shall maintain and make
98 available a written description of the appeal procedure by which either
99 the enrollee or the provider of record may seek review of
100 determinations not to certify an admission, service, procedure or
101 extension of stay. The procedures for appeals shall include the
102 following:

103 (A) Each utilization review company shall notify in writing the
104 enrollee and provider of record of its determination on the appeal as
105 soon as practical, but in no case later than thirty days after receiving
106 the required documentation on the appeal.

107 (B) On appeal, all determinations not to certify an admission,
108 service, procedure or extension of stay shall be made by a licensed

109 practitioner of the healing arts.

110 (3) The process established by each utilization review company may
111 include a reasonable period within which an appeal [must] shall be
112 filed to be considered.

113 (4) Each utilization review company shall also provide for an
114 expedited appeals process for emergency or life threatening situations.
115 Each utilization review company shall complete the adjudication of
116 such expedited appeals within two business days of the date the
117 appeal is filed and all information necessary to complete the appeal is
118 received by the utilization review company.

119 (5) Each utilization review company shall utilize written clinical
120 criteria and review procedures which are established and periodically
121 evaluated and updated with appropriate involvement from
122 practitioners.

123 (6) Physicians, nurses and other licensed health professionals
124 making utilization review decisions shall have current licenses from a
125 state licensing agency in the United States or appropriate certification
126 from a recognized accreditation agency in the United States, provided,
127 any final determination not to certify an admission, service, procedure
128 or extension of stay for an enrollee within this state, except for a claim
129 brought pursuant to chapter 568, shall be made by a physician, nurse
130 or other licensed health professional under the authority of a
131 physician, nurse or other licensed health professional who has a
132 current Connecticut license from the Department of Public Health.

133 (7) In cases where an appeal to reverse a determination not to certify
134 is unsuccessful, each utilization review company shall (A) assure that a
135 practitioner in a specialty related to the condition is reasonably
136 available to review the case, and (B) prior to making a final
137 determination, provide the enrollee an opportunity to request a
138 hearing which shall be conducted in person, by telephone or by other
139 means at the enrollee's discretion. At the hearing, the utilization review

140 company shall make available the practitioner responsible for
141 reviewing the case. When the reason for the determination not to
142 certify is based on medical necessity, including whether a treatment is
143 experimental or investigational, each utilization review company shall
144 have the case reviewed by a physician who is a specialist in the field
145 related to the condition that is the subject of the appeal. Any such
146 review, except for a claim brought pursuant to chapter 568, that
147 upholds a final determination not to certify in the case of an enrollee
148 within this state shall be conducted by such practitioner or physician
149 under the authority of a practitioner or physician who has a current
150 Connecticut license from the Department of Public Health. The review
151 shall be completed within thirty days of the request for review. The
152 utilization review company shall be financially responsible for the
153 review and shall maintain, for the commissioner's verification,
154 documentation of the review, including the name of the reviewing
155 physician.

156 (8) Except as provided in subsection (e) of this section, each
157 utilization review company shall make review staff available by toll-
158 free telephone, at least forty hours per week during normal business
159 hours.

160 (9) Each utilization review company shall comply with all
161 applicable federal and state laws to protect the confidentiality of
162 individual medical records. Summary and aggregate data shall not be
163 considered confidential if it does not provide sufficient information to
164 allow identification of individual patients.

165 (10) Each utilization review company shall allow a minimum of
166 twenty-four hours following an emergency admission, service or
167 procedure for an enrollee or [his] the enrollee's representative to notify
168 the utilization review company and request certification or continuing
169 treatment for that condition.

170 (11) No utilization review company may give an employee any
171 financial incentive based on the number of denials of certification such

172 employee makes.

