



General Assembly

January Session, 2011

Raised Bill No. 1158

LCO No. 4351

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Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING UTILIZATION REVIEW, GRIEVANCES AND EXTERNAL APPEALS PROCESSES OF HEALTH CARRIERS.

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

1 Section 1. (NEW) (*Effective July 1, 2011*) As used in this section and
2 sections 2 to 13, inclusive, of this act:

3 (1) "Adverse determination" means:

4 (A) The denial, reduction, termination or failure to provide or make
5 payment, in whole or in part, for a benefit under the health carrier's
6 health benefit plan requested by a covered person or a covered
7 person's treating health care professional, based on a determination by
8 a health carrier or its designee utilization review company:

9 (i) That, based upon the information provided, (I) upon application
10 of any utilization review technique, such benefit does not meet the
11 health carrier's requirements for medical necessity, appropriateness,
12 health care setting, level of care or effectiveness, or (II) is determined to
13 be experimental or investigational;

14 (ii) Of a covered person's eligibility to participate in the health

15 carrier's health benefit plan;

16 (B) Any prospective review, concurrent review or retrospective
17 review determination that denies, reduces or terminates or fails to
18 provide or make payment, in whole or in part, for a benefit under the
19 health carrier's health benefit plan requested by a covered person or a
20 covered person's treating health care professional; or

21 (C) "Adverse determination" includes a rescission of coverage
22 determination for grievance purposes.

23 (2) "Authorized representative" means:

24 (A) A person to whom a covered person has given express written
25 consent to represent the covered person for the purposes of this section
26 and sections 2 to 13, inclusive, of this act;

27 (B) A person authorized by law to provide substituted consent for a
28 covered person;

29 (C) A family member of the covered person or the covered person's
30 treating health care professional when the covered person is unable to
31 provide consent;

32 (D) A health care professional when the covered person's health
33 benefit plan requires that a request for a benefit under the plan be
34 initiated by the health care professional; or

35 (E) In the case of an urgent care request, a health care professional
36 with knowledge of the covered person's medical condition.

37 (3) "Best evidence" means evidence based on (A) randomized
38 clinical trials, (B) if randomized clinical trials are not available, cohort
39 studies or case-control studies, (C) if subparagraphs (A) and (B) of this
40 subdivision are not available, case-series, or (D) if subparagraphs (A)
41 to (C), inclusive, of this subdivision are not available, expert opinion.

42 (4) "Case-control study" means a retrospective evaluation of two

43 groups of patients with different outcomes to determine which specific
44 interventions the patients received.

45 (5) "Case-series" means an evaluation of a series of patients with a
46 particular outcome, without the use of a control group.

47 (6) "Certification" means a determination by a health carrier or its
48 designee utilization review company that a request for a benefit under
49 the health carrier's health benefit plan has been reviewed and, based
50 on the information provided, satisfies the health carrier's requirements
51 for medical necessity, appropriateness, health care setting, level of care
52 and effectiveness.

53 (7) "Clinical peer" means a physician or other health care
54 professional who holds a nonrestricted license in a state of the United
55 States and in the same or similar specialty as typically manages the
56 medical condition, procedure or treatment under review.

57 (8) "Clinical review criteria" means the written screening
58 procedures, decision abstracts, clinical protocols and practice
59 guidelines used by the health carrier to determine the medical
60 necessity and appropriateness of health care services.

61 (9) "Cohort study" means a prospective evaluation of two groups of
62 patients with only one group of patients receiving a specific
63 intervention or specific interventions.

64 (10) "Commissioner" means the Insurance Commissioner.

65 (11) "Concurrent review" means utilization review conducted
66 during a patient's stay or course of treatment in a facility, the office of a
67 health care professional or other inpatient or outpatient health care
68 setting, including home care.

69 (12) "Covered benefits" or "benefits" means health care services to
70 which a covered person is entitled under the terms of a health benefit
71 plan.

72 (13) "Covered person" means a policyholder, subscriber, enrollee or
73 other individual participating in a health benefit plan.

74 (14) "Discharge planning" means the formal process for
75 determining, prior to discharge from a facility, the coordination and
76 management of the care that a patient receives following discharge
77 from a facility.

78 (15) "Emergency medical condition" means a medical condition
79 manifesting itself by acute symptoms of sufficient severity, including
80 severe pain, such that a prudent lay-person with an average
81 knowledge of health and medicine, acting reasonably, would have
82 believed that the absence of immediate medical attention would result
83 in serious impairment to bodily functions or serious dysfunction of a
84 bodily organ or part, or would place the person's health or, with
85 respect to a pregnant woman, the health of the woman or her unborn
86 child, in serious jeopardy.

87 (16) "Emergency services" means, with respect to an emergency
88 medical condition:

89 (A) A medical screening examination that is within the capability of
90 the emergency department of a hospital, including ancillary services
91 routinely available to the emergency department to evaluate such
92 emergency medical condition; and

93 (B) Such further medical examination and treatment, to the extent
94 they are within the capability of the staff and facilities available at a
95 hospital, to stabilize a patient.

96 (17) "Evidence-based standard" means the conscientious, explicit
97 and judicious use of the current best evidence based on an overall
98 systematic review of medical research when making determinations
99 about the care of individual patients.

100 (18) "Expert opinion" means a belief or an interpretation by
101 specialists with experience in a specific area about the scientific

102 evidence pertaining to a particular service, intervention or therapy.

103 (19) "Facility" means an institution providing health care services or
104 a health care setting. "Facility" includes hospitals and other licensed
105 inpatient centers, ambulatory surgical or treatment centers, skilled
106 nursing centers, residential treatment centers, diagnostic, laboratory
107 and imaging centers, and rehabilitation and other therapeutic health
108 care settings.

109 (20) "Final adverse determination" means an adverse determination
110 (A) that has been upheld by the health carrier at the completion of the
111 internal grievance process pursuant to section 5 or 6 of this act, or (B)
112 for which the internal appeals process has been deemed exhausted in
113 accordance with section 4, 5 or 7 of this act.

114 (21) "Grievance" means a written complaint or, if the complaint
115 involves an urgent care request, an oral complaint, submitted by or on
116 behalf of a covered person regarding:

117 (A) The availability, delivery or quality of health care services,
118 including a complaint regarding an adverse determination made
119 pursuant to utilization review;

120 (B) Claims payment, handling or reimbursement for health care
121 services; or

122 (C) Any matter pertaining to the contractual relationship between a
123 covered person and a health carrier.

124 (22) (A) "Health benefit plan" means an insurance policy or contract,
125 certificate or agreement offered, delivered, issued for delivery,
126 renewed, amended or continued in this state to provide, deliver,
127 arrange for, pay for or reimburse any of the costs of health care
128 services;

129 (B) "Health benefit plan" does not include:

130 (i) Coverage of the type specified in subdivisions (5) to (9), inclusive,
131 (14) and (15) of section 38a-469 of the general statutes or any
132 combination thereof;

133 (ii) Coverage issued as a supplement to liability insurance;

134 (iii) Liability insurance, including general liability insurance and
135 automobile liability insurance;

136 (iv) Workers' compensation insurance;

137 (v) Automobile medical payment insurance;

138 (vi) Credit insurance;

139 (vii) Coverage for on-site medical clinics;

140 (viii) Other insurance coverage similar to the coverages specified in
141 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are
142 specified in regulations issued pursuant to the Health Insurance
143 Portability and Accountability Act of 1996, P.L. 104-191, as amended
144 from time to time, under which benefits for health care services are
145 secondary or incidental to other insurance benefits;

146 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
147 term care, nursing home care, home health care, community-based
148 care or any combination thereof, or (III) other similar, limited benefits
149 specified in regulations issued pursuant to the Health Insurance
150 Portability and Accountability Act of 1996, P.L. 104-191, as amended
151 from time to time, provided any benefits specified in subparagraphs
152 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided
153 under a separate insurance policy, certificate or contract and are not
154 otherwise an integral part of a health benefit plan; or

155 (x) Coverage of the type specified in subdivisions (3) and (13) of
156 section 38a-469 of the general statutes or other fixed indemnity
157 insurance if (I) they are provided under a separate insurance policy,

158 certificate or contract, (II) there is no coordination between the
159 provision of the benefits and any exclusion of benefits under any
160 group health plan maintained by the same plan sponsor, and (III) the
161 benefits are paid with respect to an event without regard to whether
162 benefits were also provided under any group health plan maintained
163 by the same plan sponsor.

164 (23) "Health care center" has the same meaning as provided in
165 section 38a-175 of the general statutes.

166 (24) "Health care professional" means a physician or other health
167 care practitioner licensed, accredited or certified to perform specified
168 health care services consistent with state law.

169 (25) "Health care services" has the same meaning as provided in
170 section 38a-478 of the general statutes, as amended by this act.

171 (26) "Health carrier" means an entity subject to the insurance laws
172 and regulations of this state or subject to the jurisdiction of the
173 commissioner, that contracts or offers to contract to provide, deliver,
174 arrange for, pay for or reimburse any of the costs of health care
175 services, including a sickness and accident insurance company, a
176 health care center, a managed care organization, a hospital service
177 corporation, a medical service corporation or any other entity
178 providing a plan of health insurance, health benefits or health care
179 services.

180 (27) "Health information" means information or data, whether oral
181 or recorded in any form or medium, and personal facts or information
182 about events or relationships that relate to (A) the past, present or
183 future physical, mental, or behavioral health or condition of covered
184 person or a member of the covered person's family, (B) the provision of
185 health care services to a covered person, or (C) payment for the
186 provision of health care services to a covered person.

187 (28) "Independent review organization" has the same meaning as

188 provided in section 38a-226 of the general statutes, as amended by this
189 act.

190 (29) "Medical or scientific evidence" means evidence found in the
191 following sources:

192 (A) Peer-reviewed scientific studies published in or accepted for
193 publication by medical journals that meet nationally recognized
194 requirements for scientific manuscripts and that submit most of their
195 published articles for review by experts who are not part of the
196 editorial staff;

197 (B) Peer-reviewed medical literature, including literature relating to
198 therapies reviewed and approved by a qualified institutional review
199 board, biomedical compendia and other medical literature that meet
200 the criteria of the National Institutes of Health's Library of Medicine
201 for indexing in Index Medicus (Medline) or Elsevier Science for
202 indexing in Excerpta Medicus (EMBASE);

203 (C) Medical journals recognized by the Secretary of the United
204 States Department of Health and Human Services under Section
205 1861(t)(2) of the Social Security Act;

206 (D) The following standard reference compendia: (i) The American
207 Hospital Formulary Service - Drug Information; (ii) Drug Facts and
208 Comparisons; (iii) The American Dental Association's Accepted Dental
209 Therapeutics; and (iv) The United States Pharmacopoeia - Drug
210 Information;

211 (E) Findings, studies or research conducted by or under the auspices
212 of federal government agencies and nationally recognized federal
213 research institutes, including: (i) The Agency for Healthcare Research
214 and Quality; (ii) the National Institutes of Health; (iii) the National
215 Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers
216 for Medicare and Medicaid Services; (vi) the Food and Drug
217 Administration; and (vii) any national board recognized by the

218 National Institutes of Health for the purpose of evaluating the medical
219 value of health care services; or

220 (F) Any other findings, studies or research conducted by or under
221 the auspices of a source comparable to those listed in subparagraphs
222 (E)(i) to (E)(v), inclusive, of this subdivision.

223 (30) "Participating provider" means a health care professional who,
224 under a contract with the health carrier, its contractor or subcontractor,
225 has agreed to provide health care services to covered persons, with an
226 expectation of receiving payment or reimbursement directly or
227 indirectly from the health carrier, other than coinsurance, copayments
228 or deductibles.

229 (31) "Person" has the same meaning as provided in section 38a-1 of
230 the general statutes.

231 (32) "Prospective review" means utilization review conducted prior
232 to an admission or the provision of a health care service or a course of
233 treatment, in accordance with a health carrier's requirement that such
234 service or treatment be approved, in whole or in part, prior to such
235 service's or treatment's provision.

236 (33) "Protected health information" means health information (A)
237 that identifies an individual who is the subject of the information, or
238 (B) for which there is a reasonable basis to believe that such
239 information could be used to identify such individual.

240 (34) "Randomized clinical trial" means a controlled, prospective
241 study of patients that have been randomized into an experimental
242 group and a control group at the beginning of the study, with only the
243 experimental group of patients receiving a specific intervention, and
244 that includes study of the groups for variables and anticipated
245 outcomes over time.

246 (35) "Rescission" means a cancellation or discontinuance of coverage
247 under a health benefit plan that has a retroactive effect. "Rescission"

248 does not include a cancellation or discontinuance of coverage under a
249 health benefit plan if (A) such cancellation or discontinuance has a
250 prospective effect only, or (B) such cancellation or discontinuance is
251 effective retroactively to the extent it is attributable to the covered
252 person's failure to timely pay required premiums or contributions
253 towards the cost of such coverage.

254 (36) "Retrospective review" means any review of a request for a
255 benefit that is not a prospective review or concurrent review.
256 "Retrospective review" does not include a review of a request that is
257 limited to the veracity of documentation or the accuracy of coding.

258 (37) "Stabilize" means, with respect to an emergency medical
259 condition, that (A) no material deterioration of such condition is likely,
260 within reasonable medical probability, to result from or occur during
261 the transfer of the individual from a facility, or (B) with respect to a
262 pregnant woman, the woman has delivered, including the placenta.

263 (38) "Urgent care request" means a request for a health care service
264 or course of treatment for which the time period for making a non-
265 urgent care request determination (A) could seriously jeopardize the
266 life or health of the covered person or the ability of the covered person
267 to regain maximum function, or (B) in the opinion of a health care
268 professional with knowledge of the covered person's medical
269 condition, would subject the covered person to severe pain that cannot
270 be adequately managed without the health care service or treatment
271 being requested.

272 (39) "Utilization review" has the same meaning as provided in
273 section 38a-226 of the general statutes, as amended by this act.

274 (40) "Utilization review company" has the same meaning as
275 provided in section 38a-226 of the general statutes, as amended by this
276 act.

277 Sec. 2. (NEW) (*Effective July 1, 2011*) (a) Sections 1 to 13, inclusive, of

278 this act shall apply to (1) any health carrier offering a health benefit
279 plan and that provides or performs utilization review including
280 prospective, concurrent or retrospective review benefit determinations,
281 and (2) any utilization review company or designee of a health carrier
282 that performs utilization review on the health carrier's behalf,
283 including prospective, concurrent or retrospective review benefit
284 determinations.

285 (b) Each health carrier shall be responsible for monitoring all
286 utilization review program activities carried out by or on behalf of
287 such health carrier. Such health carrier shall comply with the
288 provisions of sections 1 to 13, inclusive, of this act and any regulations
289 adopted thereunder, and shall be responsible for ensuring that any
290 utilization review company or other entity such health carrier contracts
291 with to perform utilization review complies with said sections and
292 regulations. Each health carrier shall ensure that appropriate personnel
293 have operational responsibility for the activities of the health carrier's
294 utilization review program.

295 (c) (1) A health carrier that requires utilization review of a benefit
296 request under a health benefit plan shall implement a utilization
297 review program and develop a written document that describes all
298 utilization review activities and procedures, whether or not delegated,
299 for (A) the filing of benefit requests, (B) the notification to covered
300 persons of utilization review and benefit determinations, and (C) the
301 review of adverse determinations and grievances in accordance with
302 sections 5 and 6 of this act.

303 (2) Such document shall describe the following:

304 (A) Procedures to evaluate the medical necessity, appropriateness,
305 health care setting, level of care or effectiveness of health care services;

306 (B) Data sources and clinical review criteria used in making
307 determinations;

308 (C) Procedures to ensure consistent application of clinical review
309 criteria and compatible determinations;

310 (D) Data collection processes and analytical methods used to assess
311 utilization of health care services;

312 (E) Provisions to ensure the confidentiality of clinical, proprietary
313 and protected health information;

314 (F) The health carrier's organizational mechanism, such as a
315 utilization review committee or quality assurance or other committee,
316 that periodically assesses the health carrier's utilization review
317 program and reports to the health carrier's governing body; and

318 (G) The health carrier's staff position that is responsible for the day-
319 to-day management of the utilization review program.

320 (d) Each health carrier shall:

321 (1) Include in the insurance policy, certificate of coverage or
322 handbook provided to covered persons a clear and comprehensive
323 description of:

324 (A) Its utilization review and benefit determination procedures;

325 (B) Its grievance procedures, including the grievance procedures for
326 requesting a review of an adverse determination;

327 (C) A description of the external review procedures set forth in
328 sections 9 to 11, inclusive, of this act, in a format prescribed by the
329 commissioner and including a statement that discloses that:

330 (i) A covered person may file a request for an external review of an
331 adverse determination or a final adverse determination with the
332 commissioner and that such review is available when the adverse
333 determination or the final adverse determination involves an issue of
334 medical necessity, appropriateness, health care setting, level of care or
335 effectiveness. Such disclosure shall include the contact information of

336 the commissioner; and

337 (ii) When filing a request for an external review of an adverse
338 determination or a final adverse determination, the covered person
339 shall be required to authorize the release of any medical records that
340 may be required to be reviewed for the purpose of making a decision
341 on such request;

342 (D) A statement of the rights and responsibilities of covered persons
343 with respect to each of the procedures under subparagraphs (A) to (C),
344 inclusive, of this subdivision. Such statement shall include a disclosure
345 that a covered person has the right to contact the commissioner's office
346 or the Office of Healthcare Advocate at any time for assistance and
347 shall include the contact information for said offices;

348 (2) Inform its covered persons, at the time of initial enrollment and
349 at least annually thereafter, of its grievance procedures. This
350 requirement may be fulfilled by including such procedures in an
351 enrollment agreement or update to such agreement;

352 (3) Inform a covered person and the covered person's health care
353 professional of the health carrier's grievance procedures whenever the
354 health carrier denies certification of a benefit requested by a covered
355 person's health care professional;

356 (4) Include in materials intended for prospective covered persons a
357 summary of its utilization review and benefit determination
358 procedures;

359 (5) Print on its membership or identification cards a toll-free
360 telephone number for utilization review and benefit determinations;

361 (6) Maintain records of all benefit requests, claims and notices
362 associated with utilization review and benefit determinations made in
363 accordance with sections 4 and 7 of this act for not less than six years
364 after such requests, claims and notices were made. Each health carrier
365 shall make such records available for examination by covered persons,

366 provided such records are subject to disclosure pursuant to section 1-
367 210 of the general statutes, the commissioner and appropriate federal
368 oversight agencies upon request; and

369 (7) Maintain records in accordance with section 12 of this act of all
370 grievances received. Each health carrier shall make such records
371 available for examination by covered persons, provided such records
372 are subject to disclosure pursuant to section 1-210 of the general
373 statutes, the commissioner and appropriate federal oversight agencies
374 upon request.

375 (e) (1) On or before March first annually, each health carrier shall
376 file with the commissioner:

377 (A) A summary report of its utilization review program activities in
378 the calendar year immediately preceding; and

379 (B) A report that includes for each type of health benefit plan
380 offered by the health carrier:

381 (i) A certificate of compliance certifying that the utilization review
382 program of the health carrier or its designee complies with all
383 applicable state and federal laws concerning confidentiality and
384 reporting requirements;

385 (ii) The number of covered lives;

386 (iii) The total number of grievances received;

387 (iv) The number of grievances resolved at each level, if applicable,
388 and their resolution;

389 (v) The number of grievances appealed to the commissioner of
390 which the health carrier has been informed;

391 (vi) The number of grievances referred to alternative dispute
392 resolution procedures or resulting in litigation; and

393 (vii) A synopsis of actions being taken to correct any problems
394 identified.

395 (2) The commissioner shall adopt regulations, in accordance with
396 chapter 54, to establish the form and content of the reports specified in
397 subdivision (1) of this subsection.

398 Sec. 3. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
399 contract with (A) health care professionals to administer such health
400 carrier's utilization review program and oversee utilization review
401 determinations, and (B) with clinical peers to evaluate the clinical
402 appropriateness of an adverse determination.

403 (2) Each utilization review program shall use documented clinical
404 review criteria that are based on sound clinical evidence and are
405 evaluated periodically by the health carrier's organizational
406 mechanism specified in subparagraph (F) of subdivision (2) of
407 subsection (c) of section 2 of this act to assure such program's ongoing
408 effectiveness. A health carrier may develop its own clinical review
409 criteria or it may purchase or license clinical review criteria from
410 qualified vendors approved by the commissioner. Each health carrier
411 shall make its clinical review criteria available upon request to
412 authorized government agencies.

413 (b) Each health carrier shall:

414 (1) Have procedures in place to ensure that the health care
415 professionals administering such health carrier's utilization review
416 program are applying the clinical review criteria consistently in
417 utilization review determinations;

418 (2) Have data systems sufficient to support utilization review
419 program activities and to generate management reports to enable the
420 health carrier to monitor and manage health care services effectively;

421 (3) Provide covered persons and participating providers with access
422 to its utilization review staff through a toll-free telephone number or

423 any other free calling option or by electronic means;

424 (4) Coordinate the utilization review program with other medical
425 management activity conducted by the health carrier, such as quality
426 assurance, credentialing, contracting with health care professionals,
427 data reporting, grievance procedures, processes for assessing member
428 satisfaction and risk management; and

429 (5) Routinely assess the effectiveness and efficiency of its utilization
430 review program.

431 (c) If a health carrier delegates any utilization review activities to a
432 utilization review company, the health carrier shall maintain adequate
433 oversight, which shall include (1) a written description of the
434 utilization review company's activities and responsibilities, including
435 such company's reporting requirements, (2) evidence of the health
436 carrier's formal approval of the utilization review company program,
437 and (3) a process by which the health carrier shall evaluate the
438 utilization review company's performance.

439 (d) When conducting utilization review, the health carrier shall (1)
440 collect only the information necessary, including pertinent clinical
441 information, to make the utilization review or benefit determination,
442 and (2) ensure that such review is conducted in a manner to ensure the
443 independence and impartiality of the individual or individuals
444 involved in making the utilization review or benefit determination. No
445 health carrier shall make decisions regarding the hiring, compensation,
446 termination, promotion or other similar matters of such individual or
447 individuals based on the likelihood that the individual or individuals
448 will support the denial of benefits.

