General Assembly **Substitute Bill No. 1158**

January Session, 2011 *____SB01158JUD__050911___*

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; or

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.

21 "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 such trials and studies are not
40 available, case-series, or (D) if such trials, studies and case-series are
41 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) "Emergency medical condition" means a medical condition
75 manifesting itself by acute symptoms of sufficient severity, including
76 severe pain, such that a prudent lay-person with an average
77 knowledge of health and medicine, acting reasonably, would have
78 believed that the absence of immediate medical attention would result
79 in serious impairment to bodily functions or serious dysfunction of a
80 bodily organ or part, or would place the person's health or, with
81 respect to a pregnant woman, the health of the woman or her unborn
82 child, in serious jeopardy.

83 (15) "Emergency services" means, with respect to an emergency
84 medical condition:

85 (A) A medical screening examination that is within the capability of
86 the emergency department of a hospital, including ancillary services
87 routinely available to the emergency department to evaluate such
88 emergency medical condition; and

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

92 (16) "Evidence-based standard" means the conscientious, explicit
93 and judicious use of the current best evidence based on an overall
94 systematic review of medical research when making determinations
95 about the care of individual patients.

96 (17) "Expert opinion" means a belief or an interpretation by
97 specialists with experience in a specific area about the scientific
98 evidence pertaining to a particular service, intervention or therapy.

99 (18) "Facility" means an institution providing health care services or
100 a health care setting. "Facility" includes a hospital and other licensed
101 inpatient center, ambulatory surgical or treatment center, skilled
102 nursing center, residential treatment center, diagnostic, laboratory and
103 imaging center, and rehabilitation and other therapeutic health care

104 setting.

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

110 (20) "Grievance" means a written complaint or, if the complaint
111 involves an urgent care request, an oral complaint, submitted by or on
112 behalf of a covered person regarding:

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

116 (B) Claims payment, handling or reimbursement for health care
117 services; or

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

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

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

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

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

130 (iii) Liability insurance, including general liability insurance and
131 automobile liability insurance;

132 (iv) Workers' compensation insurance;

133 (v) Automobile medical payment insurance;

134 (vi) Credit insurance;

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

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

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

151 (x) Coverage of the type specified in subdivisions (3) and (13) of
152 section 38a-469 of the general statutes or other fixed indemnity
153 insurance if (I) they are provided under a separate insurance policy,
154 certificate or contract, (II) there is no coordination between the
155 provision of the benefits and any exclusion of benefits under any
156 group health plan maintained by the same plan sponsor, and (III) the
157 benefits are paid with respect to an event without regard to whether
158 benefits were also provided under any group health plan maintained
159 by the same plan sponsor.

160 (22) "Health care center" has the same meaning as provided in
161 section 38a-175 of the general statutes.

162 (23) "Health care professional" means a physician or other health
163 care practitioner licensed, accredited or certified to perform specified
164 health care services consistent with state law.

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

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

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

183 (27) "Independent review organization" has the same meaning as
184 provided in section 38a-226 of the general statutes, as amended by this
185 act.

186 (28) "Medical or scientific evidence" means evidence found in the
187 following sources:

188 (A) Peer-reviewed scientific studies published in or accepted for
189 publication by medical journals that meet nationally recognized
190 requirements for scientific manuscripts and that submit most of their
191 published articles for review by experts who are not part of the

192 editorial staff;

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

199 (C) Medical journals recognized by the Secretary of the United
200 States Department of Health and Human Services under Section
201 1861(t)(2) of the Social Security Act;

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

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

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

219 (29) "Participating provider" means a health care professional who,
220 under a contract with the health carrier, its contractor or subcontractor,
221 has agreed to provide health care services to covered persons, with an

222 expectation of receiving payment or reimbursement directly or
223 indirectly from the health carrier, other than coinsurance, copayments
224 or deductibles.

225 (30) "Person" has the same meaning as provided in section 38a-1 of
226 the general statutes.

227 (31) "Prospective review" means utilization review conducted prior
228 to an admission or the provision of a health care service or a course of
229 treatment, in accordance with a health carrier's requirement that such
230 service or treatment be approved, in whole or in part, prior to such
231 service's or treatment's provision.

232 (32) "Protected health information" means health information (A)
233 that identifies an individual who is the subject of the information, or
234 (B) for which there is a reasonable basis to believe that such
235 information could be used to identify such individual.

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

242 (34) "Rescission" means a cancellation or discontinuance of coverage
243 under a health benefit plan that has a retroactive effect. "Rescission"
244 does not include a cancellation or discontinuance of coverage under a
245 health benefit plan if (A) such cancellation or discontinuance has a
246 prospective effect only, or (B) such cancellation or discontinuance is
247 effective retroactively to the extent it is attributable to the covered
248 person's failure to timely pay required premiums or contributions
249 towards the cost of such coverage.

250 (35) "Retrospective review" means any review of a request for a
251 benefit that is not a prospective review or concurrent review.

252 "Retrospective review" does not include a review of a request that is
253 limited to the veracity of documentation or the accuracy of coding.

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

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

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

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

273 Sec. 2. (NEW) (*Effective July 1, 2011*) (a) Sections 1 to 13, inclusive, of
274 this act shall apply to (1) any health carrier offering a health benefit
275 plan and that provides or performs utilization review including
276 prospective, concurrent or retrospective review benefit determinations,
277 and (2) any utilization review company or designee of a health carrier
278 that performs utilization review on the health carrier's behalf,
279 including prospective, concurrent or retrospective review benefit
280 determinations.

281 (b) Each health carrier shall be responsible for monitoring all

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

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

299 (2) Such document shall describe the following:

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

302 (B) Data sources and clinical review criteria used in making
303 determinations;

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

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

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

310 (F) The health carrier's organizational mechanism, such as a

311 utilization review committee or quality assurance or other committee,
312 that periodically assesses the health carrier's utilization review
313 program and reports to the health carrier's governing body; and

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

316 (d) Each health carrier shall:

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

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

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

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

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

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

338 (D) A statement of the rights and responsibilities of covered persons

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

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

348 (3) Inform a covered person and the covered person's health care
349 professional of the health carrier's grievance procedures whenever the
350 health carrier denies certification of a benefit requested by a covered
351 person's health care professional;

352 (4) Include in materials intended for prospective covered persons a
353 summary of its utilization review and benefit determination
354 procedures;

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

357 (6) Maintain records of all benefit requests, claims and notices
358 associated with utilization review and benefit determinations made in
359 accordance with sections 4 and 7 of this act for not less than six years
360 after such requests, claims and notices were made. Each health carrier
361 shall make such records available for examination by covered persons,
362 provided such records are subject to disclosure pursuant to section 1-
363 210 of the general statutes, the commissioner and appropriate federal
364 oversight agencies upon request; and

365 (7) Maintain records in accordance with section 12 of this act of all
366 grievances received. Each health carrier shall make such records
367 available for examination by covered persons, provided such records
368 are subject to disclosure pursuant to section 1-210 of the general

369 statutes, the commissioner and appropriate federal oversight agencies
370 upon request.

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

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

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

377 (i) A certificate of compliance certifying that the utilization review
378 program of the health carrier or its designee complies with all
379 applicable state and federal laws concerning confidentiality and
380 reporting requirements;

381 (ii) The number of covered lives;

382 (iii) The total number of grievances received;

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

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

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

389 (vii) A synopsis of actions being taken to correct any problems
390 identified.

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

394 Sec. 3. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall

395 contract with (A) health care professionals to administer such health
396 carrier's utilization review program and oversee utilization review
397 determinations, and (B) with clinical peers to evaluate the clinical
398 appropriateness of an adverse determination.

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

409 (b) Each health carrier shall:

410 (1) Have procedures in place to ensure that the health care
411 professionals administering such health carrier's utilization review
412 program are applying the clinical review criteria consistently in
413 utilization review determinations;

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

417 (3) Provide covered persons and participating providers with access
418 to its utilization review staff through a toll-free telephone number or
419 any other free calling option or by electronic means;

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

425 (5) Routinely assess the effectiveness and efficiency of its utilization
426 review program.

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

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

445 Sec. 4. (NEW) (*Effective July 1, 2011*) (a) Each health carrier shall
446 maintain written procedures for making utilization review and benefit
447 determinations on benefit requests submitted to the health carrier by
448 covered persons or their authorized representatives and for notifying
449 covered persons and their authorized representatives of its
450 determinations with respect to such requests within the specified time
451 periods under this section.

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

455 (A) A health carrier shall make the determination and notify the

456 covered person and, if applicable, the covered person's authorized
457 representative of the determination, whether or not the carrier certifies
458 the provision of the benefit, within a reasonable period of time
459 appropriate to the covered person's medical condition but not later
460 than fifteen days after the health carrier receives the request.

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

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

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

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

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

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

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

485 (4) With respect to a failure specified in this subsection and
486 subsections (c) and (d) of this section, the provisions of said
487 subsections shall apply only in the case of a failure that is a
488 communication:

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

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

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

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

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

514 (2) If the determination is an adverse determination, the health

515 carrier shall notify the covered person and, if applicable, the covered
516 person's authorized representative of the adverse determination in
517 accordance with subsection (f) of this section.

