



# Senate

General Assembly

**File No. 62**

January Session, 2011

Substitute Senate Bill No. 922

*Senate, March 14, 2011*

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 NOTIFICATION OF THE SERVICES OF THE OFFICE OF THE HEALTHCARE ADVOCATE.***

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2 general statutes is repealed and the following is substituted in lieu  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 October 1, 2011*):

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) Except as provided in subparagraph (F) of this subdivision with  
36 respect to a final notice, each notice of a determination not to certify an  
37 admission, service, procedure or extension of stay shall include in  
38 writing (i) the principal reasons for the determination, (ii) the  
39 procedures to initiate an appeal of the determination or the name and  
40 telephone number of the person to contact with regard to an appeal  
41 pursuant to the provisions of this section, [and] (iii) a statement that  
42 the enrollee may contact the Office of the Healthcare Advocate for  
43 assistance with the filing of an appeal, and the Internet web site  
44 address, electronic mail address and telephone number of said office,  
45 and (iv) the procedure to appeal to the commissioner pursuant to  
46 section 38a-478n.

47 (F) Each notice of a final determination not to certify an admission,  
48 service, procedure or extension of stay shall include in writing (i) the  
49 principal reasons for the determination, (ii) a statement that all internal  
50 appeal mechanisms have been exhausted, [and] (iii) a copy of the  
51 application and procedures prescribed by the commissioner for filing  
52 an appeal to the commissioner pursuant to section 38a-478n, and (iv) a  
53 statement that the enrollee may contact the Office of the Healthcare  
54 Advocate for assistance with the filing of an appeal, and the Internet  
55 web site address, electronic mail address and telephone number of  
56 said office.

57 Sec. 2. Subsection (a) of section 38a-478m of the general statutes is  
58 repealed and the following is substituted in lieu thereof (*Effective*  
59 *October 1, 2011*):

60 (a) Each managed care organization or health insurer, as defined in  
61 section 38a-478n, shall establish and maintain an internal grievance  
62 procedure to assure that enrollees, as defined in section 38a-478n, may  
63 seek a review of any grievance that may arise from a managed care  
64 organization's or health insurer's action or inaction, other than action  
65 or inaction based on utilization review, and obtain a timely resolution  
66 of any such grievance. Such grievance procedure shall comply with the  
67 following requirements:

68 (1) Enrollees shall be informed of the grievance procedure at the  
69 time of initial enrollment and at not less than annual intervals  
70 thereafter, which notification may be met by inclusion in an enrollment  
71 agreement or update. Each enrollee and the enrollee's provider shall  
72 also be informed of the grievance procedure when a decision has been  
73 made not to certify an admission, service or extension of stay ordered  
74 by the provider.

75 (2) Notices to enrollees and providers describing the grievance  
76 procedure shall explain: (A) The process for filing a grievance with the  
77 managed care organization or health insurer, which may be  
78 communicated orally, electronically or in writing; (B) that the enrollee,  
79 or a person acting on behalf of an enrollee, including the enrollee's

80 health care provider, may make a request for review of a grievance;  
81 and (C) the time periods within which the managed care organization  
82 or health insurer must resolve the grievance. Such notices shall also  
83 include a statement that the enrollee may contact the Office of the  
84 Healthcare Advocate for assistance with the filing of a grievance with  
85 respect to a decision made by the managed care organization or health  
86 insurer not to certify an admission, service or extension of stay ordered  
87 by the provider, and the Internet web site address, electronic mail  
88 address and telephone number of said office.

89 (3) Each managed care organization and health insurer shall notify  
90 its enrollee in writing in cases where an appeal to reverse a denial of a  
91 claim based on medical necessity is unsuccessful. Each notice of a final  
92 denial of a claim based on medical necessity shall include (A) a written  
93 statement that all internal appeal mechanisms have been exhausted,  
94 and (B) a 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 Sec. 3. Section 38a-483b of the general statutes is repealed and the  
98 following is substituted in lieu thereof (*Effective October 1, 2011*):

99 Except as otherwise provided in this title, each insurer, health care  
100 center, hospital and medical service corporation or other entity  
101 delivering, issuing for delivery, renewing, amending or continuing any  
102 individual health insurance policy in this state, providing coverage of  
103 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
104 38a-469, shall complete any coverage determination with respect to  
105 such policy and notify the insured or the insured's health care provider  
106 of its decision not later than forty-five days after a request for such  
107 determination is received by the insurer, health care center, hospital  
108 and medical service corporation or other entity. In the case of a denial  
109 of coverage, such entity shall notify the insured and the insured's  
110 health care provider of the reasons for such denial [. If the reasons for  
111 such denial include that the requested service is not medically  
112 necessary or is not a covered benefit under such policy, the entity] and

113 shall (1) notify the insured that such insured may contact the Office of  
114 the Healthcare Advocate [if the insured believes the insured has been  
115 given erroneous information] for assistance with the filing of an  
116 appeal, and (2) provide to such insured the contact information for  
117 said office.