173 (12) Each utilization review company shall annually file with the
174 commissioner:

175 (A) The names of all managed care organizations, as defined in
176 section 38a-478, that the utilization review company services in
177 Connecticut;

178 (B) Any utilization review services for which the utilization review
179 company has contracted out for services and the name of such
180 company providing the services;

181 (C) The number of utilization review determinations not to certify
182 an admission, service, procedure or extension of stay and the outcome
183 of such determination upon appeal within the utilization review
184 company. Determinations related to mental or nervous conditions, as
185 defined in section 38a-514, shall be reported separately from all other
186 determinations reported under this subdivision; and

187 (D) The following information relative to requests for utilization
188 review of mental health services for enrollees of fully insured health
189 benefit plans or self-insured or self-funded employee health benefit
190 plans, separately and by category: (i) The reason for the request,
191 including, but not limited to, an inpatient admission, service,
192 procedure or extension of inpatient stay or an outpatient treatment, (ii)
193 the number of requests denied by type of request, and (iii) whether the
194 request was denied or partially denied.

195 (13) Any utilization review decision to initially deny services shall
196 be made by a licensed health professional.

197 Sec. 4. Section 38a-478m of the general statutes is repealed and the
198 following is substituted in lieu thereof (*Effective July 1, 2007*):

199 (a) Each managed care organization or health insurer, as defined in
200 section 38a-478n, as amended by this act, shall establish and maintain

201 an internal grievance procedure to assure that enrollees, as defined in
202 section 38a-478n, as amended by this act, may seek a review of any
203 grievance that may arise from a managed care organization's or health
204 insurer's action or inaction, other than action or inaction based on
205 utilization review, and obtain a timely resolution of any such
206 grievance. Such grievance procedure shall comply with the following
207 requirements:

208 (1) Enrollees shall be informed of the grievance procedure at the
209 time of initial enrollment and at not less than annual intervals
210 thereafter, which notification may be met by inclusion in an enrollment
211 agreement or update. Each enrollee and the enrollee's provider shall
212 also be informed of the grievance procedure when a decision has been
213 made not to certify an admission, service or extension of stay ordered
214 by the provider.

215 (2) Notices to enrollees and providers describing the grievance
216 procedure shall explain: (A) The process for filing a grievance with the
217 managed care organization or health insurer, which may be
218 communicated orally, electronically or in writing; (B) that the enrollee,
219 or a person acting on behalf of an enrollee, including the enrollee's
220 health care provider, may make a request for review of a grievance;
221 and (C) the time periods within which the managed care organization
222 or health insurer [must] shall resolve the grievance.

223 (3) Each managed care organization and health insurer shall notify
224 its enrollee in writing in cases where an appeal to reverse a denial of a
225 claim based on medical necessity is unsuccessful. Each notice of a final
226 denial of a claim based on medical necessity shall include (A) a written
227 statement that all internal appeal mechanisms have been exhausted,
228 and (B) a copy of the application and procedures prescribed by the
229 commissioner for filing an appeal to the commissioner pursuant to
230 section 38a-478n, as amended by this act.

231 (b) With respect to a final appeal or review under the internal
232 grievance procedure, the managed care organization or health insurer

233 shall provide the enrollee an opportunity to request a hearing, which
234 shall be conducted in person, by telephone or by other means at the
235 enrollee's discretion.

236 [(b)] (c) All reviews conducted under this section shall be resolved
237 not later than sixty days from the date the enrollee or person acting on
238 behalf of the enrollee commences the complaint, unless an extension is
239 requested by the enrollee or person acting on behalf of the enrollee.

240 [(c)] (d) A managed care organization that fails to provide notice of
241 the resolution of a complaint within the time provided in subsection
242 [(b)] (c) of this section shall be fined twenty-five dollars for each failure
243 to provide notice. Any fines collected under this section shall be paid
244 to the Insurance Commissioner and deposited in the Insurance Fund
245 established in section 38a-52a. The amount of such fines shall be
246 allocated to the Office of the Healthcare Advocate for the purposes set
247 forth in section 38a-1041.