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

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

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

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

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

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

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

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

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

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

569 (A) Information sufficient to identify the benefit request or claim
570 involved, including the date of service, if applicable, the health care
571 professional, the claim amount, if applicable, the diagnosis code and its
572 corresponding meaning and the treatment code and its corresponding
573 meaning;

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

577 reaching the denial;

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

580 (D) A description of any additional material or information
581 necessary for the covered person to perfect the benefit request or claim,
582 including an explanation of why the material or information is
583 necessary to perfect the request or claim;

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

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

594 (G) If the adverse determination is based on medical necessity or an
595 experimental or investigational treatment or similar exclusion or limit,
596 the written statement of the scientific or clinical rationale for the
597 adverse determination and (i) an explanation of the scientific or clinical
598 rationale used to make the determination that applies the terms of the
599 health benefit plan to the covered person's medical circumstances, or
600 (ii) a statement that an explanation will be provided to the covered
601 person free of charge upon request and instructions for requesting a
602 copy of such explanation; and

603 (H) A statement explaining the right of the covered person to
604 contact the commissioner's office or the Office of the Healthcare
605 Advocate at any time for assistance or, upon completion of the health
606 carrier's internal grievance process as provided under sections 5 and 6

607 of this act, to file a civil suit in a court of competent jurisdiction. Such
608 statement shall include the contact information for said offices.

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

614 (A) Include a statement in the English version of the notice,
615 prominently displayed in the non-English language required pursuant
616 to federal law, offering the provision of the notice in the non-English
617 language;

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

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

625 (3) If the adverse determination is a rescission, the health carrier
626 shall, in addition to the notice required under subdivision (1) of this
627 subsection, include with the copy of the application to the
628 commissioner for approval of such rescission that is required to be sent
629 to the covered person pursuant to section 38a-477b of the general
630 statutes, a written statement that includes:

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

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

635 (C) A disclosure that the covered person or the covered person's

636 authorized representative may file immediately, without waiting for
637 the date such advance notice of the proposed rescission ends, a
638 grievance with the health carrier to request a review of the adverse
639 determination to rescind coverage, pursuant to sections 5 and 6 of this
640 act;

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

644 (E) The date such advance notice of the proposed rescission ends
645 and the date back to which the coverage will be retroactively
646 rescinded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

724 (B) For purposes of subparagraph (A)(ii) of this subdivision and
725 subparagraph (C) of subdivision (6) of subsection (i) of this section, a
726 document, record or other information shall be considered "relevant"
727 to a covered person's benefit request if the document, record or other

728 information:

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

730 (ii) Was submitted, considered or generated in the course of making
731 the adverse determination under review, regardless of whether the
732 document, record or other information was relied upon in making the
733 benefit determination;

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

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

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

747 (h) (1) The health carrier shall notify the covered person and, if
748 applicable, the covered person's authorized representative in writing
749 or by electronic means of its decision within the time period under
750 subdivision (2) or (3) of this subsection. Such time period shall begin
751 on the date the health carrier receives the grievance in accordance with
752 the health carrier's procedures for filing such grievance, regardless of
753 whether all of the information necessary to make the decision
754 accompanies the filing.

755 (2) For a grievance of an adverse determination involving a
756 prospective or concurrent review request, the health carrier shall make
757 a decision and notify the covered person and, if applicable, the covered

758 person's authorized representative of the decision within a reasonable
759 period of time appropriate to the covered person's medical condition
760 but not later than thirty days after the health carrier receives the
761 grievance.

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

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

779 (i) Each health carrier shall provide promptly to a covered person
780 and, if applicable, the covered person's authorized representative a
781 notice of decision. Such notice may be provided in writing or by
782 electronic means and shall comply with the requirements of
783 subdivision (2) of subsection (f) of section 4 of this act. Such notice
784 shall, in a manner calculated to be understood by the covered person
785 or the covered person's authorized representative, set forth:

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

788 (2) Information sufficient to identify the claim involved with respect

789 to the grievance, including the date of service, if applicable, the health
790 care professional, the claim amount, if applicable, the diagnosis code
791 and its corresponding meaning and the treatment code and its
792 corresponding meaning;

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

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

799 (5) Reference to the evidence or documentation used as the basis for
800 the decision;

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

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

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

809 (C) A statement that the covered person may receive from the health
810 carrier, free of charge and upon request, reasonable access to and
811 copies of, all documents, records and other information relevant, as the
812 term "relevant" is described in subparagraph (B) of subdivision (1) of
813 subsection (g) of this section, to the adverse determination under
814 review;

815 (D) If the final adverse determination is based on a health carrier's
816 internal rule, guideline, protocol or other similar criterion, (i) the
817 specific rule, guideline, protocol or other similar criterion, or (ii) a

818 statement that a specific rule, guideline, protocol or other similar
819 criterion of the health carrier was relied upon to make the final adverse
820 determination and that a copy of such rule, guideline, protocol or other
821 similar criterion will be provided to the covered person free of charge
822 upon request, and instructions for requesting such copy;

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

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

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

840 (j) (1) Whenever a health carrier fails to strictly adhere to the
841 requirements of this section with respect to receiving and resolving
842 grievances involving an adverse determination, the covered person
843 shall be deemed to have exhausted the internal grievance process of
844 such health carrier and may file a request for an external review in
845 accordance with the provisions of section 9 of this act, regardless of
846 whether the health carrier asserts that it substantially complied with
847 the requirements of this section or that any error it committed was de
848 minimis.

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

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

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

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

871 (3) (A) Upon receipt of a grievance, a health carrier shall designate
872 an individual or individuals to conduct a review of the grievance.

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

876 (C) The health carrier shall provide the covered person and, if
877 applicable, the covered person's authorized representative with the
878 name, address and telephone number of the individual or the

879 organizational unit designated to coordinate the review on behalf of
880 the health carrier.

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

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

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

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

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

899 (3) The individual's or individuals' decision in clear terms and the
900 health benefit plan contract basis for such decision in sufficient detail
901 for the covered person to respond further to the health carrier's
902 position; and

903 (4) Reference to the evidence or documentation used as the basis for
904 the decision.

905 Sec. 7. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
906 establish written procedures for (A) expedited utilization review and
907 benefit determinations with respect to prospective urgent care requests

908 and concurrent review urgent care requests, and (B) notifying covered
909 persons or covered persons' authorized representatives of such
910 procedures. Each health carrier shall make expedited utilization
911 review and benefit determinations within the specified time periods
912 under this section.

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

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

930 (2) If the determination is an adverse determination, the health
931 carrier shall notify the covered person and, if applicable, the covered
932 person's authorized representative of the adverse determination in
933 accordance with subsection (e) of this section.

934 (3) (A) If the covered person or the covered person's authorized
935 representative, as applicable, has failed to provide information
936 necessary for the health carrier to make a determination, the health
937 carrier shall notify the covered person or the covered person's
938 authorized representative, as applicable, as soon as possible but not
939 later than twenty-four hours after the health carrier receives such

940 request. Such notice may be provided orally or, if requested by the
941 covered person or the covered person's authorized representative,
942 shall be provided in writing and shall:

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

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

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

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

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

966 (c) (1) If a health carrier receives an urgent care request that fails to
967 meet the health carrier's filing procedures, the health carrier shall
968 notify the covered person and, if applicable, the covered person's
969 authorized representative of such failure and shall provide in the

970 notice information on the proper procedures to be followed for filing
971 such request.

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

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

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

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

987 (d) (1) For a concurrent review urgent care request involving a
988 request by the covered person or the covered person's authorized
989 representative to extend the course of treatment beyond the initial
990 period of time or the number of treatments, if such request is made at
991 least twenty-four hours prior to the expiration of the prescribed period
992 of time or number of treatments, the health carrier shall make a
993 determination and shall notify the covered person and, if applicable,
994 the covered person's authorized representative of the determination as
995 soon as possible, taking into account the covered person's medical
996 condition, but not later than twenty-four hours after the health carrier
997 receives such request.

998 (2) (A) If a covered person has been admitted to an acute care
999 hospital and the attending health care professional determines that the

1000 covered person's life will be endangered or other serious injury or
1001 illness could occur if the covered person is discharged or if treatment is
1002 delayed, the attending health care professional may transmit a
1003 concurrent review urgent care request for an expedited review to the
1004 utilization review company or designee of the covered person's health
1005 carrier performing utilization review on the health carrier's behalf. If
1006 such attending health care professional receives no response from the
1007 utilization review company or designee after three hours have passed
1008 since the health care professional sent the request and all information
1009 needed to complete the review, the request shall be deemed approved.

1010 (B) Each utilization review company or designee of a health carrier
1011 that performs utilization review on the health carrier's behalf shall
1012 make review staff available from eight o'clock a.m. to nine o'clock p.m.
1013 to process requests transmitted pursuant to this subdivision.

