



General Assembly

February Session, 2010

Raised Bill No. 393

LCO No. 1897

01897_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

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2 the general statutes is repealed and the following is substituted in lieu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)____ 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) _____ 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 not later
19 than thirty days after the insurer receives the information requested.

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

31 Sec. 3. (NEW) (*Effective January 1, 2011*) The Insurance
32 Commissioner, in consultation with the clearinghouse established
33 under section 19a-720 of the general statutes, shall establish provider
34 network adequacy standards for insurers, health care centers, fraternal
35 benefit societies, hospital service corporations, medical service
36 corporations or other entities delivering, issuing for delivery,
37 renewing, amending or continuing an individual or group health
38 insurance policy or medical benefits plan in this state providing
39 coverage of the types specified in subdivisions (1), (2), (4), (11) and (12)
40 of section 38a-469 of the general statutes. Such standards shall take into
41 account, but not be limited to, geographic distribution of insureds or
42 enrollees, geographic coverage areas of participating providers in a
43 provider network and the rate of new patients accepted by
44 participating providers in a provider network.

45 Sec. 4. Subparagraph (A) of subdivision (1) of subsection (a) of
46 section 38a-226c of the 2010 supplement to the general statutes is
47 repealed and the following is substituted in lieu thereof (*Effective*
48 *January 1, 2011*):

49 (A) Notification of any prospective determination by the utilization
50 review company shall be mailed or otherwise communicated to the
51 provider of record or the enrollee or other appropriate individual
52 within two business days of the receipt of all information necessary to
53 complete the review, provided any determination not to certify an
54 admission, service, procedure or extension of stay shall be in writing.
55 After a prospective determination that authorizes an admission,
56 service, procedure or extension of stay has been communicated to the
57 appropriate individual, based on accurate information from the
58 provider, the utilization review company [may] shall not reverse such
59 determination or refuse to pay for such admission, service, procedure
60 or extension of stay if such admission, service, procedure or extension
61 of stay has taken place in reliance on such determination.

62 Sec. 5. (NEW) (*Effective January 1, 2011*) An insurer, health care
63 center, fraternal benefit society, hospital service corporation, medical
64 service corporation or other entity delivering, issuing for delivery,
65 renewing, amending or continuing an individual or group health
66 insurance policy or medical benefits plan in this state providing
67 coverage of the types specified in subdivisions (1), (2), (4), (11) and (12)
68 of section 38a-469 of the general statutes, that preauthorizes an
69 admission, service, procedure or extension of stay other than through a
70 utilization review company, as defined in section 38a-226 of the
71 general statutes, shall not reverse such preauthorization or refuse to
72 pay for such admission, service, procedure or extension of stay if such
73 admission, service, procedure or extension of stay has taken place in
74 reliance on such preauthorization.

75 Sec. 6. (NEW) (*Effective January 1, 2011*) No contract between an
76 insurer, health care center, fraternal benefit society, hospital service
77 corporation, medical service corporation or other entity delivering,
78 issuing for delivery, renewing, amending or continuing an individual
79 or group dental plan in this state and a dentist licensed pursuant to
80 chapter 379 of the general statutes shall contain any provision that
81 requires such dentist to provide services or procedures at a set fee to

82 such entity's insureds or enrollees, unless such services or procedures
83 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	<i>January 1, 2011</i>	New section
Sec. 6	<i>January 1, 2011</i>	New section

Statement of Purpose:

To establish certain standards for contracts between health care providers and insurers.

[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.]