



Senate

General Assembly

File No. 207

February Session, 2010

Substitute Senate Bill No. 393

Senate, March 30, 2010

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 substitute bill ought to pass.

AN ACT CONCERNING STANDARDS IN HEALTH CARE PROVIDER CONTRACTS.

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

1 Section 1. Subparagraph (B) of subdivision (15) of section 38a-816 of
2 the general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective January 1, 2011*):

4 (B) Each insurer, or other entity responsible for providing payment
5 to a health care provider pursuant to an insurance policy subject to this
6 section, shall pay claims not later than [forty-five] (i) sixty days after
7 receipt by the insurer of the claimant's proof of loss form in paper
8 format or the health care provider's request for payment in paper
9 format filed in accordance with the insurer's practices or procedures,
10 or (ii) fifteen days after the claimant or health care provider has
11 electronically filed a claim or request for payment, except that when
12 there is a deficiency in the information needed for processing a claim,
13 as determined in accordance with section 38a-477, the insurer shall [(i)]
14 (I) send written notice to the claimant or health care provider, as the

15 case may be, of all alleged deficiencies in information needed for
16 processing a claim not later than thirty days after the insurer receives a
17 claim for payment or reimbursement under the contract, and [(ii)] (II)
18 pay claims for payment or reimbursement under the contract, for a
19 claim or request that was filed in paper format, not later than thirty
20 days after the insurer receives the information requested, and for a
21 claim or request that was filed electronically, not later than fifteen days
22 after the insurer receives the information requested.

23 Sec. 2. (NEW) (*Effective January 1, 2011*) The Insurance
24 Commissioner shall establish procedures to be used by insurers, health
25 care centers, fraternal benefit societies, hospital service corporations,
26 medical service corporations or other entities delivering, issuing for
27 delivery, renewing, amending or continuing an individual or group
28 health insurance policy or medical benefits plan in this state providing
29 coverage of the types specified in subdivisions (1), (2), (4), (11) and (12)
30 of section 38a-469 of the general statutes for the (1) solicitation of
31 health care providers, as defined in section 38a-478 of the general
32 statutes, to participate in provider networks of such entities, and (2)
33 maintenance of provider participation in such networks.

34 Sec. 3. (NEW) (*Effective January 1, 2011*) Each insurer, health care
35 center, managed care organization or other entity that delivers, issues
36 for delivery, renews, amends or continues an individual or group
37 health insurance policy or medical benefits plan, or preferred provider
38 network, as defined in section 38a-479aa of the general statutes, that
39 contracts with a health care provider, as defined in section 38a-478 of
40 the general statutes, for the purposes of providing covered health care
41 services to its enrollees, shall maintain a network of such providers
42 that is consistent with the standards established by the National
43 Committee for Quality Assurance's Managed Behavioral Healthcare
44 Organization Standards and Guidelines for quality management and
45 improvement.

46 Sec. 4. Subparagraph (A) of subdivision (1) of subsection (a) of
47 section 38a-226c of the 2010 supplement to the general statutes is

48 repealed and the following is substituted in lieu thereof (*Effective*
49 *January 1, 2011*):

50 (A) Notification of any prospective determination by the utilization
51 review company shall be mailed or otherwise communicated to the
52 provider of record or the enrollee or other appropriate individual
53 within two business days of the receipt of all information necessary to
54 complete the review, provided any determination not to certify an
55 admission, service, procedure or extension of stay shall be in writing.
56 After a prospective determination that authorizes an admission,
57 service, procedure or extension of stay has been communicated to the
58 appropriate individual, based on accurate information from the
59 provider, the utilization review company [may] shall not reverse such
60 determination and no insurer, health care center, fraternal benefit
61 society, hospital service corporation, medical service corporation or
62 other entity responsible for paying claims shall refuse to pay for such
63 admission, service, procedure or extension of stay if such admission,
64 service, procedure or extension of stay has taken place in reliance on
65 such determination.