1014 (C) The commissioner shall develop a standardized process for the
1015 transmission of and responses to concurrent review urgent care
1016 requests described in subparagraph (A) of this subdivision.

1017 (3) If the determination is an adverse determination, the health
1018 carrier shall notify the covered person and, if applicable, the covered
1019 person's authorized representative of the adverse determination in
1020 accordance with subsection (e) of this section.

1021 (e) (1) Each health carrier shall provide promptly to a covered
1022 person and, if applicable, the covered person's authorized
1023 representative a notice of an adverse determination. Such notice may
1024 be provided orally, in writing or by electronic means and shall comply
1025 with the requirements of subdivisions (1) and (2) of subsection (f) of
1026 section 4 of this act. In addition, such notice shall include a description
1027 of the health carrier's expedited review procedures established
1028 pursuant to section 8 of this act, including any time limits applicable to
1029 such procedures.

1030 (2) If the notice is provided orally, the health carrier shall provide

1031 such notice in writing or by electronic means to the covered person
1032 and the covered person's health care professional of record not later
1033 than three days after providing the oral notice.

1034 (f) (1) Whenever a health carrier fails to strictly adhere to the
1035 requirements of this section with respect to making expedited
1036 utilization review and benefit determinations of a prospective urgent
1037 care request or concurrent review urgent care request, the covered
1038 person shall be deemed to have exhausted the internal grievance
1039 process of such health carrier and may file a request for an external
1040 review in accordance with the provisions of section 9 of this act,
1041 regardless of whether the health carrier asserts that it substantially
1042 complied with the requirements of this section or that any error it
1043 committed was de minimis.

1044 (2) A covered person who has exhausted the internal grievance
1045 process of a health carrier may, in addition to filing a request for an
1046 external review, pursue any available remedies under state or federal
1047 law on the basis that the health carrier failed to provide a reasonable
1048 internal grievance process that would yield a decision on the merits of
1049 the claim.

1050 Sec. 8. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
1051 establish written procedures for the expedited review of grievances
1052 involving adverse determinations of prospective or concurrent urgent
1053 care requests. Such procedures shall allow a covered person or a
1054 covered person's authorized representative to request orally or in
1055 writing such expedited review.

1056 (2) (A) At the same time a covered person or a covered person's
1057 authorized representative files a request for an expedited review under
1058 this section, the covered person or the covered person's authorized
1059 representative may file a request for an expedited external review of
1060 the adverse determination:

1061 (i) Pursuant to section 10 of this act if the covered person has a

1062 medical condition for which the time period for completion of an
1063 external review, as set forth in section 9 of this act, would seriously
1064 jeopardize the life or health of the covered person or would jeopardize
1065 the covered person's ability to regain maximum function; or

1066 (ii) Pursuant to section 11 of this act if the adverse determination
1067 involves a denial of coverage based on a determination that the
1068 recommended or requested health care service or treatment is
1069 experimental or investigational and the covered person's treating
1070 health care professional certifies in writing that such recommended or
1071 requested health care service or treatment would be significantly less
1072 effective if not promptly initiated.

1073 (B) Upon the receipt of the request for an expedited external review
1074 pursuant to this subdivision, the independent review organization
1075 assigned to conduct the expedited external review shall determine
1076 whether the covered person shall be required to complete the
1077 expedited review of the grievance prior to conducting the expedited
1078 external review.

1079 (C) If the independent review organization determines that the
1080 covered person must complete the expedited review of the grievance
1081 under this section prior to the conducting of the expedited external
1082 review, the independent review organization shall immediately notify
1083 the covered person and, if applicable, the covered person's authorized
1084 representative (i) of such determination, and (ii) that the organization
1085 shall not proceed with the expedited external review until the
1086 completion of the expedited grievance review.

1087 (b) Each health carrier shall designate an appropriate clinical peer or
1088 peers to review such adverse determination. Such clinical peer or peers
1089 shall not have been involved in the initial adverse determination.

1090 (c) In an expedited review under this section, all necessary
1091 information, including the health carrier's decision, shall be
1092 transmitted between the health carrier and the covered person or the

1093 covered person's authorized representative, as applicable, by
1094 telephone, facsimile, electronic means or any other expeditious method
1095 available.

1096 (d) As expeditiously as the covered person's medical condition
1097 requires but not later than seventy-two hours after the health carrier
1098 receives the request for the expedited review, the health carrier shall
1099 make an expedited review decision under this section and shall notify
1100 the covered person and, if applicable, the covered person's authorized
1101 representative of the decision as set forth in subsection (f) of this
1102 section. For the purposes of calculating the time period within which a
1103 health carrier is required to make a determination under this
1104 subsection, such time period shall begin on the date the health carrier
1105 receives the request in accordance with the health carrier's procedures
1106 for filing such request, regardless of whether all of the information
1107 necessary to make the decision accompanies the filing.

1108 (e) If the expedited review requested is for a grievance involving an
1109 adverse determination with respect to a concurrent review urgent care
1110 request, the treatment shall be continued without liability to the
1111 covered person until the covered person has been notified of the
1112 determination.

1113 (f) (1) Each health carrier shall provide promptly to a covered
1114 person and, if applicable, the covered person's authorized
1115 representative a notice of decision. Such notice may be provided
1116 orally, in writing or by electronic means and shall comply with the
1117 requirements of subdivision (2) of subsection (f) of section 4 of this act.
1118 Such notice shall, in a manner calculated to be understood by the
1119 covered person or the covered person's authorized representative, set
1120 forth:

1121 (A) The titles and qualifying credentials of the individual or
1122 individuals participating in the expedited review process;

1123 (B) Information sufficient to identify the claim involved with respect

1124 to the grievance, including the date of service, if applicable, the health
1125 care professional, the claim amount, if applicable, the diagnosis code
1126 and its corresponding meaning and the treatment code and its
1127 corresponding meaning;

1128 (C) A statement of such individual's or individuals' understanding
1129 of the covered person's grievance;

1130 (D) The individual's or individuals' decision in clear terms and the
1131 health benefit plan contract basis for such decision in sufficient detail
1132 for the covered person to respond further to the health carrier's
1133 position;

1134 (E) Reference to the evidence or documentation used as the basis for
1135 the decision; and

1136 (F) If the decision involves a final adverse determination:

1137 (i) The specific reason or reasons for the final adverse
1138 determination, including the denial code and its corresponding
1139 meaning, as well as a description of the health carrier's standard, if
1140 any, that was used in reaching the denial;

1141 (ii) Reference to the specific health benefit plan provisions on which
1142 the determination is based;

1143 (iii) A description of any additional material or information
1144 necessary for the covered person to perfect the request, including an
1145 explanation of why the material or information is necessary to perfect
1146 the request;

1147 (iv) If the final adverse determination is based on a health carrier's
1148 internal rule, guideline, protocol or other similar criterion, (I) the
1149 specific rule, guideline, protocol or other similar criterion, or (II) a
1150 statement that a specific rule, guideline, protocol or other similar
1151 criterion of the health carrier was relied upon to make the adverse
1152 determination and that a copy of such rule, guideline, protocol or other

1153 similar criterion will be provided to the covered person free of charge
1154 upon request, and instructions for requesting such copy;

1155 (v) If the final adverse determination is based on medical necessity
1156 or an experimental or investigational treatment or similar exclusion or
1157 limit, the written statement of the scientific or clinical rationale for the
1158 adverse determination and (I) an explanation of the scientific or clinical
1159 rationale used to make the determination that applies the terms of the
1160 health benefit plan to the covered person's medical circumstances, or
1161 (II) a statement that an explanation will be provided to the covered
1162 person free of charge upon request and instructions for requesting a
1163 copy of such explanation;

1164 (vi) A statement describing the procedures for obtaining an external
1165 review of the final adverse determination pursuant to section 9 of this
1166 act;

1167 (vii) A statement disclosing the covered person's right to bring a
1168 civil action in a court of competent jurisdiction;

1169 (viii) The following statement: "You and your plan may have other
1170 voluntary alternative dispute resolution options such as mediation.
1171 One way to find out what may be available is to contact your state
1172 Insurance Commissioner."; and

1173 (ix) A statement disclosing the covered person's right to contact the
1174 commissioner's office or the Office of the Healthcare Advocate at any
1175 time. Such disclosure shall include the contact information for said
1176 offices.

1177 (2) If the notice is provided orally, the health carrier shall provide
1178 such notice in writing or by electronic means to the covered person
1179 and the covered person's health care professional of record not later
1180 than three days after providing the oral notice.

1181 Sec. 9. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a
1182 covered person's authorized representative may file a request for an

1183 external review of an adverse determination or a final adverse
1184 determination in accordance with the provisions of this section. All
1185 requests for external review shall be made in writing to the
1186 commissioner. The commissioner may prescribe the form and content
1187 of external review requests.

1188 (2) All requests for external review shall be accompanied by a filing
1189 fee specified in section 38a-11 of the general statutes, as amended by
1190 this act. If the commissioner finds the covered person is indigent or
1191 unable to pay the fee, the commissioner shall waive the fee.