449 Sec. 4. (NEW) (*Effective July 1, 2011*) (a) Each health carrier shall
450 maintain written procedures for making utilization review and benefit
451 determinations on benefit requests submitted to the health carrier by
452 covered persons or their authorized representatives and for notifying
453 covered persons and their authorized representatives of its

454 determinations with respect to such requests within the specified time
455 periods under this section.

456 (b) (1) Subject to the provisions of subdivision (2) of this subsection,
457 for a prospective review determination or a non-urgent care
458 concurrent review determination of a benefit request:

459 (A) A health carrier shall make the determination and notify the
460 covered person and, if applicable, the covered person's authorized
461 representative of the determination, whether or not the carrier certifies
462 the provision of the benefit, within a reasonable period of time
463 appropriate to the covered person's medical condition but not later
464 than fifteen days after the health carrier receives the request.

465 (B) If the determination is an adverse determination, the health
466 carrier shall notify the covered person and, if applicable, the covered
467 person's authorized representative of the adverse determination in
468 accordance with subsection (f) of this section.

469 (2) The time period specified in subparagraph (A) of subdivision (1)
470 of this subsection may be extended once by the health carrier for up to
471 fifteen days, provided the health carrier:

472 (A) Determines that an extension is necessary due to circumstances
473 beyond the health carrier's control; and

474 (B) Notifies the covered person and, if applicable, the covered
475 person's authorized representative prior to the expiration of the initial
476 fifteen-day time period, of the circumstances requiring the extension of
477 time and the date by which the health carrier expects to make a
478 determination.

479 (3) If the extension pursuant to subdivision (2) of this subsection is
480 necessary due to the failure of the covered person or the covered
481 person's authorized representative to submit information necessary to
482 reach a determination on the request, the health carrier shall:

483 (A) Specifically describe in the notice of extension the required
484 information necessary to complete the request; and

485 (B) Provide the covered person and, if applicable, the covered
486 person's authorized representative with not less than forty-five days
487 after the date of receipt of the notice to provide the specified
488 information.

489 (4) With respect to a failure specified in this subsection and
490 subsections (c) and (d) of this section, the provisions of said
491 subsections shall apply only in the case of a failure that is a
492 communication:

493 (A) By a covered person or the covered person's authorized
494 representative that is received by the individual or the organizational
495 unit of the health carrier responsible for handling benefit matters; and

496 (B) That refers to a specific covered person, a specific medical
497 condition or symptom and a specific health care service, treatment or
498 provider for which certification is being requested.

499 (c) (1) Whenever a health carrier receives a prospective review
500 request or a non-urgent care concurrent review request from a covered
501 person or a covered person's authorized representative that fails to
502 meet the health carrier's filing procedures, the health carrier shall
503 notify the covered person and, if applicable, the covered person's
504 authorized representative of such failure and shall provide in the
505 notice information on the proper procedures to be followed for filing
506 such request.

507 (2) The health carrier shall provide to the covered person and, if
508 applicable, the covered person's authorized representative the notice
509 required under subdivision (1) of this subsection not later than five
510 days after such request is determined a failure pursuant to subdivision
511 (1) of this subsection. The health carrier may provide such notice
512 orally, provided the health carrier provides confirmation in writing to

513 the covered person and the covered person's health care professional
514 of record not later than five days after providing the oral notice.

515 (d) (1) For a retrospective review determination, a health carrier
516 shall make the determination within a reasonable period of time but
517 not later than thirty days after the health carrier receives such request.

518 (2) If the determination is an adverse determination, the health
519 carrier shall notify the covered person and, if applicable, the covered
520 person's authorized representative of the adverse determination in
521 accordance with subsection (f) of this section.

522 (3) The time period specified in subdivision (1) of this subsection
523 may be extended once by the health carrier for up to fifteen days,
524 provided the health carrier:

525 (A) Determines that an extension is necessary due to circumstances
526 beyond the health carrier's control; and

527 (B) Notifies the covered person and, if applicable, the covered
528 person's authorized representative prior to the expiration of the initial
529 thirty-day time period, of the circumstances requiring the extension of
530 time and the date by which the health carrier expects to make a
531 determination.

532 (4) If the extension pursuant to subdivision (3) of this subsection is
533 necessary due to the failure of the covered person or the covered
534 person's authorized representative to submit information necessary to
535 reach a determination on the request, the health carrier shall:

536 (A) Specifically describe in the notice of extension the required
537 information necessary to complete the request; and

538 (B) Provide the covered person and, if applicable, the covered
539 person's authorized representative with not less than forty-five days
540 after the date of receipt of the notice to provide the specified
541 information.

542 (e) (1) For the purposes of calculating the time periods within which
543 a health carrier is required to make a determination under subsections
544 (b) and (d) of this section, such time period shall begin on the date the
545 request is received by the health carrier in accordance with the health
546 carrier's procedures established pursuant to this section for filing a
547 request, regardless of whether all of the information necessary to make
548 the determination accompanies the filing.

549 (2) If the time period for a health carrier to make a determination
550 under subsections (b) and (d) of this section is extended due to the
551 covered person's or the covered person's authorized representative's,
552 as applicable, failure to submit the information necessary to make the
553 determination, such time period shall be tolled from the date on which
554 the health carrier sends the notification of the extension to the covered
555 person or the covered person's authorized representative, as
556 applicable, until the earlier of (A) the date on which the covered
557 person or the covered person's authorized representative, as
558 applicable, provides the specified information to the health carrier, or
559 (B) the date on which the specified information was to have been
560 submitted.

561 (3) If the covered person or the covered person's authorized
562 representative fails to submit the specified information before the end
563 of the period of the extension, as specified in subdivision (3) of
564 subsection (b) of this section or subdivision (4) of subsection (d) of this
565 section, the health carrier may deny certification of the benefit
566 requested.

567 (f) (1) Each health carrier shall provide promptly to a covered
568 person and, if applicable, the covered person's authorized
569 representative a notice of an adverse determination. Such notice may
570 be provided in writing or by electronic means and shall, in a manner
571 calculated to be understood by the covered person or the covered
572 person's authorized representative, set forth:

573 (A) Information sufficient to identify the benefit request or claim

574 involved, including the date of service, if applicable, the health care
575 professional, the claim amount, if applicable, the diagnosis code and its
576 corresponding meaning and the treatment code and its corresponding
577 meaning;

578 (B) The specific reason or reasons for the adverse determination,
579 including the denial code and its corresponding meaning, as well as a
580 description of the health carrier's standard, if any, that was used in
581 reaching the denial;

582 (C) Reference to the specific health benefit plan provisions on which
583 the determination is based;

584 (D) A description of any additional material or information
585 necessary for the covered person to perfect the benefit request or claim,
586 including an explanation of why the material or information is
587 necessary to perfect the request or claim;

588 (E) A description of the health carrier's internal grievance process,
589 including any time limits applicable to such process;

590 (F) If the adverse determination is based on a health carrier's
591 internal rule, guideline, protocol or other similar criterion, (i) the
592 specific rule, guideline, protocol or other similar criterion, or (ii) a
593 statement that a specific rule, guideline, protocol or other similar
594 criterion of the health carrier was relied upon to make the adverse
595 determination and that a copy of such rule, guideline, protocol or other
596 similar criterion will be provided to the covered person free of charge
597 upon request, and instructions for requesting such copy;

598 (G) If the adverse determination is based on medical necessity or an
599 experimental or investigational treatment or similar exclusion or limit,
600 the written statement of the scientific or clinical rationale for the
601 adverse determination and (i) an explanation of the scientific or clinical
602 rationale used to make the determination that applies the terms of the
603 health benefit plan to the covered person's medical circumstances, or

604 (ii) a statement that an explanation will be provided to the covered
605 person free of charge upon request and instructions for requesting a
606 copy of such explanation; and

607 (H) A statement explaining the right of the covered person to
608 contact the commissioner's office or the Office of the Healthcare
609 Advocate at any time for assistance or, upon completion of the health
610 carrier's internal grievance process as provided under sections 5 and 6
611 of this act, to file a civil suit in a court of competent jurisdiction. Such
612 statement shall include the contact information for said offices.

613 (2) A health carrier shall provide the notice required under this
614 section in a culturally and linguistically appropriate manner in
615 accordance with federal law. If a health carrier is required to provide
616 such notice in a culturally and linguistically appropriate manner, the
617 health carrier shall:

618 (A) Include a statement in the English version of the notice,
619 prominently displayed in the non-English language required pursuant
620 to federal law, offering the provision of the notice in the non-English
621 language;

622 (B) Once a utilization review or benefit determination request has
623 been made by a covered person, provide all subsequent notices to such
624 person in both English and the non-English language; and

625 (C) To the extent the health carrier maintains a consumer assistance
626 process, such as a telephone hotline that answers questions or provides
627 assistance with filing claims and appeals, provide such assistance in
628 the non-English language.

629 (3) If the adverse determination is a rescission, the health carrier
630 shall, in addition to the notice required under subdivision (1) of this
631 subsection, include with the copy of the application to the
632 commissioner for approval of such rescission that is required to be sent
633 to the covered person pursuant to section 38a-477b of the general

634 statutes, a written statement that includes:

635 (A) Clear identification of the alleged fraudulent act, practice or
636 omission or the intentional misrepresentation of material fact;

637 (B) An explanation as to why the act, practice or omission was
638 fraudulent or was an intentional misrepresentation of a material fact;

639 (C) A disclosure that the covered person or the covered person's
640 authorized representative may file immediately, without waiting for
641 the date such advance notice of the proposed rescission ends, a
642 grievance with the health carrier to request a review of the adverse
643 determination to rescind coverage, pursuant to sections 5 and 6 of this
644 act;

645 (D) A description of the health carrier's grievance procedures
646 established under sections 5 and 6 of this act, including any time limits
647 applicable to those procedures; and

648 (E) The date such advance notice of the proposed rescission ends
649 and the date back to which the coverage will be retroactively
650 rescinded.

651 (g) (1) Whenever a health carrier fails to strictly adhere to the
652 requirements of this section with respect to making utilization review
653 and benefit determinations of a benefit request or claim, the covered
654 person shall be deemed to have exhausted the internal grievance
655 process of such health carrier and may file a request for an external
656 review in accordance with the provisions of section 9 of this act,
657 regardless of whether the health carrier asserts it substantially
658 complied with the requirements of this section or that any error it
659 committed was de minimis.

660 (2) A covered person who has exhausted the internal grievance
661 process of a health carrier may, in addition to filing a request for an
662 external review, pursue any available remedies under state or federal
663 law on the basis that the health carrier failed to provide a reasonable

664 internal grievance process that would yield a decision on the merits of
665 the claim.

666 Sec. 5. (NEW) (*Effective July 1, 2011*) (a) (1) Except as specified in
667 section 9 of this act, a health carrier shall establish and maintain
668 written procedures for receiving and resolving grievances from
669 covered persons, in accordance with this section and section 6 of this
670 act.

671 (2) Each health carrier shall file a copy of such procedures, including
672 all forms used to process requests made pursuant to section 6 of this
673 act, with the commissioner. Any subsequent material modifications to
674 such procedures shall also be filed with the commissioner.

675 (3) In addition to the copy of the procedures required to be filed
676 under subdivision (1) of this subsection, each health carrier shall file
677 annually with the commissioner, as part of its annual report required
678 under subsection (e) of section 2 of this act, a certificate of compliance
679 stating that the health carrier has established and maintains grievance
680 procedures for each of its health benefit plans that fully comply with
681 the provisions of sections 5 to 8, inclusive, of this act.

682 (b) A covered person or a covered person's authorized
683 representative may file a grievance of an adverse determination that
684 was based, in whole or in part, on medical necessity with the health
685 carrier not later than one hundred eighty days after the covered person
686 or the covered person's authorized representative, as applicable,
687 receives the notice of an adverse determination sent pursuant to
688 section 4 of this act.

689 (c) The health carrier shall provide the covered person and, if
690 applicable, the covered person's authorized representative with the
691 name, address and telephone number of the individual or the
692 organizational unit designated to coordinate the review of such
693 grievance on behalf of the health carrier.

694 (d) When conducting a review of an adverse determination under
695 this section, the health carrier shall ensure that such review is
696 conducted in a manner to ensure the independence and impartiality of
697 the individual or individuals involved in making the review decision.
698 No health carrier shall make decisions regarding the hiring,
699 compensation, termination, promotion or other similar matters of such
700 individual or individuals based on the likelihood that the individual or
701 individuals will support the denial of benefits.

702 (e) (1) If the adverse determination involves utilization review, the
703 health carrier shall designate an appropriate clinical peer or peers to
704 review such adverse determination. Such clinical peer or peers shall
705 not have been involved in the initial adverse determination.

706 (2) In designating an appropriate clinical peer or peers, the health
707 carrier shall ensure that, if more than one clinical peer is involved in
708 the review, a majority of the individuals reviewing the adverse
709 determination shall be health care professionals who have appropriate
710 expertise.

711 (f) The individual or individuals conducting a review under this
712 section shall take into consideration all comments, documents, records
713 and other information relevant to the covered person's benefit request
714 that is the subject of the adverse determination under review, that are
715 submitted by the covered person or the covered person's authorized
716 representative, regardless of whether such information was submitted
717 or considered in making the initial adverse determination.

718 (g) (1) (A) A covered person or, if applicable, the covered person's
719 authorized representative may:

720 (i) Submit written comments, documents, records and other
721 material relevant to the covered person's benefit request that is the
722 subject of the adverse determination under review, for consideration
723 by the individual or individuals conducting the review; and

724 (ii) Receive from the health carrier, free of charge and upon request,
725 reasonable access to and copies of all documents, records and other
726 information relevant to the covered person's benefit request that is the
727 subject of the adverse determination under review.

728 (B) For purposes of subparagraph (A)(ii) of this subdivision and
729 subparagraph (C) of subdivision (6) of subsection (i) of this section, a
730 document, record or other information shall be considered "relevant"
731 to a covered person's benefit request if the document, record or other
732 information:

733 (i) Was relied upon in making the benefit determination;

734 (ii) Was submitted, considered or generated in the course of making
735 the adverse determination under review, regardless of whether the
736 document, record or other information was relied upon in making the
737 benefit determination;

738 (iii) Demonstrates that, in making the benefit determination, the
739 health carrier or its designated representatives consistently applied
740 required administrative procedures and safeguards with respect to the
741 covered person as other similarly situated covered persons; or

742 (iv) Constitutes a statement of policy or guidance concerning the
743 denied health care service or treatment for the covered person's
744 diagnosis, regardless of whether the policy or guidance was relied
745 upon in making the benefit determination.

746 (2) The health carrier shall notify the covered person and, if
747 applicable, the covered person's authorized representative of the
748 provisions of subdivision (1) of this subsection not later than three
749 business days after the health carrier receives a grievance under
750 subsection (b) of this section.

751 (h) (1) The health carrier shall notify the covered person and, if
752 applicable, the covered person's authorized representative in writing
753 or by electronic means of its decision within the time period under

754 subdivision (2) or (3) of this subsection. Such time period shall begin
755 on the date the health carrier receives the grievance in accordance with
756 the health carrier's procedures for filing such grievance, regardless of
757 whether all of the information necessary to make the decision
758 accompanies the filing.

759 (2) For a grievance of an adverse determination involving a
760 prospective or concurrent review request, the health carrier shall make
761 a decision and notify the covered person and, if applicable, the covered
762 person's authorized representative of the decision within a reasonable
763 period of time appropriate to the covered person's medical condition
764 but not later than thirty days after the health carrier receives the
765 grievance.

766 (3) For a grievance of an adverse determination involving a
767 retrospective review request, the health carrier shall make a decision
768 and notify the covered person and, if applicable, the covered person's
769 authorized representative of the decision within a reasonable period of
770 time but not later than sixty days after the health carrier receives the
771 grievance.

772 (4) Prior to issuing a decision in accordance with the time period
773 provided in subdivision (2) or (3) of this subsection, the health carrier
774 shall provide free of charge to the covered person or the covered
775 person's authorized representative, as applicable, any new or
776 additional evidence relied upon or generated by the health carrier, or
777 at the discretion of the health carrier, any new or additional evidence
778 relied upon or generated by the health carrier in connection with the
779 grievance, sufficiently in advance of the date the decision is required to
780 be made to permit the covered person or the covered person's
781 authorized representative, as applicable, a reasonable opportunity to
782 respond prior to such date.

783 (i) Each health carrier shall provide promptly to a covered person
784 and, if applicable, the covered person's authorized representative a
785 notice of decision. Such notice may be provided in writing or by

786 electronic means and shall comply with the requirements of
787 subdivision (2) of subsection (f) of section 4 of this act. Such notice
788 shall, in a manner calculated to be understood by the covered person
789 or the covered person's authorized representative, set forth:

790 (1) The titles and qualifying credentials of the individual or
791 individuals participating in the review process;

792 (2) Information sufficient to identify the claim involved with respect
793 to the grievance, including the date of service, if applicable, the health
794 care professional, the claim amount, if applicable, the diagnosis code
795 and its corresponding meaning and the treatment code and its
796 corresponding meaning;

797 (3) A statement of such individual's or individuals' understanding
798 of the covered person's grievance;

799 (4) The individual's or individuals' decision in clear terms and the
800 health benefit plan contract basis or scientific or clinical rationale for
801 such decision in sufficient detail for the covered person to respond
802 further to the health carrier's position;

803 (5) Reference to the evidence or documentation used as the basis for
804 the decision;

805 (6) For a decision issued pursuant to subsection (h) of this section
806 that upholds the adverse determination:

807 (A) The specific reason or reasons for the final adverse
808 determination, including the denial code and its corresponding
809 meaning, as well as a description of the health carrier's standard, if
810 any, that was used in reaching the denial;

811 (B) Reference to the specific health benefit plan provisions on which
812 the decision is based;

813 (C) A statement that the covered person may receive from the health

814 carrier, free of charge and upon request, reasonable access to and
815 copies of, all documents, records and other information relevant, as the
816 term "relevant" is described in subparagraph (B) of subdivision (1) of
817 subsection (g) of this section to the adverse determination under
818 review;

819 (D) If the final adverse determination is based on a health carrier's
820 internal rule, guideline, protocol or other similar criterion, (i) the
821 specific rule, guideline, protocol or other similar criterion, or (ii) a
822 statement that a specific rule, guideline, protocol or other similar
823 criterion of the health carrier was relied upon to make the final adverse
824 determination and that a copy of such rule, guideline, protocol or other
825 similar criterion will be provided to the covered person free of charge
826 upon request, and instructions for requesting such copy;

827 (E) If the final adverse determination is based on medical necessity
828 or an experimental or investigational treatment or similar exclusion or
829 limit, the written statement of the scientific or clinical rationale for the
830 final adverse determination and (i) an explanation of the scientific or
831 clinical rationale used to make the determination that applies the terms
832 of the health benefit plan to the covered person's medical
833 circumstances, or (ii) a statement that an explanation will be provided
834 to the covered person free of charge upon request and instructions for
835 requesting a copy of such explanation;

836 (7) If applicable, the following statement: "You and your plan may
837 have other voluntary alternative dispute resolution options such as
838 mediation. One way to find out what may be available is to contact
839 your state Insurance Commissioner."; and

840 (8) A statement disclosing the covered person's right to contact the
841 commissioner's office or the Office of the Healthcare Advocate at any
842 time. Such disclosure shall include the contact information for said
843 offices.

844 (j) (1) Whenever a health carrier fails to strictly adhere to the

845 requirements of this section with respect to receiving and resolving
846 grievances involving an adverse determination, the covered person
847 shall be deemed to have exhausted the internal grievance process of
848 such health carrier and may file a request for an external review in
849 accordance with the provisions of section 9 of this act, regardless of
850 whether the health carrier asserts that it substantially complied with
851 the requirements of this section or that any error it committed was de
852 minimis.

853 (2) A covered person who has exhausted the internal grievance
854 process of a health carrier may, in addition to filing a request for an
855 external review, pursue any available remedies under state or federal
856 law on the basis that the health carrier failed to provide a reasonable
857 internal grievance process that would yield a decision on the merits of
858 the claim.

859 Sec. 6. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
860 include in its grievance procedures written procedures (A) for the
861 review of a grievance of an adverse determination that was not based
862 on medical necessity, and (B) that permit a covered person or the
863 covered person's authorized representative to file a grievance that does
864 not involve an adverse determination. The provisions of sections 1 to
865 13, inclusive, of this act shall not apply to a grievance that does not
866 involve an adverse determination.

867 (2) (A) A covered person or the covered person's authorized
868 representative may submit written material for the individual or
869 individuals designated by the health carrier pursuant to subdivision
870 (3) of this subsection to consider when conducting such review.

871 (B) The health carrier shall notify the covered person and, if
872 applicable, the covered person's authorized representative of the
873 provisions of subparagraph (A) of this subdivision not later than three
874 business days after the health carrier receives a grievance.

875 (3) (A) Upon receipt of a grievance, a health carrier shall designate

876 an individual or individuals to conduct a review of the grievance.

877 (B) The health carrier shall not designate the same individual or
878 individuals who denied the claim or handled the matter that is the
879 subject of the grievance to conduct the review of the grievance.

880 (C) The health carrier shall provide the covered person and, if
881 applicable, the covered person's authorized representative with the
882 name, address and telephone number of the individual or the
883 organizational unit designated to coordinate the review on behalf of
884 the health carrier.

885 (b) (1) The health carrier shall notify the covered person and, if
886 applicable, the covered person's authorized representative in writing,
887 of its decision not later than twenty business days after the health
888 carrier received the grievance.

889 (2) If the health carrier is unable to comply with the time period
890 specified in subdivision (1) of this subsection due to circumstances
891 beyond the health carrier's control, the time period may be extended
892 by the health carrier for up to ten business days, provided that on or
893 before the twentieth business day after the health carrier received the
894 grievance, the health carrier provides written notice to the covered
895 person and, if applicable, the covered person's authorized
896 representative of the extension and the reasons for the delay.

897 (c) The written decision issued pursuant to subsection (b) of this
898 section shall contain:

899 (1) The titles and qualifying credentials of the individual or
900 individuals participating in the review process;

901 (2) A statement of such individual's or individuals' understanding
902 of the covered person's grievance;

903 (3) The individual's or individuals' decision in clear terms and the
904 health benefit plan contract basis for such decision in sufficient detail

905 for the covered person to respond further to the health carrier's
906 position; and

907 (4) Reference to the evidence or documentation used as the basis for
908 the decision.