248 Sec. 5. Section 38a-478n of the general statutes is repealed and the
249 following is substituted in lieu thereof (*Effective from passage*):

250 (a) Any enrollee, or any provider acting on behalf of an enrollee
251 with the enrollee's consent, who has exhausted the internal
252 mechanisms provided by a managed care organization, health insurer
253 or utilization review company to appeal the denial of a claim based on
254 medical necessity or a determination not to certify an admission,
255 service, procedure or extension of stay, regardless of whether such
256 determination was made before, during or after the admission, service,
257 procedure or extension of stay, may appeal such denial or
258 determination to the commissioner. As used in this section and section
259 38a-478m, as amended by this act, "health insurer" means any entity,
260 other than a managed care organization, which delivers, issues for
261 delivery, renews or amends an individual or group health plan in this
262 state, "health plan" means a plan of health insurance providing
263 coverage of the type specified in subdivision (1), (2), (4), (10), (11), (12)
264 and (13) of section 38a-469, but does not include a managed care plan

265 offered by a managed care organization, and "enrollee" means a person
266 who has contracted for or who participates in a managed care plan or
267 health plan for himself or his eligible dependents.

268 (b) (1) To appeal a denial or determination pursuant to this section
269 an enrollee or any provider acting on behalf of an enrollee shall, not
270 later than [thirty] sixty days after receiving final written notice of the
271 denial or determination from the enrollee's managed care organization,
272 health insurer or utilization review company, file a written request
273 with the commissioner. The appeal shall be on forms prescribed by the
274 commissioner and shall include the filing fee set forth in subdivision
275 (2) of this subsection and a general release executed by the enrollee for
276 all medical records pertinent to the appeal. The managed care
277 organization, health insurer or utilization review company named in
278 the appeal shall also pay to the commissioner the filing fee set forth in
279 subdivision (2) of this subsection. If the Insurance Commissioner
280 receives three or more appeals of denials or determinations by the
281 same managed care organization or utilization review company with
282 respect to the same procedural or diagnostic coding, the Insurance
283 Commissioner may, on said commissioner's own motion, issue an
284 order specifying how such managed care organization or utilization
285 review company shall make determinations about such procedural or
286 diagnostic coding.

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

295 (3) Upon receipt of the appeal together with the executed release
296 and appropriate fee, the commissioner shall assign the appeal for

297 review to an entity as defined in subsection (c) of this section.

298 (4) Upon receipt of the request for appeal from the commissioner,
299 the entity conducting the appeal shall conduct a preliminary review of
300 the appeal and accept the appeal if such entity determines: (A) The
301 individual was or is an enrollee of the managed care organization or
302 health insurer; (B) the benefit or service that is the subject of the
303 complaint or appeal reasonably appears to be a covered service, benefit
304 or service under the agreement provided by contract to the enrollee;
305 (C) the enrollee has exhausted all internal appeal mechanisms
306 provided; (D) the enrollee has provided all information required by the
307 commissioner to make a preliminary determination including the
308 appeal form, a copy of the final decision of denial and a fully-executed
309 release to obtain any necessary medical records from the managed care
310 organization or health insurer and any other relevant provider.

311 (5) Upon completion of the preliminary review, the entity
312 conducting such review shall immediately notify the member or
313 provider, as applicable, in writing as to whether the appeal has been
314 accepted for full review and, if not so accepted, the reasons why the
315 appeal was not accepted for full review.

316 (6) If accepted for full review, the entity shall conduct such review
317 in accordance with the regulations adopted by the commissioner, after
318 consultation with the Commissioner of Public Health, in accordance
319 with the provisions of chapter 54.

320 (c) To provide for such appeal the Insurance Commissioner, after
321 consultation with the Commissioner of Public Health, shall engage
322 impartial health entities to provide for medical review under the
323 provisions of this section. Such review entities shall include (1) medical
324 peer review organizations, (2) independent utilization review
325 companies, provided any such organizations or companies are not
326 related to or associated with any managed care organization or health
327 insurer, and (3) nationally recognized health experts or institutions
328 approved by the commissioner.