1192 (3) The health carrier that issued the adverse determination or the
1193 final adverse determination that is the subject of the external review
1194 request shall pay the independent review organization for the cost of
1195 conducting the external review, whether such review is a standard
1196 external review or an expedited external review.

1197 (4) An external review decision, whether such review is a standard
1198 external review or an expedited external review, shall be binding on
1199 the health carrier and the covered person, except to the extent such
1200 health carrier or covered person has other remedies available under
1201 federal or state law. A covered person or a covered person's authorized
1202 representative shall not file a subsequent request for an external
1203 review or an expedited external review that involves the same adverse
1204 determination or final adverse determination for which the covered
1205 person or the covered person's authorized representative already
1206 received an external review decision or an expedited external review
1207 decision.

1208 (5) Each health carrier shall maintain written records of external
1209 reviews as set forth in section 12 of this act.

1210 (6) Each independent review organization that conducts external
1211 reviews shall maintain written records as set forth in subsection (e) of
1212 section 38a-226d of the general statutes, as amended by this act.

1213 (b) (1) A covered person or a covered person's authorized
1214 representative shall not file a request for an external review until the
1215 covered person or the covered person's authorized representative has
1216 exhausted the health carrier's internal grievance process.

1217 (2) A covered person shall be deemed to have exhausted the health
1218 carrier's internal grievance process:

1219 (A) If the covered person or the covered person's authorized
1220 representative has not received a written decision on the covered
1221 person's or the covered person's authorized representative's request for
1222 a prospective or a nonurgent care concurrent review from the health
1223 carrier within thirty days after such request was filed with the health
1224 carrier, except to the extent the covered person or the covered person's
1225 authorized representative requested or agreed to a delay; or

1226 (B) In accordance with subsection (g) of section 4 of this act.

1227 (3) Notwithstanding subdivision (2) of this subsection, a covered
1228 person or a covered person's authorized representative shall not file a
1229 request for an external review of an adverse determination involving a
1230 retrospective review determination made pursuant to section 4 of this
1231 act until the covered person has exhausted the health carrier's internal
1232 grievance process.

1233 (c) (1) At the same time a health carrier sends to a covered person or
1234 a covered person's authorized representative a written notice of an
1235 adverse determination or a final adverse determination issued by the
1236 health carrier under sections 5 to 8, inclusive, of this act, the health
1237 carrier shall include a written disclosure to the covered person and, if
1238 applicable, the covered person's authorized representative of the
1239 covered person's right to request an external review to be conducted
1240 pursuant to section 9 of this act.

1241 (2) The written notice shall include:

1242 (A) The following statement or a statement in substantially similar

1243 language: "We have denied your request for the provision of or
1244 payment for a health care service or course of treatment. You may have
1245 the right to have our decision reviewed by health care professionals
1246 who have no association with us by submitting a request for external
1247 review to the office of the Insurance Commissioner, if our decision
1248 involved making a judgment as to the medical necessity,
1249 appropriateness, health care setting, level of care or effectiveness of the
1250 health care service or treatment you requested.";

1251 (B) For a notice related to an adverse determination, a statement
1252 informing the covered person that:

1253 (i) If the covered person has a medical condition for which the time
1254 period for completion of an expedited review of a grievance involving
1255 an adverse determination as set forth in sections 7 and 8 of this act,
1256 would seriously jeopardize the life or health of the covered person or
1257 would jeopardize the covered person's ability to regain maximum
1258 function, the covered person or the covered person's authorized
1259 representative may (I) file a request for an expedited external review to
1260 be conducted pursuant to section 10 of this act, or (II) file a request for
1261 an expedited external review to be conducted pursuant to section 11 of
1262 this act if the adverse determination involves a denial of coverage
1263 based on a determination that the recommended or requested health
1264 care service or treatment is experimental or investigational and the
1265 covered person's treating health care professional certifies in writing
1266 that such recommended or requested health care service or treatment
1267 would be significantly less effective if not promptly initiated; and

1268 (ii) Such request for expedited external review may be filed at the
1269 same time the covered person or the covered person's authorized
1270 representative files a request for an expedited review of a grievance
1271 involving an adverse determination, as set forth in sections 7 and 8 of
1272 this act, except that the independent review organization assigned to
1273 conduct the expedited external review shall determine whether the
1274 covered person shall be required to complete the expedited review of

1275 the grievance prior to conducting the expedited external review;

1276 (C) For a notice related to a final adverse determination, a statement
1277 informing the covered person that:

1278 (i) If the covered person has a medical condition for which the time
1279 period for completion of an external review, as set forth in section 9 of
1280 this act, would seriously jeopardize the life or health of the covered
1281 person or would jeopardize the covered person's ability to regain
1282 maximum function, the covered person or the covered person's
1283 authorized representative may file a request for an expedited external
1284 review pursuant to section 10 of this act; or

1285 (ii) If the final adverse determination concerns (I) an admission,
1286 availability of care, continued stay or health care service for which the
1287 covered person received emergency services but has not been
1288 discharged from a facility, the covered person or the covered person's
1289 authorized representative may file a request for an expedited external
1290 review to be conducted pursuant to section 10 of this act, or (II) a
1291 denial of coverage based on a determination that the recommended or
1292 requested health care service or treatment is experimental or
1293 investigational and the covered person's treating health care
1294 professional certifies in writing that such recommended or requested
1295 health care service or treatment would be significantly less effective if
1296 not promptly initiated, the covered person or the covered person's
1297 authorized representative may file a request for an expedited external
1298 review to be conducted pursuant to section 11 of this act;

1299 (D) (i) A copy of the description of both the standard and expedited
1300 external review procedures the health carrier is required to provide
1301 pursuant to sections 9 to 11, inclusive, of this act, highlighting the
1302 provisions in the external review procedures that give the covered
1303 person or the covered person's authorized representative the
1304 opportunity to submit additional information and including any forms
1305 used to process an external review;

1306 (ii) As part of any forms provided under subparagraph (D)(i) of this
1307 subdivision, an authorization form or other document approved by the
1308 commissioner that complies with the requirements of 45 CFR 164.508,
1309 as amended from time to time, by which the covered person shall
1310 authorize the health carrier and the covered person's treating health
1311 care professional to release, transfer or otherwise divulge, in
1312 accordance with sections 38a-975 to 38a-999a, inclusive, of the general
1313 statutes, the covered person's protected health information including
1314 medical records for purposes of conducting an external review.

1315 (d) (1) Not later than one hundred twenty days after a covered
1316 person or a covered person's authorized representative receives a
1317 notice of an adverse determination or a final adverse determination
1318 pursuant to sections 5 to 8, inclusive, of this act, the covered person or
1319 the covered person's authorized representative may file a request for
1320 an external review with the commissioner in accordance with this
1321 section.

1322 (2) Not later than one business day after the commissioner receives
1323 such request, the commissioner shall send a copy of such request to the
1324 health carrier that issued the adverse determination or the final
1325 adverse determination that is the subject of the request.

1326 (3) Not later than five business days after the health carrier receives
1327 the copy of such request from the commissioner, the health carrier
1328 shall complete a preliminary review of the request to determine
1329 whether:

1330 (A) The individual is or was a covered person under the health
1331 benefit plan at the time the health care service was requested or, in the
1332 case of a retrospective review, was a covered person in the health
1333 benefit plan at the time the health care service was provided;

1334 (B) The health care service that is the subject of the adverse
1335 determination or the final adverse determination is a covered service
1336 under the covered person's health benefit plan but for the health

1337 carrier's determination that the health care service is not covered
1338 because it does not meet the health carrier's requirements for medical
1339 necessity, appropriateness, health care setting, level of care or
1340 effectiveness;

1341 (C) The covered person has exhausted the health carrier's internal
1342 grievance process; and

1343 (D) The covered person has provided all the information and forms
1344 required to process an external review, including an authorization
1345 form as set forth in subparagraph (D)(ii) of subdivision (2) of
1346 subsection (c) of this section.

1347 (4) (A) Not later than one business day after the completion of the
1348 preliminary review, the health carrier shall notify the commissioner,
1349 the covered person and, if applicable, the covered person's authorized
1350 representative in writing whether the request for an external review is
1351 complete and eligible for external review. The commissioner may
1352 specify the form for the health carrier's notice of initial determination
1353 under this subdivision and any supporting information required to be
1354 included in the notice.

1355 (B) If the request:

1356 (i) Is not complete, the health carrier shall notify the commissioner
1357 and the covered person and, if applicable, the covered person's
1358 authorized representative in writing and include in the notice what
1359 information or materials are needed to perfect the request; or

1360 (ii) Is not eligible for external review, the health carrier shall notify
1361 the commissioner, the covered person and, if applicable, the covered
1362 person's authorized representative in writing and include in the notice
1363 the reasons for its ineligibility.

1364 (C) The notice of initial determination shall include a statement
1365 informing the covered person and, if applicable, the covered person's
1366 authorized representative that a health carrier's initial determination

1367 that the request for an external review is ineligible for review may be
1368 appealed to the commissioner.