909 Sec. 7. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
910 establish written procedures for (A) expedited utilization review and
911 benefit determinations with respect to prospective urgent care requests
912 and concurrent review urgent care requests, and (B) notifying covered
913 persons or covered persons' authorized representatives of such
914 procedures. Each health carrier shall make expedited utilization
915 review and benefit determinations within the specified time periods
916 under this section.

917 (2) In determining whether a benefit request shall be considered an
918 urgent care request, an individual acting on behalf of a health carrier
919 shall apply the judgment of a prudent layperson who possesses an
920 average knowledge of health and medicine, except that any benefit
921 request determined to be an urgent care request by a health care
922 professional with knowledge of the covered person's medical
923 condition shall be deemed an urgent care request.

924 (b) (1) For a prospective urgent care request, unless the covered
925 person or the covered person's authorized representative has failed to
926 provide information necessary for the health carrier to determine
927 whether or to what extent the benefit requested is a covered benefit or
928 payable under the covered person's health benefit plan, the health
929 carrier shall notify the covered person and, if applicable, the covered
930 person's authorized representative of the health carrier's determination
931 with respect to the request as soon as possible, taking into account the
932 covered person's medical condition, but not later than twenty-four
933 hours after the health carrier receives such request.

934 (2) If the determination is an adverse determination, the health
935 carrier shall notify the covered person and, if applicable, the covered

936 person's authorized representative of the adverse determination in
937 accordance with subsection (e) of this section.

938 (3) (A) If the covered person or the covered person's authorized
939 representative, as applicable, has failed to provide information
940 necessary for the health carrier to make a determination, the health
941 carrier shall notify the covered person or the covered person's
942 authorized representative, as applicable, as soon as possible but not
943 later than twenty-four hours after the health carrier receives such
944 request. Such notice may be provided orally or, if requested by the
945 covered person or the covered person's authorized representative,
946 shall be provided in writing and shall:

947 (i) State what specific information is needed; and

948 (ii) Provide the covered person or the covered person's authorized
949 representative, as applicable, a reasonable period of time to submit the
950 specified information, taking into account the covered person's
951 medical condition, but not less than forty-eight hours after notifying
952 the covered person or the covered person's authorized representative,
953 as applicable.

954 (B) The health carrier shall notify the covered person and, if
955 applicable, the covered person's authorized representative of its
956 determination as soon as possible but not later than forty-eight hours
957 after the earlier of (i) the date on which the covered person or the
958 covered person's authorized representative, as applicable, provides the
959 specified information to the health carrier, or (ii) the date on which the
960 specified information was to have been submitted.

961 (C) If the covered person or the covered person's authorized
962 representative fails to submit the specified information before the end
963 of the period of the extension, as specified in subparagraph (A)(ii) of
964 this subdivision, the health carrier may deny certification of the benefit
965 requested.

966 (D) If the determination is an adverse determination, the health
967 carrier shall notify the covered person and, if applicable, the covered
968 person's authorized representative of the adverse determination in
969 accordance with subsection (e) of this section.

970 (c) (1) If a health carrier receives an urgent care request that fails to
971 meet the health carrier's filing procedures, the health carrier shall
972 notify the covered person and, if applicable, the covered person's
973 authorized representative of such failure and shall provide in the
974 notice information on the proper procedures to be followed for filing
975 such request.

976 (2) The health carrier shall provide to the covered person and, if
977 applicable, the covered person's authorized representative the notice
978 required under subdivision (1) of this subsection as soon as possible
979 but not later than twenty-four hours after the health carrier receives
980 such request. Such notice may be provided orally or, if requested by
981 the covered person or the covered person's authorized representative,
982 shall be provided in writing.

983 (3) The provisions of this subsection shall apply only in the case of a
984 failure that is a communication:

985 (A) By a covered person or the covered person's authorized
986 representative that is received by the individual or the organizational
987 unit of the health carrier responsible for handling benefit matters; and

988 (B) That refers to a specific covered person, a specific medical
989 condition or symptom and a specific health care service, treatment or
990 provider for which certification is being requested.

991 (d) (1) For a concurrent review urgent care request involving a
992 request by the covered person or the covered person's authorized
993 representative to extend the course of treatment beyond the initial
994 period of time or the number of treatments, if such request is made at
995 least twenty-four hours prior to the expiration of the prescribed period

996 of time or number of treatments, the health carrier shall make a
997 determination and shall notify the covered person and, if applicable,
998 the covered person's authorized representative of the determination as
999 soon as possible, taking into account the covered person's medical
1000 condition, but not later than twenty-four hours after the health carrier
1001 receives such request.

1002 (2) (A) If a covered person has been admitted to an acute care
1003 hospital and the attending health care professional determines that the
1004 covered person's life will be endangered or other serious injury or
1005 illness could occur if the covered person is discharged or if treatment is
1006 delayed, the attending health care professional may transmit a
1007 concurrent review urgent care request for an expedited review to the
1008 utilization review company or designee of the covered person's health
1009 carrier performing utilization review on the health carrier's behalf. If
1010 such attending health care professional receives no response from the
1011 utilization review company or designee after three hours have passed
1012 since the health care professional sent the request and all information
1013 needed to complete the review, the request shall be deemed approved.

1014 (B) Each utilization review company or designee of a health carrier
1015 that performs utilization review on the health carrier's behalf shall
1016 make review staff available from eight o'clock a.m. to nine o'clock p.m.
1017 to process requests transmitted pursuant to this subdivision.

1018 (C) The commissioner shall develop a standardized process for the
1019 transmission of and responses to concurrent review urgent care
1020 requests described in subparagraph (A) of this subdivision.

1021 (3) If the determination is an adverse determination, the health
1022 carrier shall notify the covered person and, if applicable, the covered
1023 person's authorized representative of the adverse determination in
1024 accordance with subsection (e) of this section.

1025 (e) (1) Each health carrier shall provide promptly to a covered
1026 person and, if applicable, the covered person's authorized

1027 representative a notice of an adverse determination. Such notice may
1028 be provided orally, in writing or by electronic means and shall comply
1029 with the requirements of subdivisions (1) and (2) of subsection (f) of
1030 section 4 of this act. In addition, such notice shall include a description
1031 of the health carrier's expedited review procedures established
1032 pursuant to section 8 of this act, including any time limits applicable to
1033 such procedures.

1034 (2) If the notice is provided orally, the health carrier shall provide
1035 such notice in writing or by electronic means to the covered person
1036 and the covered person's health care professional of record not later
1037 than three days after providing the oral notice.

1038 (f) (1) Whenever a health carrier fails to strictly adhere to the
1039 requirements of this section with respect to making expedited
1040 utilization review and benefit determinations of a prospective urgent
1041 care request or concurrent review urgent care request, the covered
1042 person shall be deemed to have exhausted the internal grievance
1043 process of such health carrier and may file a request for an external
1044 review in accordance with the provisions of section 9 of this act,
1045 regardless of whether the health carrier asserts that it substantially
1046 complied with the requirements of this section or that any error it
1047 committed was de minimis.

1048 (2) A covered person who has exhausted the internal grievance
1049 process of a health carrier may, in addition to filing a request for an
1050 external review, pursue any available remedies under state or federal
1051 law on the basis that the health carrier failed to provide a reasonable
1052 internal grievance process that would yield a decision on the merits of
1053 the claim.

1054 Sec. 8. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
1055 establish written procedures for the expedited review of grievances
1056 involving adverse determinations of prospective or concurrent urgent
1057 care requests. Such procedures shall allow a covered person or a
1058 covered person's authorized representative to request orally or in

1059 writing such expedited review.

1060 (2) (A) At the same time a covered person or a covered person's
1061 authorized representative files a request for an expedited review under
1062 this section, the covered person or the covered person's authorized
1063 representative may file a request for an expedited external review of
1064 the adverse determination:

1065 (i) Pursuant to section 10 of this act if the covered person has a
1066 medical condition for which the time period for completion of an
1067 external review as set forth in section 9 of this act, would seriously
1068 jeopardize the life or health of the covered person or would jeopardize
1069 the covered person's ability to regain maximum function; or

1070 (ii) Pursuant to section 11 of this act if the adverse determination
1071 involves a denial of coverage based on a determination that the
1072 recommended or requested health care service or treatment is
1073 experimental or investigational and the covered person's treating
1074 health care professional certifies in writing that such recommended or
1075 requested health care service or treatment would be significantly less
1076 effective if not promptly initiated.

1077 (B) Upon the receipt of the request for an expedited external review
1078 pursuant to this subdivision, the independent review organization
1079 assigned to conduct the expedited external review shall determine
1080 whether the covered person shall be required to complete the
1081 expedited review of the grievance prior to conducting the expedited
1082 external review.

1083 (C) If the independent review organization determines that the
1084 covered person must complete the expedited review of the grievance
1085 under this section prior to the conducting of the expedited external
1086 review, the independent review organization shall immediately notify
1087 the covered person and, if applicable, the covered person's authorized
1088 representative (i) of such determination, and (ii) that the organization
1089 shall not proceed with the expedited external review until the

1090 completion of the expedited grievance review.

1091 (b) Each health carrier shall designate an appropriate clinical peer or
1092 peers to review such adverse determination. Such clinical peer or peers
1093 shall not have been involved in the initial adverse determination.

1094 (c) In an expedited review under this section, all necessary
1095 information, including the health carrier's decision, shall be
1096 transmitted between the health carrier and the covered person or the
1097 covered person's authorized representative, as applicable, by
1098 telephone, facsimile, electronic means or any other expeditious method
1099 available.

1100 (d) As expeditiously as the covered person's medical condition
1101 requires but not later than seventy-two hours after the health carrier
1102 receives the request for the expedited review, the health carrier shall
1103 make an expedited review decision under this section and shall notify
1104 the covered person and, if applicable, the covered person's authorized
1105 representative of the decision as set forth in subsection (f) of this
1106 section. For the purposes of calculating the time period within which a
1107 health carrier is required to make a determination under this
1108 subsection, such time period shall begin on the date the health carrier
1109 receives the request in accordance with the health carrier's procedures
1110 for filing such request, regardless of whether all of the information
1111 necessary to make the decision accompanies the filing.

1112 (e) If the expedited review requested is for a grievance involving an
1113 adverse determination with respect to a concurrent review urgent care
1114 request, the treatment shall be continued without liability to the
1115 covered person until the covered person has been notified of the
1116 determination.

1117 (f) (1) Each health carrier shall provide promptly to a covered
1118 person and, if applicable, the covered person's authorized
1119 representative a notice of decision. Such notice may be provided
1120 orally, in writing or by electronic means and shall comply with the

1121 requirements of subdivision (2) of subsection (f) of section 4 of this act.
1122 Such notice shall, in a manner calculated to be understood by the
1123 covered person or the covered person's authorized representative, set
1124 forth:

1125 (A) The titles and qualifying credentials of the individual or
1126 individuals participating in the expedited review process;

1127 (B) Information sufficient to identify the claim involved with respect
1128 to the grievance, including the date of service, if applicable, the health
1129 care professional, the claim amount, if applicable, the diagnosis code
1130 and its corresponding meaning and the treatment code and its
1131 corresponding meaning;

1132 (C) A statement of such individual's or individuals' understanding
1133 of the covered person's grievance;

1134 (D) The individual's or individuals' decision in clear terms and the
1135 health benefit plan contract basis for such decision in sufficient detail
1136 for the covered person to respond further to the health carrier's
1137 position;

1138 (E) Reference to the evidence or documentation used as the basis for
1139 the decision; and

1140 (F) If the decision involves a final adverse determination:

1141 (i) The specific reason or reasons for the final adverse
1142 determination, including the denial code and its corresponding
1143 meaning, as well as a description of the health carrier's standard, if
1144 any, that was used in reaching the denial;

1145 (ii) Reference to the specific health benefit plan provisions on which
1146 the determination is based;

1147 (iii) A description of any additional material or information
1148 necessary for the covered person to perfect the request, including an

1149 explanation of why the material or information is necessary to perfect
1150 the request;

1151 (iv) If the final adverse determination is based on a health carrier's
1152 internal rule, guideline, protocol or other similar criterion, (I) the
1153 specific rule, guideline, protocol or other similar criterion, or (II) a
1154 statement that a specific rule, guideline, protocol or other similar
1155 criterion of the health carrier was relied upon to make the adverse
1156 determination and that a copy of such rule, guideline, protocol or other
1157 similar criterion will be provided to the covered person free of charge
1158 upon request, and instructions for requesting such copy;

1159 (v) If the final adverse determination is based on medical necessity
1160 or an experimental or investigational treatment or similar exclusion or
1161 limit, the written statement of the scientific or clinical rationale for the
1162 adverse determination and (I) an explanation of the scientific or clinical
1163 rationale used to make the determination that applies the terms of the
1164 health benefit plan to the covered person's medical circumstances, or
1165 (II) a statement that an explanation will be provided to the covered
1166 person free of charge upon request and instructions for requesting a
1167 copy of such explanation;

1168 (vi) A statement describing the procedures for obtaining an external
1169 review of the final adverse determination pursuant to section 9 of this
1170 act;

1171 (vii) A statement disclosing the covered person's right to bring a
1172 civil action in a court of competent jurisdiction;

1173 (viii) The following statement: "You and your plan may have other
1174 voluntary alternative dispute resolution options such as mediation.
1175 One way to find out what may be available is to contact your state
1176 Insurance Commissioner."; and

1177 (ix) A statement disclosing the covered person's right to contact the
1178 commissioner's office or the Office of the Healthcare Advocate at any

1179 time. Such disclosure shall include the contact information for said
1180 offices.

1181 (2) If the notice is provided orally, the health carrier shall provide
1182 such notice in writing or by electronic means to the covered person
1183 and the covered person's health care professional of record not later
1184 than three days after providing the oral notice.

1185 Sec. 9. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a
1186 covered person's authorized representative may file a request for an
1187 external review of an adverse determination or a final adverse
1188 determination in accordance with the provisions of this section. All
1189 requests for external review shall be made in writing to the
1190 commissioner. The commissioner may prescribe the form and content
1191 of external review requests.

1192 (2) All requests for external review shall be accompanied by a filing
1193 fee specified in section 38a-11 of the general statutes, as amended by
1194 this act. If the commissioner finds the covered person is indigent or
1195 unable to pay the fee, the commissioner shall waive the fee.

1196 (3) The health carrier that issued the final adverse determination
1197 that is the subject of the external review request shall pay the
1198 independent review organization for the cost of conducting the
1199 external review, whether such review is a standard external review or
1200 an expedited external review.

1201 (4) An external review decision, whether such review is a standard
1202 external review or an expedited external review, shall be binding on
1203 the health carrier and the covered person, except to the extent such
1204 health carrier or covered person has other remedies available under
1205 federal or state law. A covered person or a covered person's authorized
1206 representative shall not file a subsequent request for an external
1207 review or an expedited external review that involves the same adverse
1208 determination or final adverse determination for which the covered
1209 person or the covered person's authorized representative already

1210 received an external review decision or an expedited external review
1211 decision.

1212 (5) Each health carrier shall maintain written records of external
1213 reviews as set forth in section 12 of this act.

1214 (6) Each independent review organization that conducts external
1215 reviews shall maintain written records as set forth in subsection (e) of
1216 section 38a-226d of the general statutes, as amended by this act.

1217 (b) (1) A covered person or a covered person's authorized
1218 representative shall not file a request for an external review until the
1219 covered person or the covered person's authorized representative has
1220 exhausted the health carrier's internal grievance process.

1221 (2) A covered person shall be deemed to have exhausted the health
1222 carrier's internal grievance process:

1223 (A) If the covered person or the covered person's authorized
1224 representative has not received a written decision on the covered
1225 person's or the covered person's authorized representative's request for
1226 a prospective or a nonurgent care concurrent review from the health
1227 carrier within thirty days after such request was filed with the health
1228 carrier, except to the extent the covered person or the covered person's
1229 authorized representative requested or agreed to a delay; or

1230 (B) In accordance with subsection (g) of section 4 of this act.

1231 (3) Notwithstanding subdivision (2) of this subsection, a covered
1232 person or a covered person's authorized representative shall not file a
1233 request for an external review of an adverse determination involving a
1234 retrospective review determination made pursuant to section 4 of this
1235 act until the covered person has exhausted the health carrier's internal
1236 grievance process.

1237 (c) (1) At the same time a health carrier sends to a covered person or
1238 a covered person's authorized representative a written notice of an

1239 adverse determination or a final adverse determination issued by the
1240 health carrier under sections 5 to 8, inclusive, of this act, the health
1241 carrier shall include a written disclosure to the covered person and, if
1242 applicable, the covered person's authorized representative of the
1243 covered person's right to request an external review to be conducted
1244 pursuant to section 9 of this act.

1245 (2) The written notice shall include:

1246 (A) The following statement or a statement in substantially similar
1247 language: "We have denied your request for the provision of or
1248 payment for a health care service or course of treatment. You may have
1249 the right to have our decision reviewed by health care professionals
1250 who have no association with us by submitting a request for external
1251 review to the office of the Insurance Commissioner, if our decision
1252 involved making a judgment as to the medical necessity,
1253 appropriateness, health care setting, level of care or effectiveness of the
1254 health care service or treatment you requested.";

1255 (B) For a notice related to an adverse determination, a statement
1256 informing the covered person that:

1257 (i) If the covered person has a medical condition for which the time
1258 period for completion of an expedited review of a grievance involving
1259 an adverse determination as set forth in sections 7 and 8 of this act,
1260 would seriously jeopardize the life or health of the covered person or
1261 would jeopardize the covered person's ability to regain maximum
1262 function, the covered person or the covered person's authorized
1263 representative may (I) file a request for an expedited external review to
1264 be conducted pursuant to section 10 of this act, or (II) file a request for
1265 an expedited external review to be conducted pursuant to section 11 of
1266 this act if the adverse determination involves a denial of coverage
1267 based on a determination that the recommended or requested health
1268 care service or treatment is experimental or investigational and the
1269 covered person's treating health care professional certifies in writing
1270 that such recommended or requested health care service or treatment

1271 would be significantly less effective if not promptly initiated; and

1272 (ii) Such request for expedited external review may be filed at the
1273 same time the covered person or the covered person's authorized
1274 representative files a request for an expedited review of a grievance
1275 involving an adverse determination, as set forth in sections 7 and 8 of
1276 this act, except that the independent review organization assigned to
1277 conduct the expedited external review shall determine whether the
1278 covered person shall be required to complete the expedited review of
1279 the grievance prior to conducting the expedited external review;

1280 (C) For a notice related to a final adverse determination, a statement
1281 informing the covered person that:

1282 (i) If the covered person has a medical condition for which the time
1283 period for completion of an external review, as set forth in section 9 of
1284 this act, would seriously jeopardize the life or health of the covered
1285 person or would jeopardize the covered person's ability to regain
1286 maximum function, the covered person or the covered person's
1287 authorized representative may file a request for an expedited external
1288 review pursuant to section 10 of this act; or

1289 (ii) If the final adverse determination concerns (I) an admission,
1290 availability of care, continued stay or health care service for which the
1291 covered person received emergency services but has not been
1292 discharged from a facility, the covered person or the covered person's
1293 authorized representative may file a request for an expedited external
1294 review to be conducted pursuant to section 10 of this act, or (II) a
1295 denial of coverage based on a determination that the recommended or
1296 requested health care service or treatment is experimental or
1297 investigational and the covered person's treating health care
1298 professional certifies in writing that such recommended or requested
1299 health care service or treatment would be significantly less effective if
1300 not promptly initiated, the covered person or the covered person's
1301 authorized representative may file a request for an expedited external
1302 review to be conducted pursuant to section 11 of this act;

1303 (D) (i) A copy of the description of both the standard and expedited
1304 external review procedures the health carrier is required to provide
1305 pursuant to sections 9 to 11, inclusive, of this act, highlighting the
1306 provisions in the external review procedures that give the covered
1307 person or the covered person's authorized representative the
1308 opportunity to submit additional information and including any forms
1309 used to process an external review;

1310 (ii) As part of any forms provided under subparagraph (D)(i) of this
1311 subdivision, an authorization form or other document approved by the
1312 commissioner that complies with the requirements of 45 CFR 164.508,
1313 as amended from time to time, by which the covered person shall
1314 authorize the health carrier and the covered person's treating health
1315 care professional to release, transfer or otherwise divulge, in
1316 accordance with sections 38a-975 to 38a-999a, inclusive, of the general
1317 statutes, the covered person's protected health information including
1318 medical records for purposes of conducting an external review.

1319 (d) (1) Not later than one hundred twenty days after a covered
1320 person or a covered person's authorized representative receives a
1321 notice of an adverse determination or a final adverse determination
1322 pursuant to sections 5 to 8, inclusive, of this act, the covered person or
1323 the covered person's authorized representative may file a request for
1324 an external review with the commissioner in accordance with this
1325 section.

1326 (2) Not later than one business day after the commissioner receives
1327 such request, the commissioner shall send a copy of such request to the
1328 health carrier that issued the adverse determination or the final
1329 adverse determination that is the subject of the request.

1330 (3) Not later than five business days after the health carrier receives
1331 the copy of such request from the commissioner, the health carrier
1332 shall complete a preliminary review of the request to determine
1333 whether:

1334 (A) The individual is or was a covered person under the health
1335 benefit plan at the time the health care service was requested or, in the
1336 case of a retrospective review, was a covered person in the health
1337 benefit plan at the time the health care service was provided;

1338 (B) The health care service that is the subject of the adverse
1339 determination or the final adverse determination is a covered service
1340 under the covered person's health benefit plan but for the health
1341 carrier's determination that the health care service is not covered
1342 because it does not meet the health carrier's requirements for medical
1343 necessity, appropriateness, health care setting, level of care or
1344 effectiveness;

1345 (C) The covered person has exhausted the health carrier's internal
1346 grievance process; and

1347 (D) The covered person has provided all the information and forms
1348 required to process an external review, including an authorization
1349 form as set forth in subparagraph (D)(ii) of subdivision (2) of
1350 subsection (c) of this section.

1351 (4) (A) Not later than one business day after the completion of the
1352 preliminary review, the health carrier shall notify the commissioner,
1353 the covered person and, if applicable, the covered person's authorized
1354 representative in writing whether the request for an external review is
1355 complete and eligible for external review. The commissioner may
1356 specify the form for the health carrier's notice of initial determination
1357 under this subdivision and any supporting information required to be
1358 included in the notice.