66 Sec. 5. (NEW) (*Effective January 1, 2011*) No contract between an
67 insurer, health care center, fraternal benefit society, hospital service
68 corporation, medical service corporation or other entity delivering,
69 issuing for delivery, renewing, amending or continuing an individual
70 or group dental plan in this state and a dentist licensed pursuant to
71 chapter 379 of the general statutes shall contain any provision that
72 requires such dentist to provide services or procedures at a set fee to
73 such entity's insureds or enrollees, unless such services or procedures
74 are covered benefits under such insured's or enrollee's dental plan.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2011</i>	38a-816(15)(B)
Sec. 2	<i>January 1, 2011</i>	New section
Sec. 3	<i>January 1, 2011</i>	New section
Sec. 4	<i>January 1, 2011</i>	38a-226c(a)(1)(A)

Sec. 5	January 1, 2011	New section
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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 the Department of Insurance to develop procedures for health insurance entities to establish and maintain provider networks, does not result in a fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis**sSB 393*****AN ACT CONCERNING STANDARDS IN HEALTH CARE PROVIDER CONTRACTS.*****SUMMARY:**

This bill makes a variety of changes in the laws relating to contracts between health care providers and health insurers. The bill:

1. increases the time an insurer has to pay paper claims and decreases the time it has to pay electronic claims;
2. requires the insurance commissioner to develop procedures by which an insurer develops and maintains a provider network;
3. requires an insurer to adhere to nationally accepted provider network standards;
4. requires an insurer to pay for health care services for which a prior authorization was received; and
5. prohibits provider contracts from setting a dentist's charges for services that are not covered benefits.

EFFECTIVE DATE: January 1, 2010

§ 1 — CLAIM PAYMENT REQUIREMENTS

Current law requires health insurers to pay claims within 45 days of receiving them. This bill instead requires them to pay claims submitted (1) on paper within 60 days and (2) electronically within 15 days. If the claim does not include all information required by law, the insurer must send written notice to the claimant requesting the information be sent within 30 days. Upon receiving the requested information, the insurer must pay a paper claim within 30 days and an electronic claim

within 15 days.

By law, if an insurer fails to pay a claim on time, it must pay the claimant the amount of the claim plus 15% interest. This is in addition to any other penalties imposed by law. If the interest due is less than \$1, the insurer must instead deposit the amount in a separate interest-bearing account. At the end of each calendar year, the insurer must donate the account funds to the UConn Health Center.

§ 2 — PROVIDER NETWORK PROCEDURES

The bill requires the insurance commissioner to establish procedures for insurers to use to (1) solicit licensed health care providers to participate in the insurers' provider networks and (2) maintain provider participation in the networks.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefit plans that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services.

§ 3 — PROVIDER NETWORK ADEQUACY

The bill requires each insurer that contracts with licensed health care providers to maintain a provider network that conforms with the standards established by the National Committee for Quality Assurance's (NCQA's) Managed Behavioral Healthcare Organization Standards and Guidelines for quality management and improvement.

For purposes of this section, insurers include HMOs, managed care organizations, preferred provider networks, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefits plans.

NCQA is a nonprofit organization that accredits and certifies a wide range of health care organizations.

§ 4 — PRIOR AUTHORIZATIONS

By law, if utilization review companies grant prior authorizations for admissions, services, procedures, or extensions of hospital stays, the companies cannot later reverse the authorizations. This bill also prohibits insurers from refusing to pay for admissions, services, procedures, or extensions of stays that were provided in reliance on the prior authorizations.

For purposes of this section, an insurer includes an HMO, fraternal benefit society, hospital or medical service corporation, or other entity responsible for paying claims.

§ 5 — DENTIST CHARGES

Under the bill, a provider contract between an insurer and a licensed dentist cannot require the dentist to provide services or procedures at a set fee unless the services or procedures are covered benefits under the dental plan.

For purposes of this section, an insurer includes an HMO, fraternal benefit society, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues an individual or group dental plan in Connecticut.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 15 Nay 4 (03/16/2010)