1369 (D) Notwithstanding a health carrier's initial determination that a
1370 request for an external review is ineligible for review, the
1371 commissioner may determine, pursuant to the terms of the covered
1372 person's health benefit plan, that such request is eligible for external
1373 review and assign an independent review organization to conduct
1374 such review. Any such review shall be conducted in accordance with
1375 this section.

1376 (e) (1) Whenever the commissioner is notified pursuant to
1377 subparagraph (A) of subdivision (4) of subsection (d) of this section
1378 that a request is eligible for external review, the commissioner shall,
1379 not later than one business day after receiving such notice:

1380 (A) Assign an independent review organization from the list of
1381 approved independent review organizations compiled and maintained
1382 by the commissioner pursuant to section 38a-226c of the general
1383 statutes, as amended by this act, to conduct the external review and
1384 notify the health carrier of the name of the assigned independent
1385 review organization. Such assignment shall be done on a random basis
1386 among those approved independent review organizations qualified to
1387 conduct the particular external review based on the nature of the
1388 health care service that is the subject of the adverse determination or
1389 the final adverse determination and other circumstances, including
1390 conflict of interest concerns as set forth in section 38a-226d of the
1391 general statutes, as amended by this act; and

1392 (B) Notify the covered person and, if applicable, the covered
1393 person's authorized representative in writing of the request's eligibility
1394 and acceptance for external review. The commissioner shall include in
1395 such notice (i) a statement that the covered person or the covered
1396 person's authorized representative may submit, not later than five
1397 days after the covered person or the covered person's authorized
1398 representative, as applicable, received such notice, additional

1399 information in writing to the assigned independent review
1400 organization that such organization shall consider when conducting
1401 the external review, and (ii) where and how such additional
1402 information is to be submitted. If additional information is submitted
1403 later than five days after the covered person or the covered person's
1404 authorized representative, as applicable, received such notice, the
1405 independent review organization may, but shall not be required to,
1406 accept and consider such additional information.

1407 (2) Not later than five business days after the health carrier receives
1408 notice of the name of the assigned independent review organization
1409 from the commissioner, the health carrier or its designee utilization
1410 review company shall provide to the assigned independent review
1411 organization the documents and any information such health carrier or
1412 utilization review company considered in making the adverse
1413 determination or the final adverse determination.

1414 (3) The failure of the health carrier or its designee utilization review
1415 company to provide the documents and information within the time
1416 specified in subdivision (2) of this subsection shall not delay the
1417 conducting of the external review.

1418 (4) (i) If the health carrier or its designee utilization review company
1419 fails to provide the documents and information within the time period
1420 specified in subdivision (2) of this subsection, the independent review
1421 organization may terminate the review and make a decision to reverse
1422 the adverse determination or the final adverse determination.

1423 (ii) Not later than one business day after terminating the review and
1424 making the decision to reverse the adverse determination or the final
1425 adverse determination, the independent review organization shall
1426 notify the commissioner, the health carrier, the covered person and, if
1427 applicable, the covered person's authorized representative in writing
1428 of such decision.

1429 (f) (1) The assigned independent review organization shall review

1430 all of the information and documents received pursuant to subsection
1431 (e) of this section. In reaching a decision, the independent review
1432 organization shall not be bound by any decisions or conclusions
1433 reached during the health carrier's utilization review process.

1434 (2) Not later than one business day after receiving any information
1435 submitted by the covered person or the covered person's authorized
1436 representative pursuant to subparagraph (B) of subdivision (1) of
1437 subsection (e) of this section, the independent review organization
1438 shall forward such information to the health carrier.

1439 (3) (A) Upon the receipt of any information forwarded pursuant to
1440 subdivision (2) of this subsection, the health carrier may reconsider its
1441 adverse determination or the final adverse determination that is the
1442 subject of the external review. Such reconsideration shall not delay or
1443 terminate the review.

1444 (B) The independent review organization shall terminate the
1445 external review if the health carrier decides, upon completion of its
1446 reconsideration and notice to such organization as provided in
1447 subparagraph (C) of this subdivision, to reverse its adverse
1448 determination or its final adverse determination and provide coverage
1449 or payment for the health care service that is the subject of the adverse
1450 determination or the final adverse determination.

1451 (C) Not later than one business day after making the decision to
1452 reverse its adverse determination or its final adverse determination,
1453 the health carrier shall notify the commissioner, the assigned
1454 independent review organization, the covered person and, if
1455 applicable, the covered person's authorized representative in writing
1456 of such decision.

1457 (g) In addition to the documents and information received pursuant
1458 to subsection (e) of this section, the independent review organization
1459 shall consider, to the extent the documents or information are available
1460 and the independent review organization considers them appropriate,

1461 the following in reaching a decision:

1462 (1) The covered person's medical records;

1463 (2) The attending health care professional's recommendation;

1464 (3) Consulting reports from appropriate health care professionals
1465 and other documents submitted by the health carrier, the covered
1466 person, the covered person's authorized representative or the covered
1467 person's treating health care professional;

1468 (4) The terms of coverage under the covered person's health benefit
1469 plan to ensure that the independent review organization's decision is
1470 not contrary to the terms of coverage under such health benefit plan;

1471 (5) The most appropriate practice guidelines, which shall include
1472 applicable evidence-based standards and may include any other
1473 practice guidelines developed by the federal government, national or
1474 professional medical societies, medical boards or medical associations;

1475 (6) Any applicable clinical review criteria developed and used by
1476 the health carrier or its designee utilization review company; and

1477 (7) The opinion or opinions of the independent review
1478 organization's clinical peer or peers who conducted the external
1479 review after considering subdivisions (1) to (6), inclusive, of this
1480 subsection.

1481 (h) (1) Not later than forty-five days after an independent review
1482 organization receives an assignment from the commissioner to conduct
1483 the external review, such organization shall notify the commissioner,
1484 the health carrier, the covered person and, if applicable, the covered
1485 person's authorized representative in writing of its decision to uphold,
1486 reverse or revise the adverse determination or the final adverse
1487 determination.

1488 (2) Such notice shall include:

1489 (A) A general description of the reason for the request for the
1490 external review;

1491 (B) The date the independent review organization received the
1492 assignment from the commissioner to conduct the external review;

1493 (C) The date the external review was conducted;

1494 (D) The date the organization made its decision;

1495 (E) The principal reason or reasons for its decision, including what
1496 applicable evidence-based standards, if any, were used as a basis for its
1497 decision;

1498 (F) The rationale for the organization's decision; and

1499 (G) Reference to the evidence or documentation, including any
1500 evidence-based standards, considered by the organization in reaching
1501 its decision.

1502 (3) Upon the receipt of a notice of the independent review
1503 organization's decision to reverse an adverse determination or a final
1504 adverse determination, the health carrier shall immediately approve
1505 the coverage that was the subject of the adverse determination or the
1506 final adverse determination.

1507 Sec. 10. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or the
1508 covered person's authorized representative may file a request for an
1509 expedited external review of an adverse determination or a final
1510 adverse determination with the commissioner, except that an
1511 expedited external review shall not be provided for a retrospective
1512 review request of an adverse determination or a final adverse
1513 determination. If the adverse determination or the final adverse
1514 determination involves a denial of coverage based on a determination
1515 that the recommended or requested health care service or treatment is
1516 experimental or investigational, a covered person or the covered
1517 person's authorized representative may file a request for an expedited

1518 external review under section 11 of this act.

1519 (2) Such request may be filed at the time the covered person
1520 receives:

1521 (A) An adverse determination, if:

1522 (i) The covered person has a medical condition for which the time
1523 period for completion of an expedited internal review of the adverse
1524 determination, as set forth in section 7 or 8 of this act, would seriously
1525 jeopardize the life or health of the covered person or would jeopardize
1526 the covered person's ability to regain maximum function; and

1527 (ii) The covered person or the covered person's authorized
1528 representative has filed a request for an expedited internal review of
1529 an adverse determination as set forth in section 7 or 8 of this act; or

1530 (B) A final adverse determination, if:

1531 (i) The covered person has a medical condition where the time
1532 period for completion of an external review, as set forth in section 9 of
1533 this act, would seriously jeopardize the life or health of the covered
1534 person or would jeopardize the covered person's ability to regain
1535 maximum function; or

1536 (ii) The final adverse determination concerns an admission,
1537 availability of care, continued stay or health care service for which the
1538 covered person received emergency services but has not been
1539 discharged from a facility.

1540 (b) (1) Upon the receipt of a request for an expedited external
1541 review, the commissioner shall immediately send a copy of such
1542 request to the health carrier that issued the adverse determination or
1543 the final adverse determination that is the subject of the request.

1544 (2) Upon the receipt of such request, the health carrier shall
1545 immediately complete a preliminary review of the request to

1546 determine whether:

1547 (A) The individual is or was a covered person under the health
1548 benefit plan at the time the health care service was requested;

1549 (B) The health care service that is the subject of the adverse
1550 determination or the final adverse determination is a covered service
1551 under the covered person's health benefit plan but for the health
1552 carrier's determination that the health care service is not covered
1553 because it does not meet the health carrier's requirements for medical
1554 necessity, appropriateness, health care setting, level of care or
1555 effectiveness;

1556 (C) The covered person has exhausted the health carrier's internal
1557 grievance process; and

1558 (D) The covered person has provided all the information and forms
1559 required to process an external review, including an authorization
1560 form as set forth in subparagraph (D)(ii) of subdivision (2) of
1561 subsection (c) of section 9 of this act.