1359 (B) If the request:

1360 (i) Is not complete, the health carrier shall notify the commissioner
1361 and the covered person and, if applicable, the covered person's
1362 authorized representative in writing and include in the notice what
1363 information or materials are needed to perfect the request; or

1364 (ii) Is not eligible for external review, the health carrier shall notify
1365 the commission, the covered person and, if applicable, the covered
1366 person's authorized representative in writing and include in the notice
1367 the reasons for its ineligibility.

1368 (C) The notice of initial determination shall include a statement
1369 informing the covered person and, if applicable, the covered person's
1370 authorized representative that a health carrier's initial determination
1371 that the request for an external review is ineligible for review may be
1372 appealed to the commissioner.

1373 (D) Notwithstanding a health carrier's initial determination that a
1374 request for an external review is ineligible for review, the
1375 commissioner may determine, pursuant to the terms of the covered
1376 person's health benefit plan, that such request is eligible for external
1377 review and assign an independent review organization to conduct
1378 such review. Any such review shall be conducted in accordance with
1379 this section.

1380 (e) (1) Whenever the commissioner is notified pursuant to
1381 subparagraph (A) of subdivision (4) of subsection (d) of this section
1382 that a request is eligible for external review, the commissioner shall,
1383 not later than one business day after receiving such notice:

1384 (A) Assign an independent review organization from the list of
1385 approved independent review organizations compiled and maintained
1386 by the commissioner pursuant to section 38a-226c of the general
1387 statutes, as amended by this act, to conduct the external review and
1388 notify the health carrier of the name of the assigned independent
1389 review organization. Such assignment shall be done on a random basis
1390 among those approved independent review organizations qualified to
1391 conduct the particular external review based on the nature of the
1392 health care service that is the subject of the adverse determination or
1393 the final adverse determination and other circumstances, including
1394 conflict of interest concerns as set forth in section 38a-226d of the
1395 general statutes, as amended by this act; and

1396 (B) Notify the covered person and, if applicable, the covered
1397 person's authorized representative in writing of the request's eligibility
1398 and acceptance for external review. The commissioner shall include in
1399 such notice (i) a statement that the covered person or the covered
1400 person's authorized representative may submit, not later than five
1401 days after the covered person or the covered person's authorized
1402 representative, as applicable, received such notice, additional
1403 information in writing to the assigned independent review
1404 organization that such organization shall consider when conducting
1405 the external review, and (ii) where and how such additional
1406 information is to be submitted. If additional information is submitted
1407 later than five days after the covered person or the covered person's
1408 authorized representative, as applicable, received such notice, the
1409 independent review organization may, but shall not be required to,
1410 accept and consider such additional information.

1411 (2) Not later than five business days after the health carrier receives
1412 notice of the name of the assigned independent review organization
1413 from the commissioner, the health carrier or its designee utilization
1414 review company shall provide to the assigned independent review
1415 organization the documents and any information such health carrier or
1416 utilization review company considered in making the adverse
1417 determination or the final adverse determination.

1418 (3) The failure of the health carrier or its designee utilization review
1419 company to provide the documents and information within the time
1420 specified in subdivision (2) of this subsection shall not delay the
1421 conducting of the external review.

1422 (4) (i) If the health carrier or its designee utilization review company
1423 fails to provide the documents and information within the time period
1424 specified in subdivision (2) of this subsection, the independent review
1425 organization may terminate the review and make a decision to reverse
1426 the adverse determination or the final adverse determination.

1427 (ii) Not later than one business day after terminating the review and

1428 making the decision to reverse the adverse determination or the final
1429 adverse determination, the independent review organization shall
1430 notify the commissioner, the health carrier, the covered person and, if
1431 applicable, the covered person's authorized representative in writing
1432 of such decision.

1433 (f) (1) The assigned independent review organization shall review
1434 all of the information and documents received pursuant to subsection
1435 (e) of this section. In reaching a decision, the independent review
1436 organization shall not be bound by any decisions or conclusions
1437 reached during the health carrier's utilization review process.

1438 (2) Upon the receipt of any information submitted by the covered
1439 person or the covered person's authorized representative pursuant to
1440 subparagraph (B) of subdivision (1) of subsection (e) of this section, the
1441 independent review organization shall forward such information to
1442 the health carrier not later than one business day after receiving such
1443 information.

1444 (3) (A) Upon the receipt of any information forwarded pursuant to
1445 subdivision (2) of this subsection, the health carrier may reconsider its
1446 adverse determination or the final adverse determination that is the
1447 subject of the external review. Such reconsideration shall not delay or
1448 terminate the review.

1449 (B) The independent review organization shall terminate the
1450 external review if the health carrier decides, upon completion of its
1451 reconsideration and notice to such organization as provided in
1452 subparagraph (C) of this subdivision, to reverse its adverse
1453 determination or its final adverse determination and provide coverage
1454 or payment for the health care service that is the subject of the adverse
1455 determination or the final adverse determination.

1456 (C) Not later than one business day after making the decision to
1457 reverse its adverse determination or its final adverse determination,
1458 the health carrier shall notify the commissioner, the assigned

1459 independent review organization, the covered person and, if
1460 applicable, the covered person's authorized representative in writing
1461 of such decision.

1462 (g) In addition to the documents and information received pursuant
1463 to subsection (e) of this section, the independent review organization
1464 shall consider, to the extent the documents or information are available
1465 and the independent review organization considers them appropriate,
1466 the following in reaching a decision:

1467 (1) The covered person's medical records;

1468 (2) The attending health care professional's recommendation;

1469 (3) Consulting reports from appropriate health care professionals
1470 and other documents submitted by the health carrier, the covered
1471 person, the covered person's authorized representative or the covered
1472 person's treating health care professional;

1473 (4) The terms of coverage under the covered person's health benefit
1474 plan to ensure that the independent review organization's decision is
1475 not contrary to the terms of coverage under such health benefit plan;

1476 (5) The most appropriate practice guidelines, which shall include
1477 applicable evidence-based standards and may include any other
1478 practice guidelines developed by the federal government, national or
1479 professional medical societies, medical boards or medical associations;

1480 (6) Any applicable clinical review criteria developed and used by
1481 the health carrier or its designee utilization review company; and

1482 (7) The opinion or opinions of the independent review
1483 organization's clinical peer or peers who conducted the external
1484 review after considering subdivisions (1) to (6), inclusive, of this
1485 subsection.

1486 (h) (1) Not later than forty-five days after an independent review

1487 organization receives an assignment from the commissioner to conduct
1488 the external review, such organization shall notify the commissioner,
1489 the health carrier, the covered person and, if applicable, the covered
1490 person's authorized representative in writing of its decision to uphold,
1491 reverse or revise the adverse determination or the final adverse
1492 determination.

1493 (2) Such notice shall include:

1494 (A) A general description of the reason for the request for the
1495 external review;

1496 (B) The date the independent review organization received the
1497 assignment from the commissioner to conduct the external review;

1498 (C) The date the external review was conducted;

1499 (D) The date the organization made its decision;

1500 (E) The principal reason or reasons for its decision, including what
1501 applicable evidence-based standards, if any, were used as a basis for its
1502 decision;

1503 (F) The rationale for the organization's decision; and

1504 (G) Reference to the evidence or documentation, including any
1505 evidence-based standards, considered by the organization in reaching
1506 its decision.

1507 (3) Upon the receipt of a notice of the independent review
1508 organization's decision to reverse an adverse determination or a final
1509 adverse determination, the health carrier shall immediately approve
1510 the coverage that was the subject of the adverse determination or the
1511 final adverse determination.

1512 Sec. 10. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or the
1513 covered person's authorized representative may file a request for an
1514 expedited external review of an adverse determination or a final

1515 adverse determination with the commissioner, except that an
1516 expedited external review shall not be provided for a retrospective
1517 review request of an adverse determination or a final adverse
1518 determination. If the adverse determination or the final adverse
1519 determination involves a denial of coverage based on a determination
1520 that the recommended or requested health care service or treatment is
1521 experimental or investigational, a covered person or the covered
1522 person's authorized representative may file a request for an expedited
1523 external review under section 11 of this act.

1524 (2) Such request may be filed at the time the covered person
1525 receives:

1526 (A) An adverse determination, if:

1527 (i) The covered person has a medical condition for which the time
1528 period for completion of an expedited internal review of the adverse
1529 determination, as set forth in section 7 or 8 of this act, would seriously
1530 jeopardize the life or health of the covered person or would jeopardize
1531 the covered person's ability to regain maximum function; and

1532 (ii) The covered person or the covered person's authorized
1533 representative has filed a request for an expedited internal review of
1534 an adverse determination as set forth in section 7 or 8 of this act; or

1535 (B) A final adverse determination, if:

1536 (i) The covered person has a medical condition where the time
1537 period for completion of an external review, as set forth in section 9 of
1538 this act, would seriously jeopardize the life or health of the covered
1539 person or would jeopardize the covered person's ability to regain
1540 maximum function; or

1541 (ii) The final adverse determination concerns an admission,
1542 availability of care, continued stay or health care service for which the
1543 covered person received emergency services but has not been
1544 discharged from a facility.

1545 (b) (1) Upon the receipt of a request for an expedited external
1546 review, the commissioner shall immediately send a copy of such
1547 request to the health carrier that issued the adverse determination or
1548 the final adverse determination that is the subject of the request.

1549 (2) Upon the receipt of such request, the health carrier shall
1550 immediately complete a preliminary review of the request to
1551 determine whether:

1552 (A) The individual is or was a covered person under the health
1553 benefit plan at the time the health care service was requested;

1554 (B) The health care service that is the subject of the adverse
1555 determination or the final adverse determination is a covered service
1556 under the covered person's health benefit plan but for the health
1557 carrier's determination that the health care service is not covered
1558 because it does not meet the health carrier's requirements for medical
1559 necessity, appropriateness, health care setting, level of care or
1560 effectiveness;

1561 (C) The covered person has exhausted the health carrier's internal
1562 grievance process; and

1563 (D) The covered person has provided all the information and forms
1564 required to process an external review, including an authorization
1565 form as set forth in subparagraph (D)(ii) of subdivision (2) of
1566 subsection (c) of section 9 of this act.

1567 (3) (A) The health carrier shall immediately notify the
1568 commissioner, the covered person and, if applicable, the covered
1569 person's authorized representative whether the request for an
1570 expedited external review is complete and eligible for expedited
1571 external review. The commissioner may specify the form for the health
1572 carrier's notice of initial determination under this subdivision and any
1573 supporting information required to be included in the notice.

1574 (B) If the request:

1575 (i) Is not complete, the health carrier shall notify the commissioner,
1576 the covered person and, if applicable, the covered person's authorized
1577 representative in writing and include in the notice what information or
1578 materials are needed to perfect the request; or

1579 (ii) Is not eligible for expedited external review, the health carrier
1580 shall notify the commissioner, the covered person and, if applicable,
1581 the covered person's authorized representative in writing and include
1582 in the notice the reasons for its ineligibility.

1583 (4) The notice of initial determination shall include a statement
1584 informing the covered person and, if applicable, the covered person's
1585 authorized representative that a health carrier's initial determination
1586 that the request for an expedited external review is ineligible for
1587 review may be appealed to the commissioner.

1588 (5) Notwithstanding a health carrier's initial determination that a
1589 request for an expedited external review is ineligible for review, the
1590 commissioner may determine, pursuant to the terms of the covered
1591 person's health benefit plan, that such request is eligible for expedited
1592 external review and assign an independent review organization to
1593 conduct such review. Any such review shall be conducted in
1594 accordance with this section.

1595 (c) Whenever the commissioner is notified pursuant to subdivision
1596 (2) of subsection (b) of this section that a request is eligible for
1597 expedited external review, the commissioner shall immediately assign
1598 an independent review organization from the list of approved
1599 independent review organizations compiled and maintained by the
1600 commissioner pursuant to section 38a-226c of the general statutes, as
1601 amended by this act, to conduct the expedited external review and
1602 notify the health carrier of the name of the assigned independent
1603 review organization. Such assignment shall be done on a random basis
1604 among those approved independent review organizations qualified to
1605 conduct the particular external review based on the nature of the
1606 health care service that is the subject of the adverse determination or

1607 the final adverse determination and other circumstances, including
1608 conflict of interest concerns as set forth in section 38a-226d of the
1609 general statutes, as amended by this act.

1610 (d) (1) Upon the receipt of the notice of the name of the assigned
1611 independent review organization from the commissioner, the health
1612 carrier or its designee utilization review company shall promptly
1613 provide to the assigned independent review organization the
1614 documents and any information such health carrier or utilization
1615 review company considered in making the adverse determination or
1616 the final adverse determination by telephone, facsimile, electronic
1617 means or any other expeditious method available.

1618 (2) The failure of the health carrier or its designee utilization review
1619 company to provide the documents and information specified in
1620 subdivision (1) of this subsection shall not delay the conducting of the
1621 expedited external review.

1622 (3) If the health carrier or its designee utilization review company
1623 fails to provide the documents and information specified in
1624 subdivision (2) of this subsection, the independent review organization
1625 may terminate the review and make a decision to reverse the adverse
1626 determination or the final adverse determination.

1627 (4) In addition to the documents and information received pursuant
1628 to subdivision (1) of this subsection, the independent review
1629 organization shall consider, to the extent the documents or information
1630 are available and the independent review organization considers them
1631 appropriate, the factors set forth in subsection (g) of section 9 of this
1632 act in reaching a decision.

1633 (e) As expeditiously as the covered person's medical condition
1634 requires but not later than seventy-two hours after the independent
1635 review organization receives the assignment from the commissioner to
1636 conduct the expedited external review, the independent review
1637 organization shall:

1638 (1) Make an expedited external review decision under this section to
1639 uphold, reverse or revise the adverse determination or the final
1640 adverse determination. In reaching a decision, the independent review
1641 organization shall not be bound by any decisions or conclusions
1642 reached during the health carrier's utilization review process; and

1643 (2) Notify the commissioner, the health carrier, the covered person
1644 and, if applicable, the covered person's authorized representative of
1645 the decision. Such notice shall include the information set forth in
1646 subdivision (2) of subsection (h) of section 9 of this act and may be
1647 provided orally, in writing or by electronic means. If the notice is
1648 provided orally, the independent review organization shall provide
1649 such notice in writing or by electronic means to the covered person
1650 and the covered person's health care professional of record not later
1651 than forty-eight hours after providing the oral notice.

1652 (3) Upon the receipt of a notice of the independent review
1653 organization's decision to reverse an adverse determination or a final
1654 adverse determination, the health carrier shall immediately approve
1655 the coverage that was the subject of the adverse determination or the
1656 final adverse determination.

1657 Sec. 11. (NEW) (*Effective July 1, 2011*) (a) (1) If a covered person or a
1658 covered person's authorized representative receives a notice of an
1659 adverse determination or a final adverse determination pursuant to
1660 sections 5 to 8, inclusive, of this act that involves a denial of coverage
1661 based on a determination that the recommended or requested health
1662 care service or treatment is experimental or investigational and the
1663 covered person's treating health care professional certifies in writing
1664 that such recommended or requested health care service or treatment
1665 would be significantly less effective if not promptly initiated, the
1666 covered person or the covered person's authorized representative may,
1667 within the time period set forth in subdivision (1) of subsection (d) of
1668 section 9 of this act, file a request for an expedited external review with
1669 the commissioner in accordance with this section.

1670 (2) Such covered person or covered person's authorized
1671 representative shall not be required to file a request for an external
1672 review prior to, or at the same time as, the filing of a request for an
1673 expedited external review and shall not be precluded from filing a
1674 request for an external review, within the time period set forth in
1675 subdivision (1) of subsection (d) of section 9 of this act, if the request
1676 for an expedited external review is determined to be ineligible for such
1677 review.

1678 (b) (1) Upon the receipt of a request for an expedited external
1679 review, the commissioner shall immediately send a copy of such
1680 request to the health carrier that issued the adverse determination or
1681 the final adverse determination that is the subject of the request.

1682 (2) Upon the receipt of such request, the health carrier shall, not
1683 later than five business days after the health carrier receives the copy
1684 of such request from the commissioner, complete a preliminary review
1685 of the request to determine whether:

1686 (A) The individual is or was a covered person under the health
1687 benefit plan at the time the health care service was requested;

1688 (B) The recommended or requested health care service or treatment
1689 that is the subject of the adverse determination or final adverse
1690 determination:

1691 (i) Is a covered benefit under the covered person's health benefit
1692 plan but for the health carrier's determination that the service or
1693 treatment is experimental or investigational for a particular medical
1694 condition; and

1695 (ii) Is not explicitly listed as an excluded benefit under the covered
1696 person's health benefit plan;

1697 (C) The covered person's treating health care professional has
1698 certified that one of the following situations is applicable:

1699 (i) Standard health care services or treatments have not been
1700 effective in improving the medical condition of the covered person;

1701 (ii) Standard health care services or treatments are not medically
1702 appropriate for the covered person; or

1703 (iii) There is no available standard health care service or treatment
1704 covered by the health carrier that is more beneficial than the
1705 recommended or requested health care service or treatment;

1706 (D) The covered person's treating health care professional:

1707 (i) Has recommended a health care service or treatment that the
1708 health care professional certifies, in writing, is likely to be more
1709 beneficial to the covered person, in the health care professional's
1710 opinion, than any available standard health care services or treatments;
1711 or

1712 (ii) Is a licensed, board certified or board eligible health care
1713 professional qualified to practice in the area of medicine appropriate to
1714 treat the covered person's condition and has certified, in writing, that
1715 scientifically valid studies using accepted protocols demonstrate that
1716 the health care service or treatment requested by the covered person
1717 that is the subject of the adverse determination or the final adverse
1718 determination is likely to be more beneficial to the covered person than
1719 any available standard health care services or treatments;

1720 (E) The covered person has exhausted the health carrier's internal
1721 grievance process; and

1722 (F) The covered person has provided all the information and forms
1723 required to process an external review, including an authorization
1724 form as set forth in subparagraph (D)(ii) of subdivision (2) of
1725 subsection (c) of section 9 of this act.

1726 (3) (A) Not later than one business day after the health carrier
1727 completes the preliminary review, the health carrier shall notify the

1728 commissioner and the covered person and, if applicable, the covered
1729 person's authorized representative in writing whether the request for
1730 an expedited external review is complete and eligible for expedited
1731 external review. The commissioner may specify the form for the health
1732 carrier's notice of initial determination under this subdivision and any
1733 supporting information required to be included in the notice.

1734 (B) If the request:

1735 (i) Is not complete, the health carrier shall notify the commissioner
1736 and the covered person and, if applicable, the covered person's
1737 authorized representative in writing and include in the notice what
1738 information or materials are needed to perfect the request; or

1739 (ii) Is not eligible for expedited external review, the health carrier
1740 shall notify the commissioner, the covered person and, if applicable,
1741 the covered person's authorized representative in writing and include
1742 in the notice the reasons for its ineligibility.

1743 (4) The notice of initial determination shall include a statement
1744 informing the covered person and, if applicable, the covered person's
1745 authorized representative that a health carrier's initial determination
1746 that the request for an expedited external review is ineligible for
1747 review may be appealed to the commissioner.

1748 (5) Notwithstanding a health carrier's initial determination that a
1749 request for an expedited external review is ineligible for review, the
1750 commissioner may determine, pursuant to the terms of the covered
1751 person's health benefit plan, that such request is eligible for expedited
1752 external review and assign an independent review organization to
1753 conduct such review. Any such review shall be conducted in
1754 accordance with this section.

1755 (c) (1) Whenever the commissioner is notified pursuant to
1756 subparagraph (A) of subdivision (3) of subsection (b) of this section
1757 that a request is eligible for expedited external review, the

1758 commissioner shall, not later than one business day after receiving
1759 such notice:

1760 (A) Assign an independent review organization from the list of
1761 approved independent review organizations compiled and maintained
1762 by the commissioner pursuant to section 38a-226c of the general
1763 statutes, as amended by this act, to conduct the expedited external
1764 review and notify the health carrier of the name of the assigned
1765 independent review organization. Such assignment shall be done on a
1766 random basis among those approved independent review
1767 organizations qualified to conduct the particular external review based
1768 on the nature of the health care service that is the subject of the adverse
1769 determination or the final adverse determination and other
1770 circumstances, including conflict of interest concerns as set forth in
1771 section 38a-226d of the general statutes, as amended by this act; and

1772 (B) Notify the covered person and, if applicable, the covered
1773 person's authorized representative in writing of the request's eligibility
1774 and acceptance for external review. The commissioner shall include in
1775 such notice (i) a statement that the covered person or the covered
1776 person's authorized representative may submit, not later than five
1777 days after the covered person or the covered person's authorized
1778 representative, as applicable, received such notice, additional
1779 information in writing to the assigned independent review
1780 organization that such organization shall consider when conducting
1781 the external review, and (ii) where and how such additional
1782 information is to be submitted. If additional information is submitted
1783 later than five days after the covered person or the covered person's
1784 authorized representative, as applicable, received such notice, the
1785 independent review organization may, but shall not be required to,
1786 accept and consider such additional information.

1787 (2) Upon the receipt of the notice of the name of the assigned
1788 independent review organization from the commissioner, the health
1789 carrier or its designee utilization review company shall, not later than

1790 five business days after receiving such notice, provide to the assigned
1791 independent review organization the documents and any information
1792 such health carrier or utilization review company considered in
1793 making the adverse determination or the final adverse determination
1794 by telephone, facsimile, electronic means or any other expeditious
1795 method available.

1796 (3) The failure of the health carrier or its designee utilization review
1797 company to provide the documents and information within the time
1798 specified in subdivision (2) of this subsection shall not delay the
1799 conducting of the expedited external review.

1800 (4) (A) If the health carrier or its designee utilization review
1801 company fails to provide the documents and information within the
1802 time period specified in subdivision (2) of this subsection, the
1803 independent review organization may terminate the review and make
1804 a decision to reverse the adverse determination or the final adverse
1805 determination.

1806 (B) Not later than one business day after terminating the review and
1807 making the decision to reverse the adverse determination or the final
1808 adverse determination, the independent review organization shall
1809 notify the commissioner, the health carrier, the covered person and, if
1810 applicable, the covered person's authorized representative in writing
1811 of such decision.