118 Sec. 4. Section 38a-513a of the general statutes is repealed and the  
119 following is substituted in lieu thereof (*Effective October 1, 2011*):

120 Except as otherwise provided in this title, each insurer, health care  
121 center, hospital and medical service corporation or other entity  
122 delivering, issuing for delivery, renewing, amending or continuing any  
123 group health insurance policy in this state, providing coverage of the  
124 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
125 469, shall complete any coverage determination with respect to such  
126 policy and notify the insured or the insured's health care provider of  
127 its decision not later than forty-five days after a request for such  
128 determination is received by the insurer, health care center, hospital  
129 and medical service corporation or other entity. In the case of a denial  
130 of coverage, such entity shall notify the insured and the insured's  
131 health care provider of the reasons for such denial [. If the reasons for  
132 such denial include that the requested service is not medically  
133 necessary or is not a covered benefit under such policy, the entity] and  
134 shall (1) notify the insured that such insured may contact the Office of  
135 the Healthcare Advocate [if the insured believes the insured has been  
136 given erroneous information] for assistance with the filing of an  
137 appeal, and (2) provide to such insured the contact information for  
138 said office.

139 Sec. 5. Section 38a-1046 of the general statutes is repealed and the  
140 following is substituted in lieu thereof (*Effective October 1, 2011*):

141 Each employer [, other than a self-insured employer,] that provides  
142 health insurance benefits to employees shall obtain from the  
143 Healthcare Advocate and post, in a conspicuous location, a notice  
144 concerning the services that the Healthcare Advocate provides.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>October 1, 2011</i>	38a-226c(a)(1)
Sec. 2	<i>October 1, 2011</i>	38a-478m(a)
Sec. 3	<i>October 1, 2011</i>	38a-483b
Sec. 4	<i>October 1, 2011</i>	38a-513a
Sec. 5	<i>October 1, 2011</i>	38a-1046

**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.

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***OFA Fiscal Note******State Impact:*** None***Municipal Impact:*** None***Explanation***

This bill requires certain private entities to both post information and notify individuals about the services of the Office of the Healthcare Advocate. Although these actions may lead to more referrals to the Office, no fiscal impact is anticipated.

***The Out Years******State Impact:*** None***Municipal Impact:*** None

**OLR Bill Analysis****sSB 922*****AN ACT CONCERNING NOTIFICATION OF THE SERVICES OF THE OFFICE OF THE HEALTHCARE ADVOCATE.*****SUMMARY:**

By law, a utilization review company, managed care organization (MCO), or health insurer must notify health benefit plan enrollees and health care providers of its determination not to certify a hospital admission or extended stay, service, or procedure. This bill adds to the information the notice must include. It requires a written statement that the enrollee may contact the Office of the Healthcare Advocate (OHA) for assistance with filing a grievance or appeal, and must include OHA's website address, email address, and telephone number.

The bill also requires all employers providing health insurance to obtain from OHA, and conspicuously post, a notice about OHA's services. Current law exempts self-insured employers from this requirement.

Finally, the bill requires certain health insurers who deny coverage of a requested service to notify the insured of his or her ability to contact OHA for assistance with filing an appeal. Current law only requires 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 OHA if the insured believes he or she has been given erroneous information. The law, which the bill extends to all denials, requires insurers to provide the insured with OHA's contact information.

The bill's provision regarding health insurer denials applies to each insurer, HMO, 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 the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

EFFECTIVE DATE: October 1, 2011

### **UTILIZATION REVIEW COMPANY DETERMINATIONS**

The bill requires a utilization review company to provide a written statement to health benefit plan enrollees and health care providers that the enrollee may contact OHA for assistance with filing an appeal, and must include OHA's website address, email address, and telephone number. This statement must be provided when the utilization review company (1) initially denies a service, procedure, admission, or hospital stay extension or (2) after appeal, upholds its claim denial. By law, an enrollee who exhausts a utilization review company's, MCO's, or health insurer's internal appeal process may file an external appeal with the insurance commissioner.

### **MCO AND HEALTH INSURER DETERMINATIONS**

By law, an MCO or health insurer must inform an enrollee of its internal grievance procedures at the time of initial enrollment and at least annually thereafter. An enrollee and his or her provider must also be notified whenever a decision is made not to certify a hospital admission or extended stay or a service the provider orders. The bill requires this notice include a statement that the enrollee may contact OHA for assistance with filing a grievance regarding such a denial and must include OHA's web site address, email address, and telephone number.

### **BACKGROUND**

#### ***Public Health Service Act Notification Requirements***

The federal health care reform law (the Patient Protection and Affordable Care Act, P.L. 111-148) amends the Public Health Service

Act to require individual and group health insurers to notify enrollees, in a culturally and linguistically appropriate manner, of (1) available internal and external appeals processes and (2) contact information for the state's healthcare consumer assistance program or ombudsman (in Connecticut, OHA) to assist enrollees with the appeals process (42 U.S.C. § 300gg-19).

***Utilization Review Companies***

A utilization review company performs prospective and concurrent assessments of the necessity and appropriateness of health care services given to or proposed for a Connecticut resident.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 13 Nay 5 (02/24/2011)