1562 (3) (A) The health carrier shall immediately notify the
1563 commissioner, the covered person and, if applicable, the covered
1564 person's authorized representative whether the request for an
1565 expedited external review is complete and eligible for expedited
1566 external review. The commissioner may specify the form for the health
1567 carrier's notice of initial determination under this subdivision and any
1568 supporting information required to be included in the notice.

1569 (B) If the request:

1570 (i) Is not complete, the health carrier shall notify the commissioner,
1571 the covered person and, if applicable, the covered person's authorized
1572 representative in writing and include in the notice what information or
1573 materials are needed to perfect the request; or

1574 (ii) Is not eligible for expedited external review, the health carrier

1575 shall notify the commissioner, the covered person and, if applicable,
1576 the covered person's authorized representative in writing and include
1577 in the notice the reasons for its ineligibility.

1578 (4) The notice of initial determination shall include a statement
1579 informing the covered person and, if applicable, the covered person's
1580 authorized representative that a health carrier's initial determination
1581 that the request for an expedited external review is ineligible for
1582 review may be appealed to the commissioner.

1583 (5) Notwithstanding a health carrier's initial determination that a
1584 request for an expedited external review is ineligible for review, the
1585 commissioner may determine, pursuant to the terms of the covered
1586 person's health benefit plan, that such request is eligible for expedited
1587 external review and assign an independent review organization to
1588 conduct such review. Any such review shall be conducted in
1589 accordance with this section.

1590 (c) Whenever the commissioner is notified pursuant to subdivision
1591 (3) of subsection (b) of this section that a request is eligible for
1592 expedited external review, the commissioner shall immediately assign
1593 an independent review organization from the list of approved
1594 independent review organizations compiled and maintained by the
1595 commissioner pursuant to section 38a-226c of the general statutes, as
1596 amended by this act, to conduct the expedited external review and
1597 notify the health carrier of the name of the assigned independent
1598 review organization. Such assignment shall be done on a random basis
1599 among those approved independent review organizations qualified to
1600 conduct the particular external review based on the nature of the
1601 health care service that is the subject of the adverse determination or
1602 the final adverse determination and other circumstances, including
1603 conflict of interest concerns as set forth in section 38a-226d of the
1604 general statutes, as amended by this act.

1605 (d) (1) Upon the receipt of the notice of the name of the assigned
1606 independent review organization from the commissioner, the health

1607 carrier or its designee utilization review company shall promptly
1608 provide to the assigned independent review organization the
1609 documents and any information such health carrier or utilization
1610 review company considered in making the adverse determination or
1611 the final adverse determination by telephone, facsimile, electronic
1612 means or any other expeditious method available.

1613 (2) The failure of the health carrier or its designee utilization review
1614 company to provide the documents and information specified in
1615 subdivision (1) of this subsection shall not delay the conducting of the
1616 expedited external review.

1617 (3) If the health carrier or its designee utilization review company
1618 fails to provide the documents and information specified in
1619 subdivision (2) of this subsection, the independent review organization
1620 may terminate the review and make a decision to reverse the adverse
1621 determination or the final adverse determination.

1622 (4) In addition to the documents and information received pursuant
1623 to subdivision (1) of this subsection, the independent review
1624 organization shall consider, to the extent the documents or information
1625 are available and the independent review organization considers them
1626 appropriate, the factors set forth in subsection (g) of section 9 of this
1627 act in reaching a decision.

1628 (e) As expeditiously as the covered person's medical condition
1629 requires but not later than seventy-two hours after the independent
1630 review organization receives the assignment from the commissioner to
1631 conduct the expedited external review, the independent review
1632 organization shall:

1633 (1) Make an expedited external review decision under this section to
1634 uphold, reverse or revise the adverse determination or the final
1635 adverse determination. In reaching a decision, the independent review
1636 organization shall not be bound by any decisions or conclusions
1637 reached during the health carrier's utilization review process; and

1638 (2) Notify the commissioner, the health carrier, the covered person
1639 and, if applicable, the covered person's authorized representative of
1640 the decision. Such notice shall include the information set forth in
1641 subdivision (2) of subsection (h) of section 9 of this act and may be
1642 provided orally, in writing or by electronic means. If the notice is
1643 provided orally, the independent review organization shall provide
1644 such notice in writing or by electronic means to the covered person
1645 and the covered person's health care professional of record not later
1646 than forty-eight hours after providing the oral notice.

1647 (3) Upon the receipt of a notice of the independent review
1648 organization's decision to reverse an adverse determination or a final
1649 adverse determination, the health carrier shall immediately approve
1650 the coverage that was the subject of the adverse determination or the
1651 final adverse determination.

1652 Sec. 11. (NEW) (*Effective July 1, 2011*) (a) (1) If a covered person or a
1653 covered person's authorized representative receives a notice of an
1654 adverse determination or a final adverse determination pursuant to
1655 sections 5 to 8, inclusive, of this act that involves a denial of coverage
1656 based on a determination that the recommended or requested health
1657 care service or treatment is experimental or investigational and the
1658 covered person's treating health care professional certifies in writing
1659 that such recommended or requested health care service or treatment
1660 would be significantly less effective if not promptly initiated, the
1661 covered person or the covered person's authorized representative may,
1662 within the time period set forth in subdivision (1) of subsection (d) of
1663 section 9 of this act, file a request for an expedited external review with
1664 the commissioner in accordance with this section.

1665 (2) Such covered person or covered person's authorized
1666 representative shall not be required to file a request for an external
1667 review prior to, or at the same time as, the filing of a request for an
1668 expedited external review and shall not be precluded from filing a
1669 request for an external review, within the time period set forth in

1670 subdivision (1) of subsection (d) of section 9 of this act, if the request
1671 for an expedited external review is determined to be ineligible for such
1672 review.

1673 (b) (1) Upon the receipt of a request for an expedited external
1674 review, the commissioner shall immediately send a copy of such
1675 request to the health carrier that issued the adverse determination or
1676 the final adverse determination that is the subject of the request.

1677 (2) Upon the receipt of such request, the health carrier shall, not
1678 later than five business days after the health carrier receives the copy
1679 of such request from the commissioner, complete a preliminary review
1680 of the request to determine whether:

1681 (A) The individual is or was a covered person under the health
1682 benefit plan at the time the health care service was requested;

1683 (B) The recommended or requested health care service or treatment
1684 that is the subject of the adverse determination or final adverse
1685 determination:

1686 (i) Is a covered benefit under the covered person's health benefit
1687 plan but for the health carrier's determination that the service or
1688 treatment is experimental or investigational for a particular medical
1689 condition; and

1690 (ii) Is not explicitly listed as an excluded benefit under the covered
1691 person's health benefit plan;

1692 (C) The covered person's treating health care professional has
1693 certified that one of the following situations is applicable:

1694 (i) Standard health care services or treatments have not been
1695 effective in improving the medical condition of the covered person;

1696 (ii) Standard health care services or treatments are not medically
1697 appropriate for the covered person; or

1698 (iii) There is no available standard health care service or treatment
1699 covered by the health carrier that is more beneficial than the
1700 recommended or requested health care service or treatment;

1701 (D) The covered person's treating health care professional:

1702 (i) Has recommended a health care service or treatment that the
1703 health care professional certifies, in writing, is likely to be more
1704 beneficial to the covered person, in the health care professional's
1705 opinion, than any available standard health care services or treatments;
1706 or

1707 (ii) Is a licensed, board certified or board eligible health care
1708 professional qualified to practice in the area of medicine appropriate to
1709 treat the covered person's condition and has certified, in writing, that
1710 scientifically valid studies using accepted protocols demonstrate that
1711 the health care service or treatment requested by the covered person
1712 that is the subject of the adverse determination or the final adverse
1713 determination is likely to be more beneficial to the covered person than
1714 any available standard health care services or treatments;

1715 (E) The covered person has exhausted the health carrier's internal
1716 grievance process; and

1717 (F) The covered person has provided all the information and forms
1718 required to process an external review, including an authorization
1719 form as set forth in subparagraph (D)(ii) of subdivision (2) of
1720 subsection (c) of section 9 of this act.

1721 (3) (A) Not later than one business day after the health carrier
1722 completes the preliminary review, the health carrier shall notify the
1723 commissioner and the covered person and, if applicable, the covered
1724 person's authorized representative in writing whether the request for
1725 an expedited external review is complete and eligible for expedited
1726 external review. The commissioner may specify the form for the health
1727 carrier's notice of initial determination under this subdivision and any

1728 supporting information required to be included in the notice.