1812 (d) (1) Not later than one business day after an independent review
1813 organization receives an assignment from the commissioner to conduct
1814 an expedited external review, the organization shall select one or more
1815 clinical peers to conduct the review, who shall be health care
1816 professionals who meet the minimum qualifications described in
1817 subdivision (4) of subsection (c) of section 38a-226c of the general
1818 statutes, as amended by this act, and, through clinical experience in the
1819 past three years, are experts in the treatment of the covered person's
1820 medical condition and knowledgeable about the recommended or
1821 requested health care service or treatment.

1822 (2) Neither the covered person, the covered person's authorized
1823 representative, if applicable, nor the health carrier shall select or
1824 control the selection of the clinical peer or peers who will conduct the
1825 expedited external review.

1826 (e) (1) Each clinical peer selected to conduct an expedited external
1827 review pursuant to subsection (d) of this section shall review all of the
1828 information and documents received pursuant to subsection (c) of this
1829 section. Such clinical peer shall not be bound by any decisions or
1830 conclusions reached during the health carrier's utilization review
1831 process.

1832 (2) Upon the receipt of any information submitted by the covered
1833 person or the covered person's authorized representative pursuant to
1834 subparagraph (B) of subdivision (1) of subsection (c) of this section, the
1835 independent review organization shall forward such information to
1836 the health carrier not later than one business day after receiving such
1837 information.

1838 (3) (A) Upon the receipt of any information forwarded pursuant to
1839 subdivision (2) of this subsection, the health carrier may reconsider its
1840 adverse determination or the final adverse determination that is the
1841 subject of the external review. Such reconsideration shall not delay or
1842 terminate the review.

1843 (B) The independent review organization shall terminate the
1844 external review if the health carrier decides, upon completion of its
1845 reconsideration and notice to such organization as provided in
1846 subparagraph (C) of this subdivision, to reverse its adverse
1847 determination or its final adverse determination and provide coverage
1848 or payment for the recommended or requested health care service or
1849 treatment that is the subject of the adverse determination or the final
1850 adverse determination.

1851 (C) Upon making a decision to reverse its adverse determination or
1852 its final adverse determination, the health carrier shall immediately

1853 notify the commissioner, the assigned independent review
1854 organization, the covered person and, if applicable, the covered
1855 person's authorized representative in writing of such decision.

1856 (4) Immediately upon making the decision to reverse its adverse
1857 determination or final adverse determination, as provided in
1858 subdivision (3) of this subsection, the health carrier shall notify the
1859 commissioner, the assigned independent review organization, the
1860 covered person and, if applicable, the covered person's authorized
1861 representative in writing of such decision.

1862 (f) (1) As expeditiously as the covered person's medical condition
1863 requires but not later than five days after being selected pursuant to
1864 subsection (d) of this section to conduct an expedited external review,
1865 a clinical peer shall provide an opinion orally or in writing to the
1866 independent review organization whether the recommended or
1867 requested health care service or treatment that is the subject of the
1868 adverse determination or the final adverse determination should be
1869 covered. If the opinion is provided orally, the clinical peer shall
1870 provide such opinion in writing or by electronic means to the
1871 independent review organization not later than forty-eight hours after
1872 providing the oral opinion.

1873 (2) Each such written opinion shall include:

1874 (A) A description of the covered person's medical condition;

1875 (B) A description of the indicators relevant to determining whether
1876 there is sufficient evidence to demonstrate that (i) the recommended or
1877 requested health care service or treatment is likely to be more
1878 beneficial to the covered person than any available standard health
1879 care services or treatments, and (ii) the adverse risks of the
1880 recommended or requested health care service or treatment would not
1881 be substantially increased over those of available standard health care
1882 services or treatments;

1883 (C) A description and analysis of any medical or scientific evidence
1884 considered in reaching the opinion;

1885 (D) A description and analysis of any evidence-based standard; and

1886 (E) Information on whether the clinical peer's rationale for the
1887 opinion is based on the documents and information set forth in
1888 subsection (g) of this section.

1889 (g) In addition to the documents and information received by the
1890 independent review organization pursuant to subsection (c) of this
1891 section, each clinical peer shall consider, to the extent the documents or
1892 information are available and the clinical peer considers them
1893 appropriate, the following in reaching an opinion:

1894 (1) The covered person's medical records;

1895 (2) The attending health care professional's recommendation;

1896 (3) Consulting reports from appropriate health care professionals
1897 and other documents submitted by the health carrier, the covered
1898 person, the covered person's authorized representative or the covered
1899 person's treating health care professional;

1900 (4) The terms of coverage under the covered person's health benefit
1901 plan to ensure that but for the health carrier's determination that the
1902 recommended or requested health care service or treatment that is the
1903 subject of the adverse determination or the final adverse determination
1904 is experimental or investigational, the clinical peer's opinion is not
1905 contrary to the terms of coverage under such health benefit plan; and

1906 (5) Whether:

1907 (A) The recommended or requested health care service or treatment
1908 has been approved by the federal Food and Drug Administration, if
1909 applicable, for the condition; or

1910 (B) Medical or scientific evidence or evidence-based standards

1911 demonstrate that (i) the expected benefits of the recommended or
1912 requested health care service or treatment is likely to be more
1913 beneficial to the covered person than any available standard health
1914 care services or treatments, and (ii) the adverse risks of the
1915 recommended or requested health care service or treatment would not
1916 be substantially increased over those of available standard health care
1917 services or treatments.

1918 (h) (1) (A) Not later than forty-eight hours after it receives the
1919 opinion or opinions of each clinical peer or peers conducting the
1920 expedited external review, the independent review organization shall
1921 make a decision in accordance with the provisions of subdivision (2) of
1922 this subsection and shall notify the commissioner, the health carrier,
1923 the covered person and, if applicable, the covered person's authorized
1924 representative of such decision. Such notice may be provided orally, in
1925 writing or by electronic means and shall include the information set
1926 forth in subdivision (3) of this subsection.

1927 (B) If the notice is provided orally, the independent review
1928 organization shall provide such notice in writing or by electronic
1929 means to the commissioner, the health carrier, the covered person and,
1930 if applicable, the covered person's authorized representative not later
1931 than forty-eight hours after providing the oral notice.

1932 (2) (A) If the majority of the clinical peers that conducted the
1933 expedited external review recommend that the recommended or
1934 requested health care service or treatment:

1935 (i) Should be covered, the independent review organization shall
1936 make a decision to reverse the health carrier's adverse determination
1937 or final adverse determination; or

1938 (ii) Should not be covered, the independent review organization
1939 shall make a decision to uphold the health carrier's adverse
1940 determination or final adverse determination.

1941 (B) (i) If the clinical peers are split evenly as to whether the
1942 recommended or requested health care service or treatment should be
1943 covered, the independent review organization shall obtain the opinion
1944 of an additional clinical peer to enable the independent review
1945 organization to make a decision based on the opinions of the majority
1946 of the clinical peers as set forth in subparagraph (A) of this
1947 subdivision. Such additional clinical peer shall consider the same
1948 documents and information considered by the clinical peers who have
1949 already provided their opinions.

1950 (ii) The selection of such additional clinical peer shall not extend the
1951 time period specified in subparagraph (A) of subdivision (1) of this
1952 subsection within which the assigned independent review
1953 organization is required to make a decision based on the opinion or
1954 opinions of the clinical peer or peers that conducted the expedited
1955 external appeal.

1956 (3) The notice required under subdivision (1) of this subsection shall
1957 include:

1958 (A) A general description of the reason for the request for the
1959 expedited external review;

1960 (B) The date the independent review organization received the
1961 assignment from the commissioner to conduct the expedited external
1962 review;

1963 (C) The date the expedited external review was conducted;

1964 (D) The date the organization made its decision;

1965 (E) The written opinion of each clinical peer that conducted the
1966 expedited external review, including the recommendation of each
1967 clinical peer as to whether the recommended or requested health care
1968 service or treatment should be covered and the rationale for the clinical
1969 peer's recommendation;

1970 (F) The principal reason or reasons for the organization's decision;
1971 and

1972 (G) The rationale for the organization's decision.

1973 (4) Upon the receipt of a notice of the independent review
1974 organization's decision to reverse an adverse determination or a final
1975 adverse determination, the health carrier shall immediately approve
1976 coverage of the recommended or requested health care service or
1977 treatment that was the subject of the adverse determination or the final
1978 adverse determination.

1979 Sec. 12. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
1980 maintain written records to document all grievances of adverse
1981 determinations it receives, including the notices and claims associated
1982 with such grievances, during a calendar year.

1983 (2) (A) Each health carrier shall maintain such records for not less
1984 than six years after the notice of an adverse determination that is the
1985 subject of a grievance was provided to a covered person or the covered
1986 person's authorized representative, as applicable, under section 4 of
1987 this act.

1988 (B) The health carrier shall make such records available for
1989 examination by covered persons, provided such records are subject to
1990 disclosure pursuant to section 1-210 of the general statutes, the
1991 commissioner and appropriate federal oversight agencies upon
1992 request. Such records shall be maintained in a manner that is
1993 reasonably clear and accessible to the commissioner.

1994 (b) For each grievance the record shall contain, at a minimum, the
1995 following information: (1) A general description of the reason for the
1996 grievance; (2) the date the health carrier received the grievance; (3) the
1997 date of each review or, if applicable, review meeting of the grievance;
1998 (4) the resolution at each level of the grievance, if applicable; (5) the
1999 date of resolution at each such level, if applicable; and (6) the name of

2000 the covered person for whom the grievance was filed.

2001 (c) Each health carrier shall submit a report annually to the
2002 commissioner, in accordance with section 2 of this act, of the
2003 grievances it received.

2004 (d) (1) Each health carrier shall maintain written records, in the
2005 aggregate by state where the covered person requesting the external
2006 review resides and by each type of health benefit plan offered by the
2007 health carrier, on all requests for external reviews that the health
2008 carrier receives notice of from the commissioner during a calendar
2009 year and shall, upon request, submit a report to the commissioner, in a
2010 format prescribed by the commissioner.

2011 (2) Such report shall include, in the aggregate by state where the
2012 covered person requesting the external review resides and by each
2013 type of health benefit plan:

2014 (A) The total number of requests for an external review;

2015 (B) From the total number of such requests reported under
2016 subparagraph (A) of this subdivision, the number of requests
2017 determined eligible for a full external review; and

2018 (C) Any other information the commissioner may request or
2019 require.

2020 (3) The health carrier shall retain the written records required
2021 pursuant to subdivision (1) of this subsection for not less than six years
2022 after the request for an external review was received.

2023 Sec. 13. (NEW) (*Effective July 1, 2011*) The commissioner may adopt
2024 regulations, in accordance with chapter 54 of the general statutes, to
2025 implement the provisions of sections 1 to 12, inclusive, of this act.

2026 Sec. 14. Section 38a-226 of the general statutes is repealed and the
2027 following is substituted in lieu thereof (*Effective July 1, 2011*):

2028 For purposes of sections 38a-226 to 38a-226d, inclusive, as amended
2029 by this act:

2030 [(1) "Utilization review" means the prospective or concurrent
2031 assessment of the necessity and appropriateness of the allocation of
2032 health care resources and services given or proposed to be given to an
2033 individual within this state. Utilization review shall not include
2034 elective requests for clarification of coverage.

2035 (2) "Utilization review company" means any company, organization
2036 or other entity performing utilization review, except:

2037 (A) An agency of the federal government;

2038 (B) An agent acting on behalf of the federal government, but only to
2039 the extent that the agent is providing services to the federal
2040 government;

2041 (C) Any agency of the state of Connecticut; or

2042 (D) A hospital's internal quality assurance program except if
2043 associated with a health care financing mechanism.]

2044 (1) "Adverse determination" has the same meaning as provided in
2045 section 1 of this act.

2046 (2) "Clinical peer" has the same meaning as provided in section 1 of
2047 this act.

2048 (3) "Commissioner" means the Insurance Commissioner.

2049 (4) "Covered person" has the same meaning as provided in section 1
2050 of this act.

2051 [(4)] (5) "Enrollee" means an individual who has contracted for or
2052 who participates in coverage under an insurance policy, a health care
2053 center contract, [an employee welfare benefits] a managed care plan, a
2054 hospital or medical services plan contract or any other fully-insured

2055 benefit program providing payment, reimbursement or
2056 indemnification for health care costs for an individual or [his] such
2057 individual's eligible dependents.

2058 [(5) "Provider of record" or "provider"] (6) "Health care provider"
2059 means the [physician or other licensed practitioner] health care
2060 professional, as defined in section 1 of this act, identified to the
2061 utilization review agent as having primary responsibility for the care,
2062 treatment and services rendered to an individual.

2063 (7) "Independent review organization" means an entity that
2064 conducts independent external reviews of adverse determinations.
2065 Such review entities include, but are not limited to, medical peer
2066 review organizations, independent utilization review companies,
2067 provided such organizations or companies are not related to or
2068 associated with any managed care organization or health insurer, and
2069 nationally recognized health experts or institutions approved by the
2070 Insurance Commissioner.

2071 (8) "Utilization review" means the use of a set of formal techniques
2072 designed to monitor the use of, or evaluate the medical necessity,
2073 appropriateness, efficacy or efficiency of, health care services as
2074 defined in section 1 of this act, health care procedures or health care
2075 settings. Such techniques may include the monitoring of or evaluation
2076 of (A) health care services performed or provided in an outpatient
2077 setting, (B) the formal process for determining, prior to discharge from
2078 a facility, the coordination and management of the care that a patient
2079 receives following discharge from a facility, (C) opportunities or
2080 requirements to obtain a clinical evaluation by a health care
2081 professional other than the one originally making a recommendation
2082 for a proposed health care service, (D) coordinated sets of activities
2083 conducted for individual patient management of serious, complicated,
2084 protracted or other health conditions, or (E) prospective review,
2085 concurrent review, retrospective review or certification, as each such
2086 term is defined in section 1 of this act.

2087 (9) "Utilization review company" means an entity that conducts
2088 utilization review.

2089 Sec. 15. Section 38a-226a of the general statutes is repealed and the
2090 following is substituted in lieu thereof (*Effective July 1, 2011*):

2091 (a) No utilization review company may conduct utilization review
2092 in this state for a health benefit plan, as defined in section 1 of this act,
2093 under the jurisdiction of the commissioner unless it is licensed by the
2094 commissioner. All licenses shall be renewed on an annual basis.

2095 (b) The annual license fee shall be two thousand five hundred
2096 dollars and shall be dedicated to the regulation of utilization review,
2097 except that the commissioner shall be authorized to use such funds as
2098 is necessary to implement the provisions of sections 38a-91aa to 38a-
2099 91qq, inclusive.

2100 (c) The request for licensure or renewal shall include the name,
2101 address, telephone number and normal business hours of the
2102 utilization review company, the name and telephone number of a
2103 person for the commissioner to contact, [, and evidence of compliance
2104 noted in the provisions of section 38a-226c.] Any material changes in
2105 the information filed in accordance with this subsection shall be filed
2106 with the commissioner [within] not later than thirty days [of] after the
2107 change.

2108 (d) The commissioner shall receive and investigate all grievances
2109 filed against utilization review companies by an enrollee. The
2110 commissioner shall code, track and review all grievances. The
2111 commissioner may impose such penalties as authorized, in accordance
2112 with section 38a-226b, as amended by this act.

2113 (e) In the absence of any contractual agreement to the contrary, the
2114 enrollee [is] shall be responsible for requesting certification and for
2115 authorizing the provider to release, in a timely manner, all information
2116 necessary to conduct the review. A utilization review company shall

2117 permit either the enrollee, the enrollee's representative or the provider
2118 of record to assist in fulfilling that responsibility.

2119 [(f) If the commissioner determines that additional data from a
2120 utilization review company are necessary to determine compliance
2121 with the provisions of sections 38a-226 to 38a-226d, inclusive, he may
2122 require the utilization review company to provide data relating to
2123 reviews, appeals and denials.]

2124 Sec. 16. Section 38a-226b of the general statutes is repealed and the
2125 following is substituted in lieu thereof (*Effective July 1, 2011*):

2126 [(1)] (a) Whenever the commissioner has reason to believe that a
2127 utilization review company subject to sections [38a-226 to 38a-226d] 1
2128 to 13, inclusive, of this act has been or is engaging in conduct in
2129 violation of said sections, and that a proceeding by the commissioner
2130 would be in the interest of the public, the commissioner shall issue and
2131 serve upon such company a statement of the charges in that respect
2132 and a notice of a hearing to be held at a time and place fixed in the
2133 notice, which shall not be less than thirty days after the date of service.
2134 At the time and place fixed for such hearing, such company shall have
2135 an opportunity to be heard and to show cause why an order should
2136 not be made by the commissioner requiring such company to cease
2137 and desist from the alleged conduct complained of.

2138 [(2)] (b) If, after such hearing, the commissioner determines that the
2139 utilization review company charged has engaged in a violation of
2140 sections [38a-226 to 38a-226d, inclusive] sections 4, 7 and 8 of this act,
2141 the commissioner shall reduce the findings to writing and shall issue
2142 and cause to be served upon the utilization review company a copy of
2143 such findings and an order requiring such company to cease and desist
2144 from engaging in such violation. The commissioner may order any of
2145 the following:

2146 [(A)] (1) Payment of a civil penalty of not more than one thousand
2147 five hundred dollars for each act or violation, provided such penalty

2148 shall not exceed an aggregate penalty of fifteen thousand dollars
2149 unless the company knew or reasonably should have known it was in
2150 violation of sections [38a-226 to 38a-226d, inclusive] section 4, 7 and 8
2151 of this act, in which case the penalty shall be not more than seven
2152 thousand five hundred dollars for each act or violation not to exceed
2153 an aggregate penalty of seventy-five thousand dollars in any six-
2154 month period;

2155 [(B)] (2) Suspension or revocation of the utilization review
2156 company's license to do business in this state if it knew or reasonably
2157 should have known that it was in violation of sections [38a-226 to 38a-
2158 226d, inclusive] sections 4, 7 and 8 of this act; or

2159 [(C)] (3) Payment of such reasonable expenses as may be necessary
2160 to compensate the commissioner in connection with the proceedings
2161 under this [subdivision] subsection, which shall be dedicated
2162 exclusively to the regulation of utilization review.

2163 [(3)] (c) Any company aggrieved by any such order of the
2164 commissioner may appeal therefrom in accordance with the provisions
2165 of section 4-183, except venue for such appeal shall be in the judicial
2166 district of New Britain.

2167 [(4)] (d) Any person who violates a cease and desist order of the
2168 commissioner made pursuant to this section and while such order is in
2169 effect shall, after notice and hearing and upon order of the
2170 commissioner, be subject to the following: [(A)] (1) A civil penalty of
2171 not more than seventy-five thousand dollars; or [(B)] (2) suspension or
2172 revocation of such person's license.

2173 (e) The commissioner may adopt regulations, in accordance with
2174 chapter 54, to carry out the provisions of this section and section 38a-
2175 226a, as amended by this act.

2176 Sec. 17. Section 38a-226c of the general statutes is repealed and the
2177 following is substituted in lieu thereof (*Effective July 1, 2011*):

2178 [(a) All utilization review companies shall meet the following
2179 minimum standards:

2180 (1) Each utilization review company shall maintain and make
2181 available procedures for providing notification of its determinations
2182 regarding certification in accordance with the following:

2183 (A) Notification of any prospective determination by the utilization
2184 review company shall be mailed or otherwise communicated to the
2185 provider of record or the enrollee or other appropriate individual
2186 within two business days of the receipt of all information necessary to
2187 complete the review, provided any determination not to certify an
2188 admission, service, procedure or extension of stay shall be in writing.
2189 After a prospective determination that authorizes an admission,
2190 service, procedure or extension of stay has been communicated to the
2191 appropriate individual, based on accurate information from the
2192 provider, the utilization review company may not reverse such
2193 determination if such admission, service, procedure or extension of
2194 stay has taken place in reliance on such determination.

2195 (B) Notification of a concurrent determination shall be mailed or
2196 otherwise communicated to the provider of record within two business
2197 days of receipt of all information necessary to complete the review or,
2198 provided all information necessary to perform the review has been
2199 received, prior to the end of the current certified period and provided
2200 any determination not to certify an admission, service, procedure or
2201 extension of stay shall be in writing.

2202 (C) The utilization review company shall not make a determination
2203 not to certify based on incomplete information unless it has clearly
2204 indicated, in writing, to the provider of record or the enrollee all the
2205 information that is needed to make such determination.

2206 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this
2207 subdivision, the utilization review company may give authorization
2208 orally, electronically or communicated other than in writing. If the

2209 determination is an approval for a request, the company shall provide
2210 a confirmation number corresponding to the authorization.

2211 (E) Except as provided in subparagraph (F) of this subdivision with
2212 respect to a final notice, each notice of a determination not to certify an
2213 admission, service, procedure or extension of stay shall include in
2214 writing (i) the principal reasons for the determination, (ii) the
2215 procedures to initiate an appeal of the determination or the name and
2216 telephone number of the person to contact with regard to an appeal
2217 pursuant to the provisions of this section, and (iii) the procedure to
2218 appeal to the commissioner pursuant to section 38a-478n.

2219 (F) Each notice of a final determination not to certify an admission,
2220 service, procedure or extension of stay shall include in writing (i) the
2221 principal reasons for the determination, (ii) a statement that all internal
2222 appeal mechanisms have been exhausted, and (iii) a copy of the
2223 application and procedures prescribed by the commissioner for filing
2224 an appeal to the commissioner pursuant to section 38a-478n.

2225 (2) Each utilization review company shall maintain and make
2226 available a written description of the appeal procedure by which either
2227 the enrollee or the provider of record may seek review of
2228 determinations not to certify an admission, service, procedure or
2229 extension of stay. An appeal by the provider of record shall be deemed
2230 to be made on behalf of the enrollee and with the consent of such
2231 enrollee if the admission, service, procedure or extension of stay has
2232 not yet been provided or if such determination not to certify creates a
2233 financial liability to the enrollee. The procedures for appeals shall
2234 include the following:

2235 (A) Each utilization review company shall notify in writing the
2236 enrollee and provider of record of its determination on the appeal as
2237 soon as practical, but in no case later than thirty days after receiving
2238 the required documentation on the appeal.

2239 (B) On appeal, all determinations not to certify an admission,

2240 service, procedure or extension of stay shall be made by a licensed
2241 practitioner of the healing arts.

