



House of Representatives

General Assembly

File No. 217

February Session, 2010

Substitute House Bill No. 5235

House of Representatives, March 30, 2010

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT REQUIRING THE PROVIDING OF CERTAIN INFORMATION UPON CERTAIN DENIALS OF HEALTH INSURANCE COVERAGE.

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

1 Section 1. Section 38a-483b of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective January 1, 2011*):

3 Except as otherwise provided in this title, each insurer, health care
4 center, hospital and medical service corporation or other entity
5 delivering, issuing for delivery, renewing, [or] amending or continuing
6 any individual health insurance policy in this state, [on or after
7 January 1, 2000,] providing coverage of the type specified in
8 subdivisions (1), (2), (4), (11) and (12) of section 38a-469, shall complete
9 any coverage determination with respect to such policy and notify the
10 insured or the insured's health care provider of its decision not later
11 than forty-five days after a request for such determination is received
12 by the insurer, health care center, hospital and medical service
13 corporation or other entity. In the case of a denial of coverage, such
14 entity shall notify the insured and the insured's health care provider of
15 the reasons for such denial. If the reasons for such denial include that

16 the requested service is not medically necessary or is not a covered
 17 benefit under such policy, the entity shall (1) notify the insured that
 18 such insured may contact the Office of the Healthcare Advocate if the
 19 insured believes the insured has been given erroneous information,
 20 and (2) provide to such insured the contact information for said office.

21 Sec. 2. Section 38a-513a of the general statutes is repealed and the
 22 following is substituted in lieu thereof (*Effective January 1, 2011*):

23 Except as otherwise provided in this title, each insurer, health care
 24 center, hospital and medical service corporation or other entity
 25 delivering, issuing for delivery, renewing, [or] amending or continuing
 26 any group health insurance policy in this state, [on or after January 1,
 27 2000,] providing coverage of the type specified in subdivisions (1), (2),
 28 (4), (11) and (12) of section 38a-469, shall complete any coverage
 29 determination with respect to such policy and notify the insured or the
 30 insured's health care provider of its decision not later than forty-five
 31 days after a request for such determination is received by the insurer,
 32 health care center, hospital and medical service corporation or other
 33 entity. In the case of a denial of coverage, such entity shall notify the
 34 insured and the insured's health care provider of the reasons for such
 35 denial. If the reasons for such denial include that the requested service
 36 is not medically necessary or is not a covered benefit under such
 37 policy, the entity shall (1) notify the insured that such insured may
 38 contact the Office of the Healthcare Advocate if the insured believes
 39 the insured has been given erroneous information, and (2) provide to
 40 such insured the contact information for said office.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2011	38a-483b
Sec. 2	January 1, 2011	38a-513a

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill, which requires health care entities to provide to certain individuals the contact information for the Office of the Healthcare Advocate, has no fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis**sHB 5235****AN ACT REQUIRING THE PROVIDING OF CERTAIN INFORMATION UPON CERTAIN DENIALS OF HEALTH INSURANCE COVERAGE.****SUMMARY:**

This bill requires certain health insurers who deny coverage of a requested service because it is not (1) medically necessary or (2) a covered benefit to notify the insured of his or her ability to contact the Office of the Healthcare Advocate if the insured believes he or she has been given erroneous information. Insurers must also provide the insured with contact information for the office.

The bill applies to each insurer, health care center, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues in Connecticut individual or group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

The bill also imposes a 45-day coverage determination and notice requirement on any of the above entities that continue an individual or group health insurance policy in Connecticut. The law already requires this for individual and group policies that are delivered, issued, amended, or renewed in the state.

EFFECTIVE DATE: January 1, 2011

BACKGROUND***Medically Necessary***

The law requires policies to include the following definition of “medically necessary.” Medically necessary services are health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient’s illness, injury, or disease;
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

“Generally accepted standards of medical practice” means standards that are (1) based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or (2) otherwise consistent with the standards set forth in policy issues involving clinical judgment (CGS §§ 38a-482a and 38a-513c).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 18 Nay 1 (03/16/2010)