1729 (B) If the request:

1730 (i) Is not complete, the health carrier shall notify the commissioner
1731 and the covered person and, if applicable, the covered person's
1732 authorized representative in writing and include in the notice what
1733 information or materials are needed to perfect the request; or

1734 (ii) Is not eligible for expedited external review, the health carrier
1735 shall notify the commissioner, the covered person and, if applicable,
1736 the covered person's authorized representative in writing and include
1737 in the notice the reasons for its ineligibility.

1738 (4) The notice of initial determination shall include a statement
1739 informing the covered person and, if applicable, the covered person's
1740 authorized representative that a health carrier's initial determination
1741 that the request for an expedited external review is ineligible for
1742 review may be appealed to the commissioner.

1743 (5) Notwithstanding a health carrier's initial determination that a
1744 request for an expedited external review is ineligible for review, the
1745 commissioner may determine, pursuant to the terms of the covered
1746 person's health benefit plan, that such request is eligible for expedited
1747 external review and assign an independent review organization to
1748 conduct such review. Any such review shall be conducted in
1749 accordance with this section.

1750 (c) (1) Whenever the commissioner is notified pursuant to
1751 subparagraph (A) of subdivision (3) of subsection (b) of this section
1752 that a request is eligible for expedited external review, the
1753 commissioner shall, not later then one business day after receiving
1754 such notice:

1755 (A) Assign an independent review organization from the list of
1756 approved independent review organizations compiled and maintained
1757 by the commissioner pursuant to section 38a-226c of the general

1758 statutes, as amended by this act, to conduct the expedited external
1759 review and notify the health carrier of the name of the assigned
1760 independent review organization. Such assignment shall be done on a
1761 random basis among those approved independent review
1762 organizations qualified to conduct the particular external review based
1763 on the nature of the health care service that is the subject of the adverse
1764 determination or the final adverse determination and other
1765 circumstances, including conflict of interest concerns as set forth in
1766 section 38a-226d of the general statutes, as amended by this act; and

1767 (B) Notify the covered person and, if applicable, the covered
1768 person's authorized representative in writing of the request's eligibility
1769 and acceptance for external review. The commissioner shall include in
1770 such notice (i) a statement that the covered person or the covered
1771 person's authorized representative may submit, not later than five
1772 days after the covered person or the covered person's authorized
1773 representative, as applicable, received such notice, additional
1774 information in writing to the assigned independent review
1775 organization that such organization shall consider when conducting
1776 the external review, and (ii) where and how such additional
1777 information is to be submitted. If additional information is submitted
1778 later than five days after the covered person or the covered person's
1779 authorized representative, as applicable, received such notice, the
1780 independent review organization may, but shall not be required to,
1781 accept and consider such additional information.

1782 (2) Upon the receipt of the notice of the name of the assigned
1783 independent review organization from the commissioner, the health
1784 carrier or its designee utilization review company shall, not later than
1785 five business days after receiving such notice, provide to the assigned
1786 independent review organization the documents and any information
1787 such health carrier or utilization review company considered in
1788 making the adverse determination or the final adverse determination
1789 by telephone, facsimile, electronic means or any other expeditious
1790 method available.

1791 (3) The failure of the health carrier or its designee utilization review
1792 company to provide the documents and information within the time
1793 specified in subdivision (2) of this subsection shall not delay the
1794 conducting of the expedited external review.

1795 (4) (A) If the health carrier or its designee utilization review
1796 company fails to provide the documents and information within the
1797 time period specified in subdivision (2) of this subsection, the
1798 independent review organization may terminate the review and make
1799 a decision to reverse the adverse determination or the final adverse
1800 determination.

1801 (B) Not later than one business day after terminating the review and
1802 making the decision to reverse the adverse determination or the final
1803 adverse determination, the independent review organization shall
1804 notify the commissioner, the health carrier, the covered person and, if
1805 applicable, the covered person's authorized representative in writing
1806 of such decision.

1807 (d) (1) Not later than one business day after an independent review
1808 organization receives an assignment from the commissioner to conduct
1809 an expedited external review, the organization shall select one or more
1810 clinical peers to conduct the review, who shall be health care
1811 professionals who meet the minimum qualifications described in
1812 subdivision (4) of subsection (c) of section 38a-226c of the general
1813 statutes, as amended by this act, and, through clinical experience in the
1814 past three years, are experts in the treatment of the covered person's
1815 medical condition and knowledgeable about the recommended or
1816 requested health care service or treatment.

1817 (2) Neither the covered person, the covered person's authorized
1818 representative, if applicable, nor the health carrier shall select or
1819 control the selection of the clinical peer or peers who will conduct the
1820 expedited external review.

1821 (e) (1) Each clinical peer selected to conduct an expedited external

1822 review pursuant to subsection (d) of this section shall review all of the
1823 information and documents received pursuant to subsection (c) of this
1824 section. Such clinical peer shall not be bound by any decisions or
1825 conclusions reached during the health carrier's utilization review
1826 process.

1827 (2) Upon the receipt of any information submitted by the covered
1828 person or the covered person's authorized representative pursuant to
1829 subparagraph (B) of subdivision (1) of subsection (c) of this section, the
1830 independent review organization shall forward such information to
1831 the health carrier not later than one business day after receiving such
1832 information.

1833 (3) (A) Upon the receipt of any information forwarded pursuant to
1834 subdivision (2) of this subsection, the health carrier may reconsider its
1835 adverse determination or the final adverse determination that is the
1836 subject of the external review. Such reconsideration shall not delay or
1837 terminate the review.

1838 (B) The independent review organization shall terminate the
1839 external review if the health carrier decides, upon completion of its
1840 reconsideration and notice to such organization as provided in
1841 subparagraph (C) of this subdivision, to reverse its adverse
1842 determination or its final adverse determination and provide coverage
1843 or payment for the recommended or requested health care service or
1844 treatment that is the subject of the adverse determination or the final
1845 adverse determination.

1846 (C) Upon making a decision to reverse its adverse determination or
1847 its final adverse determination, the health carrier shall immediately
1848 notify the commissioner, the assigned independent review
1849 organization, the covered person and, if applicable, the covered
1850 person's authorized representative in writing of such decision.

1851 (f) (1) As expeditiously as the covered person's medical condition
1852 requires but not later than five days after being selected pursuant to

1853 subsection (d) of this section to conduct an expedited external review,
1854 a clinical peer shall provide an opinion orally or in writing to the
1855 independent review organization whether the recommended or
1856 requested health care service or treatment that is the subject of the
1857 adverse determination or the final adverse determination should be
1858 covered. If the opinion is provided orally, the clinical peer shall
1859 provide such opinion in writing or by electronic means to the
1860 independent review organization not later than forty-eight hours after
1861 providing the oral opinion.

1862 (2) Each such written opinion shall include:

1863 (A) A description of the covered person's medical condition;

1864 (B) A description of the indicators relevant to determining whether
1865 there is sufficient evidence to demonstrate that (i) the recommended or
1866 requested health care service or treatment is likely to be more
1867 beneficial to the covered person than any available standard health
1868 care services or treatments, and (ii) the adverse risks of the
1869 recommended or requested health care service or treatment would not
1870 be substantially increased over those of available standard health care
1871 services or treatments;

1872 (C) A description and analysis of any medical or scientific evidence
1873 considered in reaching the opinion;

1874 (D) A description and analysis of any evidence-based standard; and

1875 (E) Information on whether the clinical peer's rationale for the
1876 opinion is based on the documents and information set forth in
1877 subsection (g) of this section.

1878 (g) In addition to the documents and information received by the
1879 independent review organization pursuant to subsection (c) of this
1880 section, each clinical peer shall consider, to the extent the documents or
1881 information are available and the clinical peer considers them
1882 appropriate, the following in reaching an opinion:

1883 (1) The covered person's medical records;

1884 (2) The attending health care professional's recommendation;

1885 (3) Consulting reports from appropriate health care professionals
1886 and other documents submitted by the health carrier, the covered
1887 person, the covered person's authorized representative or the covered
1888 person's treating health care professional;

1889 (4) The terms of coverage under the covered person's health benefit
1890 plan to ensure that but for the health carrier's determination that the
1891 recommended or requested health care service or treatment that is the
1892 subject of the adverse determination or the final adverse determination
1893 is experimental or investigational, the clinical peer's opinion is not
1894 contrary to the terms of coverage under such health benefit plan; and

1895 (5) Whether:

1896 (A) The recommended or requested health care service or treatment
1897 has been approved by the federal Food and Drug Administration, if
1898 applicable, for the condition; or

1899 (B) Medical or scientific evidence or evidence-based standards
1900 demonstrate that (i) the expected benefits of the recommended or
1901 requested health care service or treatment is likely to be more
1902 beneficial to the covered person than any available standard health
1903 care services or treatments, and (ii) the adverse risks of the
1904 recommended or requested health care service or treatment would not
1905 be substantially increased over those of available standard health care
1906 services or treatments.