2242 (3) The process established by each utilization review company may
2243 include a reasonable period within which an appeal must be filed to be
2244 considered.

2245 (4) Each utilization review company shall also provide for an
2246 expedited appeals process for emergency or life threatening situations.
2247 Each utilization review company shall complete the adjudication of
2248 such expedited appeals within two business days of the date the
2249 appeal is filed and all information necessary to complete the appeal is
2250 received by the utilization review company.

2251 (5) Each utilization review company shall utilize written clinical
2252 criteria and review procedures which are established and periodically
2253 evaluated and updated with appropriate involvement from
2254 practitioners.

2255 (6) Physicians, nurses and other licensed health professionals
2256 making utilization review decisions shall have current licenses from a
2257 state licensing agency in the United States or appropriate certification
2258 from a recognized accreditation agency in the United States, provided,
2259 any final determination not to certify an admission, service, procedure
2260 or extension of stay for an enrollee within this state, except for a claim
2261 brought pursuant to chapter 568, shall be made by a physician, nurse
2262 or other licensed health professional under the authority of a
2263 physician, nurse or other licensed health professional who has a
2264 current Connecticut license from the Department of Public Health.

2265 (7) In cases where an appeal to reverse a determination not to certify
2266 is unsuccessful, each utilization review company shall assure that a
2267 practitioner in a specialty related to the condition is reasonably
2268 available to review the case. When the reason for the determination not
2269 to certify is based on medical necessity, including whether a treatment
2270 is experimental or investigational, each utilization review company

2271 shall have the case reviewed by a physician who is a specialist in the
2272 field related to the condition that is the subject of the appeal. Any such
2273 review, except for a claim brought pursuant to chapter 568, that
2274 upholds a final determination not to certify in the case of an enrollee
2275 within this state shall be conducted by such practitioner or physician
2276 under the authority of a practitioner or physician who has a current
2277 Connecticut license from the Department of Public Health. The review
2278 shall be completed within thirty days of the request for review. The
2279 utilization review company shall be financially responsible for the
2280 review and shall maintain, for the commissioner's verification,
2281 documentation of the review, including the name of the reviewing
2282 physician.

2283 (8) Except as provided in subsection (e) of this section, each
2284 utilization review company shall make review staff available by toll-
2285 free telephone, at least forty hours per week during normal business
2286 hours.

2287 (9) Each utilization review company shall comply with all
2288 applicable federal and state laws to protect the confidentiality of
2289 individual medical records. Summary and aggregate data shall not be
2290 considered confidential if it does not provide sufficient information to
2291 allow identification of individual patients.

2292 (10) Each utilization review company shall allow a minimum of
2293 twenty-four hours following an emergency admission, service or
2294 procedure for an enrollee or his representative to notify the utilization
2295 review company and request certification or continuing treatment for
2296 that condition.

2297 (11) No utilization review company may give an employee any
2298 financial incentive based on the number of denials of certification such
2299 employee makes.

2300 (12) Each utilization review company shall annually file with the
2301 commissioner:

2302 (A) The names of all managed care organizations, as defined in
2303 section 38a-478, that the utilization review company services in
2304 Connecticut;

2305 (B) Any utilization review services for which the utilization review
2306 company has contracted out for services and the name of such
2307 company providing the services;

2308 (C) The number of utilization review determinations not to certify
2309 an admission, service, procedure or extension of stay and the outcome
2310 of such determination upon appeal within the utilization review
2311 company. Determinations related to mental or nervous conditions, as
2312 defined in section 38a-514, shall be reported separately from all other
2313 determinations reported under this subdivision; and

2314 (D) The following information relative to requests for utilization
2315 review of mental health services for enrollees of fully insured health
2316 benefit plans or self-insured or self-funded employee health benefit
2317 plans, separately and by category: (i) The reason for the request,
2318 including, but not limited to, an inpatient admission, service,
2319 procedure or extension of inpatient stay or an outpatient treatment, (ii)
2320 the number of requests denied by type of request, and (iii) whether the
2321 request was denied or partially denied.

2322 (13) Any utilization review decision to initially deny services shall
2323 be made by a licensed health professional.

2324 (b) Unless there is a contrary written agreement between the
2325 utilization review company and the hospital, all hospitals in this state
2326 shall permit each licensed utilization review company to conduct
2327 reviews on the premises. Each utilization review company shall
2328 conduct its telephone, on-site information gathering reviews and
2329 hospital communications during the hospitals' and practitioners'
2330 reasonable and normal business hours, unless other arrangements are
2331 mutually agreed upon. Each utilization review company's staff shall
2332 identify themselves by name and by the name of their organization

2333 and, for on-site reviews, shall carry photographic identification and the
2334 utilization review company's company identification card.

2335 (c) The provider of record shall provide to each utilization review
2336 company, within a reasonable period of time, all relevant information
2337 necessary for the utilization review company to certify the admission,
2338 procedure, treatment or length of stay. Failure of the provider to
2339 provide such documentation for review shall be grounds for a denial
2340 of certification in accordance with the policy of the utilization review
2341 company or the health benefit plan.

2342 (d) No provider, enrollee or agent thereof may provide to any
2343 utilization review company information which is fraudulent or
2344 misleading. If fraudulent or misleading statements have occurred, the
2345 commissioner shall provide notice of the alleged violation and
2346 opportunity to request a hearing in accordance with chapter 54 to said
2347 provider, enrollee or agent thereof. If a hearing is not requested or if
2348 after a hearing the commissioner finds that a violation has in fact
2349 occurred, the commissioner may impose a civil penalty (1) of not more
2350 than seven thousand five hundred dollars, or (2) commensurate with
2351 the value of services provided which were certified as a result of said
2352 fraudulent or misleading information. In addition, any allegation or
2353 denial made without reasonable cause and found untrue shall subject
2354 the party pleading the same to the payment of such reasonable
2355 expenses as may be necessary to compensate the department for
2356 expenses incurred due to such untrue pleading. All such payments to
2357 the department shall be dedicated exclusively to the regulation of
2358 utilization review.

2359 (e) On or after November 1, 1997, if an enrollee has been admitted to
2360 an acute care hospital and the attending physician determines that the
2361 enrollee's life will be endangered or other serious injury or illness
2362 could occur if the patient is discharged or if treatment is delayed, the
2363 attending physician may transmit, pursuant to the standardized
2364 process developed pursuant to section 38a-478p, a request for an

2365 expedited review to the utilization review company. If such attending
2366 physician receives no response, in the standardized process developed
2367 pursuant to section 38a-478p, from the utilization review company
2368 after three hours have passed since the provider sent the request and
2369 all information needed to complete the review, the request shall be
2370 deemed approved. Each utilization review company shall make review
2371 staff available from 8:00 a.m. to 9:00 p.m. to process requests pursuant
2372 to this subsection.

2373 (f) The Insurance Commissioner, after consultation with the
2374 Commissioner of Public Health, shall adopt regulations, in accordance
2375 with chapter 54, as he deems necessary to clarify or supplement the
2376 standards set forth in this section. The regulations shall include
2377 standards, which may be based on the national standards of the
2378 American Accreditation Health Care Commission, concerning the
2379 confidentiality of patient medical records.]

2380 (a) (1) The commissioner shall approve independent review
2381 organizations eligible to be assigned to conduct external reviews under
2382 sections 9 to 11, inclusive, of this act.

2383 (2) The commissioner shall (A) develop an application form for the
2384 initial approval and for the reapproval of independent review
2385 organizations, and (B) maintain and periodically update a list of
2386 approved independent review organizations.

2387 (b) (1) Any independent review organization seeking to conduct
2388 external reviews under sections 9 to 11, inclusive, of this act shall
2389 submit the application form for approval or reapproval, as applicable,
2390 to the commissioner and shall include all documentation and
2391 information necessary for the commissioner to determine if the
2392 independent review organization satisfies the minimum qualifications
2393 established under this section.

2394 (2) An approval or reapproval shall be effective for two years,
2395 unless the commissioner determines before the expiration of such

2396 approval or reapproval that the independent review organization no
2397 longer satisfies the minimum qualifications established under this
2398 section.

2399 (3) Whenever the commissioner determines that an independent
2400 review organization has lost its accreditation or no longer satisfies the
2401 minimum requirements established under this section, the
2402 commissioner shall terminate the approval of the independent review
2403 organization and remove the independent review organization from
2404 the list of approved independent review organizations specified in
2405 subdivision (2) of subsection (a) of this section.

2406 (c) To be eligible for approval by the commissioner, an independent
2407 review organization shall:

2408 (1) Have and maintain written policies and procedures that govern
2409 all aspects of both the standard external review process and the
2410 expedited external review process set forth in sections 9 to 11,
2411 inclusive, of this act that include, at a minimum:

2412 (A) A quality assurance mechanism in place that ensures:

2413 (i) That external reviews are conducted within the specified time
2414 frames and required notices are provided in a timely manner;

2415 (ii) (I) The selection of qualified and impartial clinical peers to
2416 conduct external reviews on behalf of the independent review
2417 organization and the suitable matching of such peers to specific cases,
2418 and (II) employs or contracts with an adequate number of clinical
2419 peers to meet this objective;

2420 (iii) The confidentiality of medical and treatment records and
2421 clinical review criteria;

2422 (iv) That any person employed by or under contract with the
2423 independent review organization adheres to the requirements of
2424 sections 9 to 11, inclusive, of this act; and

2425 (B) A toll-free telephone number to receive information twenty-four
2426 hours a day, seven days a week, related to external reviews and that is
2427 capable of accepting, recording or providing appropriate instruction to
2428 incoming telephone callers during other than normal business hours;

2429 (2) Agree to maintain and provide to the commissioner the
2430 information set forth in section 38a-226d, as amended by this act;

2431 (3) Not own or control, be a subsidiary of, be owned or controlled in
2432 any way by, or exercise control with a health benefit plan, a national,
2433 state or local trade association of health benefit plans, or a national,
2434 state or local trade association of health care providers; and

2435 (4) Assign as a clinical peer a physician or other appropriate health
2436 care provider who meets the following minimum qualifications:

2437 (A) Is an expert in the treatment of the covered person's medical
2438 condition that is the subject of the external review;

2439 (B) Is knowledgeable about the recommended health care service or
2440 treatment through recent or current actual clinical experience treating
2441 patients with the same or similar medical condition of the covered
2442 person;

2443 (C) Holds a nonrestricted license in a state of the United States and,
2444 for physicians, a current certification by a recognized American
2445 medical specialty board in the area or areas appropriate to the subject
2446 of the external review; and

2447 (D) Has no history of disciplinary actions or sanctions, including
2448 loss of staff privileges or participation restrictions, that have been
2449 taken or are pending by any hospital, governmental agency or unit or
2450 regulatory body that raise a substantial question as to the clinical
2451 peer's physical, mental or professional competence or moral character.

2452 (d) (1) An independent review organization that is accredited by a
2453 nationally recognized private accrediting entity that has independent

2454 review accreditation standards that the commissioner has determined
2455 are equivalent to or exceed the minimum qualifications of this section
2456 shall be presumed to be in compliance with this section.

2457 (2) The commissioner shall initially review and periodically review
2458 the independent review organization accreditation standards of a
2459 nationally recognized private accrediting entity to determine whether
2460 such entity's standards are, and continue to be, equivalent to or exceed
2461 the minimum qualifications established under this section. The
2462 commissioner may accept a review conducted by the National
2463 Association of Insurance Commissioners for the purpose of the
2464 determination under this subdivision.

2465 (3) Upon request, a nationally recognized private accrediting entity
2466 shall make its current independent review organization accreditation
2467 standards available to the commissioner or the National Association of
2468 Insurance Commissioners in order for the commissioner to determine
2469 if such entity's standards are equivalent to or exceed the minimum
2470 qualifications established under this section. The commissioner may
2471 exclude any private accrediting entity that is not reviewed by the
2472 National Association of Insurance Commissioners.

2473 Sec. 18. Section 38a-226d of the general statutes is repealed and the
2474 following is substituted in lieu thereof (*Effective July 1, 2011*):

2475 [The commissioner may find that the standards in section 38a-226c
2476 have been met if each utilization review company has received
2477 approval or accreditation by a utilization review accreditation
2478 organization, or otherwise demonstrates to the commissioner that it
2479 adheres to standards which are substantially similar to the standards
2480 in said section 38a-226c, provided such approval, accreditation or
2481 standards do not provide less protection to enrollees than is provided
2482 under said section 38a-226c.]

2483 (a) The commissioner shall not assign an independent review
2484 organization, and no independent review organization shall assign a

2485 clinical peer, to conduct an external review of a specified case if such
2486 organization or clinical peer has a material professional, familial or
2487 financial conflict of interest with any of the following:

2488 (1) The health carrier that is the subject of the external review;

2489 (2) The covered person whose treatment is the subject of the external
2490 review or the covered person's authorized representative;

2491 (3) Any officer, director or management employee of the health
2492 carrier that is the subject of the external review;

2493 (4) The health care provider, the health care provider's medical
2494 group or independent practice association recommending the health
2495 care service or treatment that is the subject of the external review;

2496 (5) The facility at which the recommended health care service or
2497 treatment would be provided; or

2498 (6) The developer or manufacturer of the principal drug, device,
2499 procedure or other therapy being recommended for the covered
2500 person whose treatment is the subject of the external review.

2501 (b) To determine whether an independent review organization or a
2502 clinical peer of the independent review organization has a material
2503 professional, familial or financial conflict of interest for purposes of
2504 subsection (a) of this section, the commissioner shall consider
2505 situations in which the independent review organization to be
2506 assigned to conduct an external review of a specified case or a clinical
2507 peer to be assigned by the independent review organization to conduct
2508 an external review of a specified case may have an apparent
2509 professional, familial or financial relationship or connection with a
2510 person described in subsection (a) of this section, but the
2511 characteristics of such relationship or connection are such that they are
2512 not a material professional, familial or financial conflict of interest that
2513 results in the disapproval of the independent review organization or
2514 the clinical peer from conducting such external review.

2515 (c) An independent review organization shall be unbiased. In
2516 addition to any other written procedures required under section 38a-
2517 226c, as amended by this act, an independent review organization shall
2518 establish and maintain written procedures to ensure that it is unbiased.

2519 (d) No independent review organization or clinical peer working on
2520 behalf of an independent review organization or an employee, agent or
2521 contractor of an independent review organization shall be liable in
2522 damages to any person for any opinions rendered or acts or omissions
2523 performed within the scope of the organization's or person's duties
2524 during or upon completion of an external review conducted pursuant
2525 to sections 9 to 11, inclusive, of this act, unless such opinion was
2526 rendered or act or omission performed in bad faith or involved gross
2527 negligence.

2528 (e) (1) Each independent review organization assigned by the
2529 commissioner to conduct an external review pursuant to sections 9 to
2530 11, inclusive, of this act shall maintain written records, in the aggregate
2531 by state where the covered person requesting the external review
2532 resides and by health carrier, on all external reviews such organization
2533 conducted during a calendar year and shall, upon request, submit a
2534 report to the commissioner, in a format prescribed by the
2535 commissioner.

2536 (2) Such report shall include, in the aggregate by state where the
2537 covered person requesting the external review resides and by health
2538 carrier:

2539 (A) The total number of requests for an external review;

2540 (B) The number of such requests resolved and, of those resolved, the
2541 number resolved upholding the adverse determination or final adverse
2542 determination and the number resolved reversing the adverse
2543 determination or final adverse determination;

2544 (C) The average length of time for resolution;

2545 (D) A summary of the types of coverages or cases for which an
2546 external review was sought;

2547 (E) The number of external reviews that were terminated as a result
2548 of reconsideration by the health carrier of its adverse determination or
2549 final adverse determination after the receipt of additional information
2550 from the covered person or the covered person's authorized
2551 representative; and

2552 (F) Any other information the commissioner may request or require.

2553 (3) Each independent review organization shall retain the written
2554 records required pursuant to subdivision (1) of this subsection for not
2555 less than six years after the assignment of an external review.

2556 (f) The commissioner may adopt regulations, in accordance with
2557 chapter 54, to carry out the provisions of this section and section 38a-
2558 226c, as amended by this act.

2559 Sec. 19. Subsection (a) of section 38a-11 of the general statutes is
2560 repealed and the following is substituted in lieu thereof (*Effective July*
2561 *1, 2011*):

2562 (a) The commissioner shall demand and receive the following fees:
2563 (1) For the annual fee for each license issued to a domestic insurance
2564 company, two hundred dollars; (2) for receiving and filing annual
2565 reports of domestic insurance companies, fifty dollars; (3) for filing all
2566 documents prerequisite to the issuance of a license to an insurance
2567 company, two hundred twenty dollars, except that the fee for such
2568 filings by any health care center, as defined in section 38a-175, shall be
2569 one thousand three hundred fifty dollars; (4) for filing any additional
2570 paper required by law, thirty dollars; (5) for each certificate of
2571 valuation, organization, reciprocity or compliance, forty dollars; (6) for
2572 each certified copy of a license to a company, forty dollars; (7) for each
2573 certified copy of a report or certificate of condition of a company to be
2574 filed in any other state, forty dollars; (8) for amending a certificate of

2575 authority, two hundred dollars; (9) for each license issued to a rating
2576 organization, two hundred dollars. In addition, insurance companies
2577 shall pay any fees imposed under section 12-211; (10) a filing fee of
2578 fifty dollars for each initial application for a license made pursuant to
2579 section 38a-769; (11) with respect to insurance agents' appointments:
2580 (A) A filing fee of fifty dollars for each request for any agent
2581 appointment, except that no filing fee shall be payable for a request for
2582 agent appointment by an insurance company domiciled in a state or
2583 foreign country which does not require any filing fee for a request for
2584 agent appointment for a Connecticut insurance company; (B) a fee of
2585 one hundred dollars for each appointment issued to an agent of a
2586 domestic insurance company or for each appointment continued; and
2587 (C) a fee of eighty dollars for each appointment issued to an agent of
2588 any other insurance company or for each appointment continued,
2589 except that (i) no fee shall be payable for an appointment issued to an
2590 agent of an insurance company domiciled in a state or foreign country
2591 which does not require any fee for an appointment issued to an agent
2592 of a Connecticut insurance company, and (ii) the fee shall be twenty
2593 dollars for each appointment issued or continued to an agent of an
2594 insurance company domiciled in a state or foreign country with a
2595 premium tax rate below Connecticut's premium tax rate; (12) with
2596 respect to insurance producers: (A) An examination fee of fifteen
2597 dollars for each examination taken, except when a testing service is
2598 used, the testing service shall pay a fee of fifteen dollars to the
2599 commissioner for each examination taken by an applicant; (B) a fee of
2600 eighty dollars for each license issued; (C) a fee of eighty dollars per
2601 year, or any portion thereof, for each license renewed; and (D) a fee of
2602 eighty dollars for any license renewed under the transitional process
2603 established in section 38a-784; (13) with respect to public adjusters: (A)
2604 An examination fee of fifteen dollars for each examination taken,
2605 except when a testing service is used, the testing service shall pay a fee
2606 of fifteen dollars to the commissioner for each examination taken by an
2607 applicant; and (B) a fee of two hundred fifty dollars for each license
2608 issued or renewed; (14) with respect to casualty adjusters: (A) An

2609 examination fee of twenty dollars for each examination taken, except
2610 when a testing service is used, the testing service shall pay a fee of
2611 twenty dollars to the commissioner for each examination taken by an
2612 applicant; (B) a fee of eighty dollars for each license issued or renewed;
2613 and (C) the expense of any examination administered outside the state
2614 shall be the responsibility of the entity making the request and such
2615 entity shall pay to the commissioner two hundred dollars for such
2616 examination and the actual traveling expenses of the examination
2617 administrator to administer such examination; (15) with respect to
2618 motor vehicle physical damage appraisers: (A) An examination fee of
2619 eighty dollars for each examination taken, except when a testing
2620 service is used, the testing service shall pay a fee of eighty dollars to
2621 the commissioner for each examination taken by an applicant; (B) a fee
2622 of eighty dollars for each license issued or renewed; and (C) the
2623 expense of any examination administered outside the state shall be the
2624 responsibility of the entity making the request and such entity shall
2625 pay to the commissioner two hundred dollars for such examination
2626 and the actual traveling expenses of the examination administrator to
2627 administer such examination; (16) with respect to certified insurance
2628 consultants: (A) An examination fee of twenty-six dollars for each
2629 examination taken, except when a testing service is used, the testing
2630 service shall pay a fee of twenty-six dollars to the commissioner for
2631 each examination taken by an applicant; (B) a fee of two hundred fifty
2632 dollars for each license issued; and (C) a fee of two hundred fifty
2633 dollars for each license renewed; (17) with respect to surplus lines
2634 brokers: (A) An examination fee of twenty dollars for each
2635 examination taken, except when a testing service is used, the testing
2636 service shall pay a fee of twenty dollars to the commissioner for each
2637 examination taken by an applicant; and (B) a fee of six hundred
2638 twenty-five dollars for each license issued or renewed; (18) with
2639 respect to fraternal agents, a fee of eighty dollars for each license
2640 issued or renewed; (19) a fee of twenty-six dollars for each license
2641 certificate requested, whether or not a license has been issued; (20)
2642 with respect to domestic and foreign benefit societies shall pay: (A) For

2643 service of process, fifty dollars for each person or insurer to be served;
2644 (B) for filing a certified copy of its charter or articles of association,
2645 fifteen dollars; (C) for filing the annual report, twenty dollars; and (D)
2646 for filing any additional paper required by law, fifteen dollars; (21)
2647 with respect to foreign benefit societies: (A) For each certificate of
2648 organization or compliance, fifteen dollars; (B) for each certified copy
2649 of permit, fifteen dollars; and (C) for each copy of a report or certificate
2650 of condition of a society to be filed in any other state, fifteen dollars;
2651 (22) with respect to reinsurance intermediaries: A fee of six hundred
2652 twenty-five dollars for each license issued or renewed; (23) with
2653 respect to life settlement providers: (A) A filing fee of twenty-six
2654 dollars for each initial application for a license made pursuant to
2655 section 38a-465a; and (B) a fee of forty dollars for each license issued or
2656 renewed; (24) with respect to life settlement brokers: (A) A filing fee of
2657 twenty-six dollars for each initial application for a license made
2658 pursuant to section 38a-465a; and (B) a fee of forty dollars for each
2659 license issued or renewed; (25) with respect to preferred provider
2660 networks, a fee of two thousand seven hundred fifty dollars for each
2661 license issued or renewed; (26) with respect to rental companies, as
2662 defined in section 38a-799, a fee of eighty dollars for each permit
2663 issued or renewed; (27) with respect to medical discount plan
2664 organizations licensed under section 38a-479rr, a fee of six hundred
2665 twenty-five dollars for each license issued or renewed; (28) with
2666 respect to pharmacy benefits managers, an application fee of one
2667 hundred dollars for each registration issued or renewed; (29) with
2668 respect to captive insurance companies, as defined in section 38a-91aa,
2669 a fee of three hundred seventy-five dollars for each license issued or
2670 renewed; [and] (30) with respect to each duplicate license issued a fee
2671 of fifty dollars for each license issued; and (31) for each request for an
2672 external review of an adverse determination or a final adverse
2673 determination pursuant to sections 9 to 11, inclusive, of this act,
2674 twenty-five dollars.