329 (d) (1) Not later than five business days after receiving a written
330 request from the commissioner, enrollee or any provider acting on
331 behalf of an enrollee with the enrollee's consent, a managed care
332 organization or health insurer whose enrollee is the subject of an
333 appeal shall provide to the commissioner, enrollee or any provider
334 acting on behalf of an enrollee with the enrollee's consent, written
335 verification of whether the enrollee's plan is fully insured, self-funded,
336 or otherwise funded. If the plan is a fully insured plan or a self-insured
337 governmental plan, the managed care organization or health insurer
338 shall send: (A) Written certification to the commissioner or reviewing
339 entity, as determined by the commissioner, that the benefit or service
340 subject to the appeal is a covered benefit or service; (B) a copy of the
341 entire policy or contract between the enrollee and the managed care
342 organization or health insurer, except that with respect to a self-
343 insured governmental plan, (i) the managed care organization or
344 health insurer shall notify the plan sponsor, and (ii) the plan sponsor
345 shall send, or require the managed care organization or health insurer
346 to send, such copy; or (C) written certification that the policy or
347 contract is accessible to the review entity electronically and clear and
348 simple instructions on how to electronically access the policy or
349 contract.

350 (2) Failure of the managed care organization or health insurer to
351 provide information or notify the plan sponsor in accordance with
352 subdivision (1) of this subsection within said five-business-day period
353 or before the expiration of the [thirty-day] sixty-day period for appeals
354 set forth in subdivision (1) of subsection (b) of this section, whichever
355 is later as determined by the commissioner, shall (A) create a
356 presumption on the review entity, solely for purposes of accepting an
357 appeal and conducting the review pursuant to subdivision (4) of
358 subsection (b) of this section, that the benefit or service is a covered
359 benefit under the applicable policy or contract, except that such
360 presumption shall not be construed as creating or authorizing benefits
361 or services in excess of those that are provided for in the enrollee's
362 policy or contract, and (B) entitle the commissioner to require the

363 managed care organization or health insurer from whom the enrollee
 364 is appealing a medical necessity determination to reimburse the
 365 department for the expenses related to the appeal, including, but not
 366 limited to, expenses incurred by the review entity.

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

369 (f) Not later than January 1, 2000, the Insurance Commissioner shall
 370 develop a comprehensive public education outreach program to
 371 educate health insurance consumers of the existence of the appeals
 372 procedure established in this section. The program shall maximize
 373 public information concerning the appeals procedure and shall
 374 include, but not be limited to: (1) The dissemination of information
 375 through mass media, interactive approaches and written materials; (2)
 376 involvement of community-based organizations in developing
 377 messages and in devising and implementing education strategies; and
 378 (3) periodic evaluations of the effectiveness of educational efforts. The
 379 Healthcare Advocate shall coordinate the outreach program and
 380 oversee the education process.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>July 1, 2007</i>	New section
Sec. 3	<i>July 1, 2007</i>	38a-226c(a)
Sec. 4	<i>July 1, 2007</i>	38a-478m
Sec. 5	<i>from passage</i>	38a-478n

Statement of Purpose:

To establish a statutory definition of "medical necessity" or "medically necessary" for health insurance coverage to ensure consistency throughout health insurance policies; to create a presumption that a procedure or treatment is medically necessary if the utilization review company's credentialed health care provider orders such procedure or treatment. The utilization review company has the burden of proof of demonstrating that the prescribed procedure or treatment is not

medically necessary; to allow a health insurer to cancel a policy based on patient misrepresentations on the insurance application only if the insurer can prove that such misrepresentations were made with the intent to deceive; to extend the time period in which a patient may file an external appeal with the Insurance Department from thirty days to sixty days; to require the utilization review company to provide an enrollee a written notice explaining the insurer's position that a particular service is not medically necessary; and to require the utilization review company to provide a patient with a hearing, which may be held by telephone, before making a decision on an appeal of a denial of a claim and to make the reviewing practitioner available for such hearing.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]