2675 Sec. 20. Section 38a-478 of the general statutes is repealed and the
2676 following is substituted in lieu thereof (*Effective July 1, 2011*):

2677 As used in this section, sections [38a-478] 38a-478a to 38a-478o,
2678 inclusive, and subsection (a) of section 38a-478s, as amended by this
2679 act:

2680 [(1) "Adverse determination" means a determination by a managed
2681 care organization, health insurer or utilization review company that an
2682 admission, service, procedure or extension of stay that is a covered
2683 benefit has been reviewed and, based upon the information provided,
2684 does not meet the managed care organization's, health insurer's or
2685 utilization review company's requirements for medical necessity,
2686 appropriateness, health care setting, level of care or effectiveness, and
2687 such requested admission, service, procedure or extension of stay, or
2688 payment for such admission, service, procedure or extension of stay
2689 has been denied, reduced or terminated.]

2690 [(2)] (1) "Commissioner" means the Insurance Commissioner.

2691 [(3)] (2) "Covered benefit" or "benefit" means a health care service to
2692 which an enrollee is entitled under the terms of a health benefit plan.

2693 [(4) Except as provided in sections 38a-478m and 38a-478n,
2694 "enrollee"] (3) "Enrollee" means a person who has contracted for or
2695 who participates in a managed care plan for such person or such
2696 person's eligible dependents.

2697 [(5)] (4) "Health care services" means services for the diagnosis,
2698 prevention, treatment, cure or relief of a health condition, illness,
2699 injury or disease.

2700 [(6)] (5) "Managed care organization" means an insurer, health care
2701 center, hospital or medical service corporation or other organization
2702 delivering, issuing for delivery, renewing, amending or continuing any
2703 individual or group health managed care plan in this state.

2704 [(7)] (6) "Managed care plan" means a product offered by a managed
2705 care organization that provides for the financing or delivery of health
2706 care services to persons enrolled in the plan through: (A)

2707 Arrangements with selected providers to furnish health care services;
2708 (B) explicit standards for the selection of participating providers; (C)
2709 financial incentives for enrollees to use the participating providers and
2710 procedures provided for by the plan; or (D) arrangements that share
2711 risks with providers, provided the organization offering a plan
2712 described under subparagraph (A), (B), (C) or (D) of this subdivision is
2713 licensed by the Insurance Department pursuant to chapter 698, 698a or
2714 700 and the plan includes utilization review, [pursuant to sections 38a-
2715 226 to 38a-226d, inclusive] as defined in section 38a-226, as amended
2716 by this act.

2717 [(8)] (7) "Preferred provider network" has the same meaning as
2718 provided in section 38a-479aa, as amended by this act.

2719 [(9)] (8) "Provider" or "health care provider" means a person licensed
2720 to provide health care services under chapters 370 to 373, inclusive, 375
2721 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

2722 [(10)] "Review entity" means an entity that conducts independent
2723 external reviews of adverse determinations. Such review entities
2724 include, but are not limited to, medical peer review organizations,
2725 independent utilization review companies, provided such
2726 organizations or companies are not related to or associated with any
2727 managed care organization or health insurer, and nationally
2728 recognized health experts or institutions approved by the Insurance
2729 Commissioner.]

2730 [(11)] (9) "Utilization review" has the same meaning as provided in
2731 section 38a-226, as amended by this act.

2732 [(12)] (10) "Utilization review company" has the same meaning as
2733 provided in section 38a-226, as amended by this act.

2734 Sec. 21. Subsection (c) of section 38a-19 of the general statutes is
2735 repealed and the following is substituted in lieu thereof (*Effective July*
2736 *1, 2011*):

2737 (c) The provisions of this section shall not apply to an order or
2738 decision of the commissioner made pursuant to section 38a-477b or
2739 [38a-478n] sections 9 to 11, inclusive, of this act.

2740 Sec. 22. Subsection (b) of section 38a-477b of the general statutes is
2741 repealed and the following is substituted in lieu thereof (*Effective July*
2742 *1, 2011*):

2743 (b) An insurer or health care center shall apply for approval of such
2744 rescission, cancellation or limitation by submitting such written
2745 information to the Insurance Commissioner on an application in such
2746 form as the commissioner prescribes. Such insurer or health care center
2747 shall provide a copy of the application for such approval to the insured
2748 or the insured's representative. Not later than seven business days
2749 after receipt of the application for such approval, the insured or the
2750 insured's representative shall have an opportunity to review such
2751 application and respond and submit relevant information to the
2752 commissioner with respect to such application. Not later than fifteen
2753 business days after the submission of information by the insured or the
2754 insured's representative, the commissioner shall issue a written
2755 decision on such application. The commissioner [may] shall only
2756 approve; [such rescission, cancellation]

2757 (1) Such rescission or limitation if the commissioner finds that [(1)]
2758 (A) the insured or such insured's representative submitted the written
2759 information [submitted] on or with the insurance application that was
2760 [false] fraudulent at the time such application was made, [and] (B) the
2761 insured or such insured's representative [knew or should have known
2762 of the falsity] intentionally misrepresented information therein [,] and
2763 such [submission] misrepresentation materially affects the risk or the
2764 hazard assumed by the insurer or health care center, or [(2)] (C) the
2765 information omitted from the insurance application was [knowingly]
2766 intentionally omitted by the insured or such insured's representative [,
2767 or the insured or such insured's representative should have known of
2768 such omission,] and such omission materially affects the risk or the

2769 hazard assumed by the insurer or health care center. Such decision
2770 shall be mailed to the insured, the insured's representative, if any, and
2771 the insurer or health care center; and

2772 (2) Such cancellation in accordance with the provisions set forth in
2773 the Public Health Service Act, 42 USC 300gg et seq., as amended from
2774 time to time.

2775 Sec. 23. Section 38a-478a of the general statutes is repealed and the
2776 following is substituted in lieu thereof (*Effective July 1, 2011*):

2777 On March [1, 1999, and] first annually, [thereafter,] the Insurance
2778 Commissioner shall submit a report [,] to the Governor and to the joint
2779 standing committees of the General Assembly having cognizance of
2780 matters relating to public health and [relating to] insurance,
2781 concerning the commissioner's responsibilities under the provisions of
2782 sections [38a-226 to 38a-226d, inclusive] 38a-226a and 38a-226b, as
2783 amended by this act, sections 1 to 13, inclusive, of this act, 38a-478 to
2784 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by
2785 this act, and 38a-993. The report shall include: (1) A summary of the
2786 quality assurance plans submitted by managed care organizations
2787 pursuant to section 38a-478c along with suggested changes to improve
2788 such plans; (2) suggested modifications to the consumer report card
2789 developed under the provisions of section 38a-478i; (3) a summary of
2790 the commissioner's procedures and activities in conducting market
2791 conduct examinations of utilization review companies and preferred
2792 provider networks, including, but not limited to: (A) The number of
2793 desk and field audits completed during the previous calendar year; (B)
2794 a summary of findings of the desk and field audits, including any
2795 recommendations made for improvements or modifications; (C) a
2796 description of complaints concerning managed care companies, and
2797 any preferred provider network that provides services to enrollees on
2798 behalf of the managed care organization, including a summary and
2799 analysis of any trends or similarities found in the managed care
2800 complaints filed by enrollees; (4) a summary of the complaints

2801 concerning managed care companies received by the Insurance
2802 Department's Consumer Affairs Division and the commissioner under
2803 [section 38a-478n] sections 9 to 11, inclusive, of this act, including a
2804 summary and analysis of any trends or similarities found in the
2805 complaints received; (5) a summary of any violations the commissioner
2806 has found against any managed care organization or any preferred
2807 provider network that provides services to enrollees on behalf of the
2808 managed care organization; and (6) a summary of the issues discussed
2809 related to health care or managed care organizations at the Insurance
2810 Department's quarterly forums throughout the state.

2811 Sec. 24. Section 38a-478b of the general statutes is repealed and the
2812 following is substituted in lieu thereof (*Effective July 1, 2011*):

2813 (a) Each managed care organization, as defined in section 38a-478,
2814 that fails to file the data, reports or information required by sections
2815 [38a-226 to 38a-226d] 1 to 13, inclusive, of this act, 38a-478 to 38a-478u,
2816 inclusive, as amended by this act, 38a-479aa, as amended by this act,
2817 and 38a-993 shall pay a late fee of one hundred dollars per day for each
2818 day from the due date of such data, reports or information to the date
2819 of filing. Each managed care organization that files incomplete data,
2820 reports or information shall be so informed by the commissioner, shall
2821 be given a date by which to remedy such incomplete filing and shall
2822 pay said late fee commencing from the new due date.

2823 (b) On June [1, 1998, and] first annually, [thereafter,] the
2824 commissioner shall submit [,] to the Governor and to the joint standing
2825 committees of the General Assembly having cognizance of matters
2826 relating to public health and [matters relating to] insurance, a list of
2827 those managed care organizations that have failed to file any data,
2828 report or information required by sections [38a-226 to 38a-226d] 1 to
2829 13, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by
2830 this act, 38a-479aa, as amended by this act, and 38a-993.

2831 Sec. 25. Section 38a-478h of the general statutes is repealed and the
2832 following is substituted in lieu thereof (*Effective July 1, 2011*):

2833 (a) Each contract delivered, issued for delivery, renewed, amended
2834 or continued in this state [on and after October 1, 1997,] between a
2835 managed care organization and a participating provider shall require
2836 the provider to give at least sixty days' advance written notice to the
2837 managed care organization and shall require the managed care
2838 organization to give at least sixty days' advance written notice to the
2839 provider in order to withdraw from or terminate the agreement.

2840 (b) The provisions of this section shall not apply: (1) When lack of
2841 such notice is necessary for the health or safety of the enrollees; (2)
2842 when a provider has entered into a contract with a managed care
2843 organization that is found to be based on fraud or material
2844 misrepresentation; or (3) when a provider engages in any fraudulent
2845 activity related to the terms of his contract with the managed care
2846 organization.

2847 (c) No managed care organization shall take or threaten to take any
2848 action against any provider in retaliation for such provider's assistance
2849 to an enrollee under the provisions of [subsection (e) of section 38a-
2850 226c or section 38a-478n] sections 9 to 11, inclusive, of this act.

2851 Sec. 26. Subsection (d) of section 38a-478r of the general statutes is
2852 repealed and the following is substituted in lieu thereof (*Effective July*
2853 *1, 2011*):

2854 (d) The Insurance Commissioner [, after consultation with the
2855 working group convened pursuant to section 38a-478p,] may develop
2856 and disseminate to hospitals in this state a claims form system that will
2857 ensure that all hospitals consistently code for the presenting and
2858 diagnosis symptoms on all emergency claims.

2859 Sec. 27. Section 38a-478s of the general statutes is repealed and the
2860 following is substituted in lieu thereof (*Effective July 1, 2011*):

2861 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended
2862 by this act, or sections 1 to 13, inclusive, of this act shall be construed to

2863 apply to the arrangements of managed care organizations or health
2864 insurers offered to individuals covered under self-insured employee
2865 welfare benefit plans established pursuant to the federal Employee
2866 Retirement Income Security Act of 1974.

2867 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, as
2868 amended by this act, and sections 1 to 13, inclusive, of this act shall not
2869 apply to any plan that provides for the financing or delivery of health
2870 care services solely for the purposes of workers' compensation benefits
2871 pursuant to chapter 568.

2872 Sec. 28. Section 38a-478t of the general statutes is repealed and the
2873 following is substituted in lieu thereof (*Effective July 1, 2011*):

2874 The Commissioner of Public Health may request and shall receive
2875 any data, report or information filed with the Insurance Commissioner
2876 pursuant to the provisions of sections [38a-226 to 38a-226d, inclusive]
2877 38a-226a and 38a-226b, as amended by this act, 38a-478 to 38a-478u,
2878 inclusive, as amended by this act, 38a-479aa, as amended by this act,
2879 and 38a-993.

2880 Sec. 29. Section 38a-478u of the general statutes is repealed and the
2881 following is substituted in lieu thereof (*Effective July 1, 2011*):

2882 The Insurance Commissioner may adopt regulations in accordance
2883 with the provisions of chapter 54 to implement the provisions of
2884 sections [38a-226 to 38a-226d, inclusive,] 38a-478 to 38a-478u, inclusive,
2885 as amended by this act, 38a-479aa, as amended by this act, and 38a-
2886 993.

2887 Sec. 30. Section 38a-479aa of the general statutes is repealed and the
2888 following is substituted in lieu thereof (*Effective July 1, 2011*):

2889 (a) As used in this part and subsection (b) of section 20-138b:

2890 (1) "Covered benefits" means health care services to which an
2891 enrollee is entitled under the terms of a managed care plan;

2892 (2) "Enrollee" means an individual who is eligible to receive health
2893 care services through a preferred provider network;

2894 (3) "Health care services" means health care related services or
2895 products rendered or sold by a provider within the scope of the
2896 provider's license or legal authorization, and includes hospital,
2897 medical, surgical, dental, vision and pharmaceutical services or
2898 products;

2899 (4) "Managed care organization" means (A) a managed care
2900 organization, as defined in section 38a-478, (B) any other health
2901 insurer, or (C) a reinsurer with respect to health insurance;

2902 (5) "Managed care plan" means a managed care plan, as defined in
2903 section 38a-478;

2904 (6) "Person" means an individual, agency, political subdivision,
2905 partnership, corporation, limited liability company, association or any
2906 other entity;

2907 (7) "Preferred provider network" means a person, which is not a
2908 managed care organization, but which pays claims for the delivery of
2909 health care services, accepts financial risk for the delivery of health
2910 care services and establishes, operates or maintains an arrangement or
2911 contract with providers relating to (A) the health care services
2912 rendered by the providers, and (B) the amounts to be paid to the
2913 providers for such services. "Preferred provider network" does not
2914 include (i) a workers' compensation preferred provider organization
2915 established pursuant to section 31-279-10 of the regulations of
2916 Connecticut state agencies, (ii) an independent practice association or
2917 physician hospital organization whose primary function is to contract
2918 with insurers and provide services to providers, (iii) a clinical
2919 laboratory, licensed pursuant to section 19a-30, whose primary
2920 payments for any contracted or referred services are made to other
2921 licensed clinical laboratories or for associated pathology services, or
2922 (iv) a pharmacy benefits manager responsible for administering

2923 pharmacy claims whose primary function is to administer the
2924 pharmacy benefit on behalf of a health benefit plan;

2925 (8) "Provider" means an individual or entity duly licensed or legally
2926 authorized to provide health care services; and

2927 (9) "Commissioner" means the Insurance Commissioner.

2928 (b) On and after May 1, 2004, no preferred provider network may
2929 enter into or renew a contractual relationship with a managed care
2930 organization unless the preferred provider network is licensed by the
2931 commissioner. On and after May 1, 2005, no preferred provider
2932 network may conduct business in this state unless it is licensed by the
2933 commissioner. Any person seeking to obtain or renew a license shall
2934 submit an application to the commissioner, on such form as the
2935 commissioner may prescribe, and shall include the filing described in
2936 this subsection, except that a person seeking to renew a license may
2937 submit only the information necessary to update its previous filing.
2938 Applications shall be submitted by March first of each year in order to
2939 qualify for the May first license issue or renewal date. The filing
2940 required from such preferred provider network shall include the
2941 following information: (1) The identity of the preferred provider
2942 network and any company or organization controlling the operation of
2943 the preferred provider network, including the name, business address,
2944 contact person, a description of the controlling company or
2945 organization and, where applicable, the following: (A) A certificate
2946 from the Secretary of the State regarding the preferred provider
2947 network's and the controlling company's or organization's good
2948 standing to do business in the state; (B) a copy of the preferred
2949 provider network's and the controlling company's or organization's
2950 financial statement completed in accordance with sections 38a-53 and
2951 38a-54, as applicable, for the end of its most recently concluded fiscal
2952 year, along with the name and address of any public accounting firm
2953 or internal accountant which prepared or assisted in the preparation of
2954 such financial statement; (C) a list of the names, official positions and

2955 occupations of members of the preferred provider network's and the
2956 controlling company's or organization's board of directors or other
2957 policy-making body and of those executive officers who are
2958 responsible for the preferred provider network's and controlling
2959 company's or organization's activities with respect to the health care
2960 services network; (D) a list of the preferred provider network's and the
2961 controlling company's or organization's principal owners; (E) in the
2962 case of an out-of-state preferred provider network, controlling
2963 company or organization, a certificate that such preferred provider
2964 network, company or organization is in good standing in its state of
2965 organization; (F) in the case of a Connecticut or out-of-state preferred
2966 provider network, controlling company or organization, a report of the
2967 details of any suspension, sanction or other disciplinary action relating
2968 to such preferred provider network, or controlling company or
2969 organization in this state or in any other state; and (G) the identity,
2970 address and current relationship of any related or predecessor
2971 controlling company or organization. For purposes of this
2972 subparagraph, "related" means that a substantial number of the board
2973 or policy-making body members, executive officers or principal
2974 owners of both companies are the same; (2) a general description of the
2975 preferred provider network and participation in the preferred provider
2976 network, including: (A) The geographical service area of and the
2977 names of the hospitals included in the preferred provider network; (B)
2978 the primary care physicians, the specialty physicians, any other
2979 contracting providers and the number and percentage of each group's
2980 capacity to accept new patients; (C) a list of all entities on whose behalf
2981 the preferred provider network has contracts or agreements to provide
2982 health care services; (D) a table listing all major categories of health
2983 care services provided by the preferred provider network; (E) an
2984 approximate number of total enrollees served in all of the preferred
2985 provider network's contracts or agreements; (F) a list of subcontractors
2986 of the preferred provider network, not including individual
2987 participating providers, that assume financial risk from the preferred
2988 provider network and to what extent each subcontractor assumes

2989 financial risk; (G) a contingency plan describing how contracted health
2990 care services will be provided in the event of insolvency; and (H) any
2991 other information requested by the commissioner; and (3) the name
2992 and address of the person to whom applications may be made for
2993 participation.

2994 (c) Any person developing a preferred provider network, or
2995 expanding a preferred provider network into a new county, pursuant
2996 to this section and subsection (b) of section 20-138b, shall publish a
2997 notice, in at least one newspaper having a substantial circulation in the
2998 service area in which the preferred provider network operates or will
2999 operate, indicating such planned development or expansion. Such
3000 notice shall include the medical specialties included in the preferred
3001 provider network, the name and address of the person to whom
3002 applications may be made for participation and a time frame for
3003 making application. The preferred provider network shall provide the
3004 applicant with written acknowledgment of receipt of the application.
3005 Each complete application shall be considered by the preferred
3006 provider network in a timely manner.

3007 (d) (1) Each preferred provider network shall file with the
3008 commissioner and make available upon request from a provider the
3009 general criteria for its selection or termination of providers. Disclosure
3010 shall not be required of criteria deemed by the preferred provider
3011 network to be of a proprietary or competitive nature that would hurt
3012 the preferred provider network's ability to compete or to manage
3013 health care services. For purposes of this section, criteria is of a
3014 proprietary or competitive nature if it has the tendency to cause
3015 providers to alter their practice pattern in a manner that would
3016 circumvent efforts to contain health care costs and criteria is of a
3017 proprietary nature if revealing the criteria would cause the preferred
3018 provider network's competitors to obtain valuable business
3019 information.

3020 (2) If a preferred provider network uses criteria that have not been

3021 filed pursuant to subdivision (1) of this subsection to judge the quality
3022 and cost-effectiveness of a provider's practice under any specific
3023 program within the preferred provider network, the preferred
3024 provider network may not reject or terminate the provider
3025 participating in that program based upon such criteria until the
3026 provider has been informed of the criteria that the provider's practice
3027 fails to meet.

3028 (e) Each preferred provider network shall permit the Insurance
3029 Commissioner to inspect its books and records.

3030 (f) Each preferred provider network shall permit the commissioner
3031 to examine, under oath, any officer or agent of the preferred provider
3032 network or controlling company or organization with respect to the
3033 use of the funds of the preferred provider network, company or
3034 organization, and compliance with (1) the provisions of this part, and
3035 (2) the terms and conditions of its contracts to provide health care
3036 services.

3037 (g) Each preferred provider network shall file with the
3038 commissioner a notice of any material modification of any matter or
3039 document furnished pursuant to this part, and shall include such
3040 supporting documents as are necessary to explain the modification.

3041 (h) Each preferred provider network shall maintain a minimum net
3042 worth of either (1) the greater of (A) two hundred fifty thousand
3043 dollars, or (B) an amount equal to eight per cent of its annual
3044 expenditures as reported on its most recent financial statement
3045 completed and filed with the commissioner in accordance with
3046 sections 38a-53 and 38a-54, as applicable, or (2) another amount
3047 determined by the commissioner.

3048 (i) Each preferred provider network shall maintain or arrange for a
3049 letter of credit, bond, surety, reinsurance, reserve or other financial
3050 security acceptable to the commissioner for the exclusive use of paying
3051 any outstanding amounts owed participating providers in the event of

3052 insolvency or nonpayment except that any remaining security may be
3053 used for the purpose of reimbursing managed care organizations in
3054 accordance with subsection (b) of section 38a-479bb. Such outstanding
3055 amount shall be at least an amount equal to the greater of (1) an
3056 amount sufficient to make payments to participating providers for two
3057 months determined on the basis of the two months within the past
3058 year with the greatest amounts owed by the preferred provider
3059 network to participating providers, (2) the actual outstanding amount
3060 owed by the preferred provider network to participating providers, or
3061 (3) another amount determined by the commissioner. Such amount
3062 may be credited against the preferred provider network's minimum
3063 net worth requirements set forth in subsection (h) of this section. The
3064 commissioner shall review such security amount and calculation on a
3065 quarterly basis.

3066 (j) Each preferred provider network shall pay the applicable license
3067 or renewal fee specified in section 38a-11. The commissioner shall use
3068 the amount of such fees solely for the purpose of regulating preferred
3069 provider networks.

3070 (k) In no event, including, but not limited to, nonpayment by the
3071 managed care organization, insolvency of the managed care
3072 organization, or breach of contract between the managed care
3073 organization and the preferred provider network, shall a preferred
3074 provider network bill, charge, collect a deposit from, seek
3075 compensation, remuneration or reimbursement from, or have any
3076 recourse against an enrollee or an enrollee's designee, other than the
3077 managed care organization, for covered benefits provided, except that
3078 the preferred provider network may collect any copayments,
3079 deductibles or other out-of-pocket expenses that the enrollee is
3080 required to pay pursuant to the managed care plan.

3081 (l) Each contract or agreement between a preferred provider
3082 network and a participating provider shall contain a provision that if
3083 the preferred provider network fails to pay for health care services as

3084 set forth in the contract, the enrollee shall not be liable to the
3085 participating provider for any sums owed by the preferred provider
3086 network or any sums owed by the managed care organization because
3087 of nonpayment by the managed care organization, insolvency of the
3088 managed care organization or breach of contract between the managed
3089 care organization and the preferred provider network.

3090 [(m) Each utilization review determination made by or on behalf of
3091 a preferred provider network shall be made in accordance with
3092 sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of
3093 a determination not to certify an admission, service, procedure or
3094 extension of stay shall be conducted in accordance with subdivision (7)
3095 of subsection (a) of section 38a-226c, and any subsequent appeal shall
3096 be referred to the managed care organization on whose behalf the
3097 preferred provider network provides services. The managed care
3098 organization shall conduct the subsequent appeal in accordance with
3099 said subdivision.]

3100 [(n)] (m) The requirements of subsections (h) and (i) of this section
3101 shall not apply to a consortium of federally qualified health centers
3102 funded by the state, providing services only to recipients of programs
3103 administered by the Department of Social Services. The Commissioner
3104 of Social Services shall adopt regulations, in accordance with chapter
3105 54, to establish criteria to certify any such federally qualified health
3106 center, including, but not limited to, minimum reserve fund
3107 requirements.

3108 Sec. 31. Subsection (d) of section 38a-479bb of the general statutes is
3109 repealed and the following is substituted in lieu thereof (*Effective July*
3110 *1, 2011*):

3111 (d) Each managed care organization shall ensure that any contract it
3112 has with a preferred provider network includes:

3113 (1) A provision that requires the preferred provider network to
3114 provide to the managed care organization at the time a contract is

3115 entered into, annually, and upon request of the managed care
3116 organization, (A) the financial statement completed in accordance with
3117 sections 38a-53 and 38a-54, as applicable, and section 38a-479aa; (B)
3118 documentation that satisfies the managed care organization that the
3119 preferred provider network has sufficient ability to accept financial
3120 risk; (C) documentation that satisfies the managed care organization
3121 that the preferred provider network has appropriate management
3122 expertise and infrastructure; (D) documentation that satisfies the
3123 managed care organization that the preferred provider network has an
3124 adequate provider network taking into account the geographic
3125 distribution of enrollees and participating providers and whether
3126 participating providers are accepting new patients; (E) an accurate list
3127 of participating providers; and (F) documentation that satisfies the
3128 managed care organization that the preferred provider network has
3129 the ability to ensure the delivery of health care services as set forth in
3130 the contract;

3131 (2) A provision that requires the preferred provider network to
3132 provide to the managed care organization a quarterly status report that
3133 includes (A) information updating the financial statement completed
3134 in accordance with sections 38a-53 and 38a-54, as applicable, and
3135 section 38a-479aa; (B) a report showing amounts paid to those
3136 providers who provide health care services on behalf of the managed
3137 care organization; (C) an estimate of payments due providers but not
3138 yet reported by providers; (D) amounts owed to providers for that
3139 quarter; and (E) the number of utilization review determinations not to
3140 certify an admission, service, procedure or extension of stay made by
3141 or on behalf of the preferred provider network and the outcome of
3142 such determination on appeal;

3143 (3) A provision that requires the preferred provider network to
3144 provide notice to the managed care organization not later than five
3145 business days after (A) any change involving the ownership structure
3146 of the preferred provider network; (B) financial or operational
3147 concerns arise regarding the financial viability of the preferred

3148 provider network; or (C) the preferred provider network's loss of a
3149 license in this or any other state;

3150 (4) A provision that if the managed care organization fails to pay for
3151 health care services as set forth in the contract, the enrollee will not be
3152 liable to the provider or preferred provider network for any sums
3153 owed by the managed care organization or preferred provider
3154 network;

3155 (5) A provision that the preferred provider network shall include in
3156 all contracts between the preferred provider network and participating
3157 providers a provision that if the preferred provider network fails to
3158 pay for health care services as set forth in the contract, for any reason,
3159 the enrollee shall not be liable to the participating provider or
3160 preferred provider network for any sums owed by the preferred
3161 provider network or any sums owed by the managed care
3162 organization because of nonpayment by the managed care
3163 organization, insolvency of the managed care organization or breach of
3164 contract between the managed care organization and the preferred
3165 provider network;

3166 (6) A provision requiring the preferred provider network to provide
3167 information to the managed care organization, satisfactory to the
3168 managed care organization, regarding the preferred provider
3169 network's reserves for financial risk;

3170 (7) A provision that (A) the preferred provider network or managed
3171 care organization shall post and maintain a letter of credit, bond,
3172 surety, reinsurance, reserve or other financial security acceptable to the
3173 commissioner, in order to satisfy the risk accepted by the preferred
3174 provider network pursuant to the contract, in an amount calculated in
3175 accordance with subsection (i) of section 38a-479aa, (B) the managed
3176 care organization shall determine who posts and maintains the
3177 security required under subparagraph (A) of this subdivision, and (C)
3178 in the event of insolvency or nonpayment, such security shall be used
3179 by the preferred provider network, or other entity designated by the

3180 commissioner, solely for the purpose of paying any outstanding
3181 amounts owed participating providers, except that any remaining
3182 security may be used for the purpose of reimbursing the managed care
3183 organization for any payments made by the managed care
3184 organization to participating providers on behalf of the preferred
3185 provider network;

3186 (8) A provision under which the managed care organization is
3187 permitted, at the discretion of the managed care organization, to pay
3188 participating providers directly and in lieu of the preferred provider
3189 network in the event of insolvency or mismanagement by the
3190 preferred provider network and that payments made pursuant to this
3191 subdivision may be made or reimbursed from the security posted
3192 pursuant to subsection (b) of this section;

3193 (9) A provision transferring and assigning contracts between the
3194 preferred provider network and participating providers to the
3195 managed care organization for the provision of future services by
3196 participating providers to enrollees, at the discretion of the managed
3197 care organization, in the event the preferred provider network (A)
3198 becomes insolvent, (B) otherwise ceases to conduct business, as
3199 determined by the commissioner, or (C) demonstrates a pattern of
3200 nonpayment of authorized claims, as determined by the commissioner,
3201 for a period in excess of ninety days;

3202 (10) A provision that each contract or agreement between the
3203 preferred provider network and participating providers shall include a
3204 provision transferring and assigning contracts between the preferred
3205 provider network and participating providers to the managed care
3206 organization for the provision of future health care services by
3207 participating providers to enrollees, at the discretion of the managed
3208 care organization, in the event the preferred provider network (A)
3209 becomes insolvent, (B) otherwise ceases to conduct business, as
3210 determined by the commissioner, or (C) demonstrates a pattern of
3211 nonpayment of authorized claims, as determined by the commissioner,

3212 for a period in excess of ninety days; and

3213 (11) A provision that the preferred provider network shall pay for
3214 the delivery of health care services and operate or maintain
3215 arrangements or contracts with providers in a manner consistent with
3216 the provisions of law that apply to the managed care organization's
3217 contracts with enrollees and providers.]; and]

3218 [(12) A provision that the preferred provider network shall ensure
3219 that utilization review determinations are made in accordance with
3220 sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of
3221 a determination not to certify an admission, service, procedure or
3222 extension of stay shall be made in accordance with subdivision (7) of
3223 subsection (a) of section 38a-226c. In cases where an appeal to reverse a
3224 determination not to certify is unsuccessful, the preferred provider
3225 network shall refer the case to the managed care organization which
3226 shall conduct the subsequent appeal, if any, in accordance with said
3227 subdivision.]

3228 Sec. 32. Section 38a-479ee of the general statutes is repealed and the
3229 following is substituted in lieu thereof (*Effective July 1, 2011*):

3230 (a) If the Insurance Commissioner determines that a preferred
3231 provider network or managed care organization, or both, has not
3232 complied with any applicable provision of this part [, sections 38a-226
3233 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
3234 amended by this act, the commissioner may (1) order the preferred
3235 provider network or managed care organization, or both if both have
3236 not complied, to cease and desist all operations in violation of this part
3237 or said sections; (2) terminate or suspend the preferred provider
3238 network's license; (3) institute a corrective action against the preferred
3239 provider network or managed care organization, or both if both have
3240 not complied; (4) order the payment of a civil penalty by the preferred
3241 provider network or managed care organization, or both if both have
3242 not complied, of not more than one thousand dollars for each and
3243 every act or violation; (5) order the payment of such reasonable

3244 expenses as may be necessary to compensate the commissioner in
3245 conjunction with any proceedings held to investigate or enforce
3246 violations of this part [, sections 38a-226 to 38a-226d, inclusive,] or
3247 sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6)
3248 use any of the commissioner's other enforcement powers to obtain
3249 compliance with this part [, sections 38a-226 to 38a-226d, inclusive,] or
3250 sections 38a-815 to 38a-819, inclusive, as amended by this act. The
3251 commissioner may hold a hearing concerning any matter governed by
3252 this part [, sections 38a-226 to 38a-226d, inclusive,] or sections 38a-815
3253 to 38a-819, inclusive, as amended by this act, in accordance with
3254 section 38a-16. Subject to the same confidentiality and liability
3255 protections set forth in subsections (c) and (k) of section 38a-14, the
3256 commissioner may engage the services of attorneys, appraisers,
3257 independent actuaries, independent certified public accountants or
3258 other professionals and specialists to assist the commissioner in
3259 conducting an investigation under this section, the cost of which shall
3260 be borne by the managed care organization or preferred provider
3261 network, or both, that is the subject of the investigation.

3262 (b) If a preferred provider network fails to comply with any
3263 applicable provision of this part [, sections 38a-226 to 38a-226d,
3264 inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended by this
3265 act, the commissioner may assign or require the preferred provider
3266 network to assign its rights and obligations under any contract with
3267 participating providers in order to ensure that covered benefits are
3268 provided.

3269 (c) The commissioner shall receive and investigate (1) any grievance
3270 filed against a preferred provider network or managed care
3271 organization, or both, by an enrollee or an enrollee's designee
3272 concerning matters governed by this part [, sections 38a-226 to 38a-
3273 226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended
3274 by this act, or (2) any referral from the Office of the Healthcare
3275 Advocate pursuant to section 38a-1041. The commissioner shall code,
3276 track and review such grievances and referrals. The preferred provider

3277 network or managed care organization, or both, shall provide the
3278 commissioner with all information necessary for the commissioner to
3279 investigate such grievances and referrals. The information collected by
3280 the commissioner pursuant to this section shall be maintained as
3281 confidential and shall not be disclosed to any person except (A) to the
3282 extent necessary to carry out the purposes of this part [, sections 38a-
3283 226 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
3284 amended by this act, (B) as allowed under this title, (C) to the
3285 Healthcare Advocate, and (D) information concerning the nature of
3286 any grievance or referral and the commissioner's final determination
3287 shall be a public record, as defined in section 1-200, provided no
3288 personal information, as defined in section 38a-975, shall be disclosed.
3289 The commissioner shall report to the Healthcare Advocate on the
3290 resolution of any matter referred to the commissioner by the
3291 Healthcare Advocate.

3292 Sec. 33. Section 38a-479ff of the general statutes is repealed and the
3293 following is substituted in lieu thereof (*Effective July 1, 2011*):

3294 No health insurer, health care center, utilization review company, as
3295 defined in section 38a-226, as amended by this act, or preferred
3296 provider network, as defined in section 38a-479aa, as amended by this
3297 act, shall take or threaten to take any adverse personnel or coverage-
3298 related action against any enrollee, provider or employee in retaliation
3299 for such enrollee, provider or employee (1) filing a complaint with the
3300 Insurance Commissioner or the Office of the Healthcare Advocate, or
3301 (2) disclosing information to the Insurance Commissioner concerning
3302 any violation of this part [, sections 38a-226 to 38a-226d, inclusive,] or
3303 sections 38a-815 to 38a-819, inclusive, as amended by this act, unless
3304 such disclosure violates the provisions of chapter 705 or the privacy
3305 provisions of the federal Health Insurance Portability and
3306 Accountability Act of 1996, [(P.L. 104-191) (HIPAA)] P.L. 104-191, as
3307 amended from time to time, or regulations adopted thereunder. Any
3308 enrollee, provider or employee who is aggrieved by a violation of this
3309 section may bring a civil action in the Superior Court to recover

3310 damages and attorneys' fees and costs.

3311 Sec. 34. Subsection (c) of section 38a-483c of the general statutes is
3312 repealed and the following is substituted in lieu thereof (*Effective July*
3313 *1, 2011*):

3314 (c) Any person who has been diagnosed with a condition that
3315 creates a life expectancy in that person of less than two years and who
3316 has been denied an otherwise covered procedure, treatment or drug on
3317 the grounds that it is experimental may request an expedited appeal as
3318 provided in [section 38a-226c] sections 7 and 8 of this act and may
3319 appeal a denial thereof to the Insurance Commissioner in accordance
3320 with the procedures established in [section 38a-478n] sections 9 to 11,
3321 inclusive, of this act.

3322 Sec. 35. Subsection (c) of section 38a-513b of the general statutes is
3323 repealed and the following is substituted in lieu thereof (*Effective July*
3324 *1, 2011*):

3325 (c) Any person who has been diagnosed with a condition that
3326 creates a life expectancy in that person of less than two years and who
3327 has been denied an otherwise covered procedure, treatment or drug on
3328 the grounds that it is experimental may request an expedited appeal as
3329 provided in [section 38a-226c] sections 7 and 8 of this act and may
3330 appeal a denial thereof to the Insurance Commissioner in accordance
3331 with the procedures established in [section 38a-478n] sections 9 to 11,
3332 inclusive, of this act.

3333 Sec. 36. Subsection (c) of section 38a-504f of the general statutes is
3334 repealed and the following is substituted in lieu thereof (*Effective July*
3335 *1, 2011*):

3336 (c) The insured, or the provider with the insured's written consent,
3337 may appeal any denial of coverage for medical necessity to an external,
3338 independent review pursuant to [section 38a-478n] sections 9 to 11,
3339 inclusive, of this act. Such external review shall be conducted by a

3340 properly qualified review agent whom the department has determined
3341 does not have a conflict of interest regarding the cancer clinical trial.

3342 Sec. 37. Subsection (c) of section 38a-542f of the general statutes is
3343 repealed and the following is substituted in lieu thereof (*Effective July*
3344 *1, 2011*):

3345 (c) The insured, or the provider with the insured's written consent,
3346 may appeal any denial of coverage for medical necessity to an external,
3347 independent review pursuant to [section 38a-478n] sections 9 to 11,
3348 inclusive, of this act. Such external review shall be conducted by a
3349 properly qualified review agent whom the department has determined
3350 does not have a conflict of interest regarding the cancer clinical trial.

3351 Sec. 38. Subdivision (22) of section 38a-816 of the general statutes is
3352 repealed and the following is substituted in lieu thereof (*Effective July*
3353 *1, 2011*):

3354 (22) Any violation of [section 38a-478m] sections 5 to 8, inclusive, of
3355 this act.

3356 Sec. 39. Subdivision (3) of section 38a-1040 of the general statutes is
3357 repealed and the following is substituted in lieu thereof (*Effective July*
3358 *1, 2011*):

3359 (3) "Managed care plan" means a product offered by a managed care
3360 organization that provides for the financing or delivery of health care
3361 services to persons enrolled in the plan through: (A) Arrangements
3362 with selected providers to furnish health care services; (B) explicit
3363 standards for the selection of participating providers; (C) financial
3364 incentives for enrollees to use the participating providers and
3365 procedures provided for by the plan; or (D) arrangements that share
3366 risks with providers, provided the organization offering a plan
3367 described under subparagraph (A), (B), (C) or (D) of this subdivision is
3368 licensed by the Insurance Department pursuant to chapter 698, 698a or
3369 700 and that the plan includes utilization review, [pursuant to sections

3370 38a-226 to 38a-226d, inclusive] as defined in section 38a-226, as
3371 amended by this act.

3372 Sec. 40. Subsections (b) and (c) of section 38a-1041 of the general
3373 statutes are repealed and the following is substituted in lieu thereof
3374 (*Effective July 1, 2011*):

3375 (b) The Office of the Healthcare Advocate may:

3376 (1) Assist health insurance consumers with managed care plan
3377 selection by providing information, referral and assistance to
3378 individuals about means of obtaining health insurance coverage and
3379 services;

3380 (2) Assist health insurance consumers to understand their rights and
3381 responsibilities under managed care plans;

3382 (3) Provide information to the public, agencies, legislators and
3383 others regarding problems and concerns of health insurance
3384 consumers and make recommendations for resolving those problems
3385 and concerns;

3386 (4) Assist consumers with the filing of complaints and appeals,
3387 including filing appeals with a managed care organization's internal
3388 appeal or grievance process and the external appeal process
3389 established under [section 38a-478n] sections 5 to 11, inclusive, of this
3390 act;

3391 (5) Analyze and monitor the development and implementation of
3392 federal, state and local laws, regulations and policies relating to health
3393 insurance consumers and recommend changes it deems necessary;

3394 (6) Facilitate public comment on laws, regulations and policies,
3395 including policies and actions of health insurers;

3396 (7) Ensure that health insurance consumers have timely access to the
3397 services provided by the office;

3398 (8) Review the health insurance records of a consumer who has
3399 provided written consent for such review;

3400 (9) Create and make available to employers a notice, suitable for
3401 posting in the workplace, concerning the services that the Healthcare
3402 Advocate provides;

3403 (10) Establish a toll-free number, or any other free calling option, to
3404 allow customer access to the services provided by the Healthcare
3405 Advocate;

3406 (11) Pursue administrative remedies on behalf of and with the
3407 consent of any health insurance consumers;

3408 (12) Adopt regulations, pursuant to chapter 54, to carry out the
3409 provisions of sections 38a-1040 to 38a-1050, inclusive; and

3410 (13) Take any other actions necessary to fulfill the purposes of
3411 sections 38a-1040 to 38a-1050, inclusive.

3412 (c) The Office of the Healthcare Advocate shall make a referral to
3413 the Insurance Commissioner if the Healthcare Advocate finds that a
3414 preferred provider network may have engaged in a pattern or practice
3415 that may be in violation of sections [38a-226 to 38a-226d, inclusive,]
3416 38a-479aa to 38a-479gg, inclusive, as amended by this act, or 38a-815 to
3417 38a-819, inclusive, as amended by this act.

3418 Sec. 41. Sections 38a-478m, 38a-478n and 38a-478p of the general
3419 statutes are repealed. (Effective July 1, 2011)

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2011	New section
Sec. 2	July 1, 2011	New section
Sec. 3	July 1, 2011	New section
Sec. 4	July 1, 2011	New section
Sec. 5	July 1, 2011	New section

Sec. 6	<i>July 1, 2011</i>	New section
Sec. 7	<i>July 1, 2011</i>	New section
Sec. 8	<i>July 1, 2011</i>	New section
Sec. 9	<i>July 1, 2011</i>	New section
Sec. 10	<i>July 1, 2011</i>	New section
Sec. 11	<i>July 1, 2011</i>	New section
Sec. 12	<i>July 1, 2011</i>	New section
Sec. 13	<i>July 1, 2011</i>	New section
Sec. 14	<i>July 1, 2011</i>	38a-226
Sec. 15	<i>July 1, 2011</i>	38a-226a
Sec. 16	<i>July 1, 2011</i>	38a-226b
Sec. 17	<i>July 1, 2011</i>	38a-226c
Sec. 18	<i>July 1, 2011</i>	38a-226d
Sec. 19	<i>July 1, 2011</i>	38a-11(a)
Sec. 20	<i>July 1, 2011</i>	38a-478
Sec. 21	<i>July 1, 2011</i>	38a-19(c)
Sec. 22	<i>July 1, 2011</i>	38a-477b(b)
Sec. 23	<i>July 1, 2011</i>	38a-478a
Sec. 24	<i>July 1, 2011</i>	38a-478b
Sec. 25	<i>July 1, 2011</i>	38a-478h
Sec. 26	<i>July 1, 2011</i>	38a-478r(d)
Sec. 27	<i>July 1, 2011</i>	38a-478s
Sec. 28	<i>July 1, 2011</i>	38a-478t
Sec. 29	<i>July 1, 2011</i>	38a-478u
Sec. 30	<i>July 1, 2011</i>	38a-479aa
Sec. 31	<i>July 1, 2011</i>	38a-479bb(d)
Sec. 32	<i>July 1, 2011</i>	38a-479ee
Sec. 33	<i>July 1, 2011</i>	38a-479ff
Sec. 34	<i>July 1, 2011</i>	38a-483c(c)
Sec. 35	<i>July 1, 2011</i>	38a-513b(c)
Sec. 36	<i>July 1, 2011</i>	38a-504f(c)
Sec. 37	<i>July 1, 2011</i>	38a-542f(c)
Sec. 38	<i>July 1, 2011</i>	38a-816(22)
Sec. 39	<i>July 1, 2011</i>	38a-1040(3)
Sec. 40	<i>July 1, 2011</i>	38a-1041(b) and (c)
Sec. 41	<i>July 1, 2011</i>	Repealer section

Statement of Purpose:

To update the requirements for utilization review, grievances and external appeals processes of health carriers to conform to federal standards.

[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.]