1907 (h) (1) (A) Not later than forty-eight hours after it receives the
1908 opinion or opinions of each clinical peer or peers conducting the
1909 expedited external review, the independent review organization shall
1910 make a decision in accordance with the provisions of subdivision (2) of
1911 this subsection and shall notify the commissioner, the health carrier,
1912 the covered person and, if applicable, the covered person's authorized

1913 representative of such decision. Such notice may be provided orally, in
1914 writing or by electronic means and shall include the information set
1915 forth in subdivision (3) of this subsection.

1916 (B) If the notice is provided orally, the independent review
1917 organization shall provide such notice in writing or by electronic
1918 means to the commissioner, the health carrier, the covered person and,
1919 if applicable, the covered person's authorized representative not later
1920 than forty-eight hours after providing the oral notice.

1921 (2) (A) If the majority of the clinical peers that conducted the
1922 expedited external review recommend that the recommended or
1923 requested health care service or treatment:

1924 (i) Should be covered, the independent review organization shall
1925 make a decision to reverse the health carrier's adverse determination
1926 or final adverse determination; or

1927 (ii) Should not be covered, the independent review organization
1928 shall make a decision to uphold the health carrier's adverse
1929 determination or final adverse determination.

1930 (B) (i) If the clinical peers are split evenly as to whether the
1931 recommended or requested health care service or treatment should be
1932 covered, the independent review organization shall obtain the opinion
1933 of an additional clinical peer to enable the independent review
1934 organization to make a decision based on the opinions of the majority
1935 of the clinical peers as set forth in subparagraph (A) of this
1936 subdivision. Such additional clinical peer shall consider the same
1937 documents and information considered by the clinical peers who have
1938 already provided their opinions.

1939 (ii) The selection of such additional clinical peer shall not extend the
1940 time period specified in subparagraph (A) of subdivision (1) of this
1941 subsection within which the assigned independent review
1942 organization is required to make a decision based on the opinion or

1943 opinions of the clinical peer or peers that conducted the expedited
1944 external appeal.

1945 (3) The notice required under subdivision (1) of this subsection shall
1946 include:

1947 (A) A general description of the reason for the request for the
1948 expedited external review;

1949 (B) The date the independent review organization received the
1950 assignment from the commissioner to conduct the expedited external
1951 review;

1952 (C) The date the expedited external review was conducted;

1953 (D) The date the organization made its decision;

1954 (E) The written opinion of each clinical peer that conducted the
1955 expedited external review, including the recommendation of each
1956 clinical peer as to whether the recommended or requested health care
1957 service or treatment should be covered and the rationale for the clinical
1958 peer's recommendation;

1959 (F) The principal reason or reasons for the organization's decision;
1960 and

1961 (G) The rationale for the organization's decision.

1962 (4) Upon the receipt of a notice of the independent review
1963 organization's decision to reverse an adverse determination or a final
1964 adverse determination, the health carrier shall immediately approve
1965 coverage of the recommended or requested health care service or
1966 treatment that was the subject of the adverse determination or the final
1967 adverse determination.

1968 Sec. 12. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
1969 maintain written records to document all grievances of adverse
1970 determinations it receives, including the notices and claims associated

1971 with such grievances, during a calendar year.

1972 (2) (A) Each health carrier shall maintain such records for not less
1973 than six years after the notice of an adverse determination that is the
1974 subject of a grievance was provided to a covered person or the covered
1975 person's authorized representative, as applicable, under section 4 of
1976 this act.

1977 (B) The health carrier shall make such records available for
1978 examination by covered persons, provided such records are subject to
1979 disclosure pursuant to section 1-210 of the general statutes, the
1980 commissioner and appropriate federal oversight agencies upon
1981 request. Such records shall be maintained in a manner that is
1982 reasonably clear and accessible to the commissioner.

1983 (b) For each grievance the record shall contain, at a minimum, the
1984 following information: (1) A general description of the reason for the
1985 grievance; (2) the date the health carrier received the grievance; (3) the
1986 date of each review or, if applicable, review meeting of the grievance;
1987 (4) the resolution at each level of the grievance, if applicable; (5) the
1988 date of resolution at each such level, if applicable; and (6) the name of
1989 the covered person for whom the grievance was filed.

1990 (c) Each health carrier shall submit a report annually to the
1991 commissioner, in accordance with section 2 of this act, of the
1992 grievances it received.

1993 (d) (1) Each health carrier shall maintain written records, in the
1994 aggregate by state where the covered person requesting the external
1995 review resides and by each type of health benefit plan offered by the
1996 health carrier, on all requests for external reviews that the health
1997 carrier receives notice of from the commissioner during a calendar
1998 year and shall, upon request, submit a report to the commissioner, in a
1999 format prescribed by the commissioner.

2000 (2) Such report shall include, in the aggregate by state where the

2001 covered person requesting the external review resides and by each
2002 type of health benefit plan:

2003 (A) The total number of requests for an external review;

2004 (B) From the total number of such requests reported under
2005 subparagraph (A) of this subdivision, the number of requests
2006 determined eligible for a full external review; and

2007 (C) Any other information the commissioner may request or
2008 require.

2009 (3) The health carrier shall retain the written records required
2010 pursuant to subdivision (1) of this subsection for not less than six years
2011 after the request for an external review was received.

2012 Sec. 13. (NEW) (*Effective July 1, 2011*) The commissioner may adopt
2013 regulations, in accordance with chapter 54 of the general statutes, to
2014 implement the provisions of sections 1 to 12, inclusive, of this act.

2015 Sec. 14. Section 38a-226 of the general statutes is repealed and the
2016 following is substituted in lieu thereof (*Effective July 1, 2011*):

2017 For purposes of sections 38a-226 to 38a-226d, inclusive<u>, as amended</u>
2018 <u>by this act</u>:

2019 **[**(1) "Utilization review" means the prospective or concurrent
2020 assessment of the necessity and appropriateness of the allocation of
2021 health care resources and services given or proposed to be given to an
2022 individual within this state. Utilization review shall not include
2023 elective requests for clarification of coverage.

2024 (2) "Utilization review company" means any company, organization
2025 or other entity performing utilization review, except:

2026 (A) An agency of the federal government;

2027 (B) An agent acting on behalf of the federal government, but only to

2028 the extent that the agent is providing services to the federal
2029 government;

2030 (C) Any agency of the state of Connecticut; or

2031 (D) A hospital's internal quality assurance program except if
2032 associated with a health care financing mechanism.]

2033 (1) "Adverse determination" has the same meaning as provided in
2034 section 1 of this act.

2035 (2) "Clinical peer" has the same meaning as provided in section 1 of
2036 this act.

2037 (3) "Commissioner" means the Insurance Commissioner.

2038 (4) "Covered person" has the same meaning as provided in section 1
2039 of this act.

2040 [(4)] (5) "Enrollee" means an individual who has contracted for or
2041 who participates in coverage under an insurance policy, a health care
2042 center contract, [an employee welfare benefits] a managed care plan, a
2043 hospital or medical services plan contract or any other fully-insured
2044 benefit program providing payment, reimbursement or
2045 indemnification for health care costs for an individual or [his] such
2046 individual's eligible dependents.

2047 [(5) "Provider of record" or "provider"] (6) "Health care provider"
2048 means the [physician or other licensed practitioner] health care
2049 professional, as defined in section 1 of this act, identified to the
2050 utilization review agent as having primary responsibility for the care,
2051 treatment and services rendered to an individual.

2052 (7) "Independent review organization" means an entity that
2053 conducts independent external reviews of adverse determinations.
2054 Such review entities include, but are not limited to, medical peer
2055 review organizations, independent utilization review companies,

2056 provided such organizations or companies are not related to or
2057 associated with any managed care organization or health insurer, and
2058 nationally recognized health experts or institutions approved by the
2059 Insurance Commissioner.

2060 (8) "Utilization review" means the use of a set of formal techniques
2061 designed to monitor the use of, or evaluate the medical necessity,
2062 appropriateness, efficacy or efficiency of, health care services as
2063 defined in section 1 of this act, health care procedures or health care
2064 settings. Such techniques may include the monitoring of or evaluation
2065 of (A) health care services performed or provided in an outpatient
2066 setting, (B) the formal process for determining, prior to discharge from
2067 a facility, the coordination and management of the care that a patient
2068 receives following discharge from a facility, (C) opportunities or
2069 requirements to obtain a clinical evaluation by a health care
2070 professional other than the one originally making a recommendation
2071 for a proposed health care service, (D) coordinated sets of activities
2072 conducted for individual patient management of serious, complicated,
2073 protracted or other health conditions, or (E) prospective review,
2074 concurrent review, retrospective review or certification, as each such
2075 term is defined in section 1 of this act.

2076 (9) "Utilization review company" means an entity that conducts
2077 utilization review.

2078 Sec. 15. Section 38a-226a of the general statutes is repealed and the
2079 following is substituted in lieu thereof (*Effective July 1, 2011*):

2080 (a) No utilization review company may conduct utilization review
2081 in this state for a health benefit plan, as defined in section 1 of this act,
2082 under the jurisdiction of the commissioner unless it is licensed by the
2083 commissioner. All licenses shall be renewed on an annual basis.

2084 (b) The annual license fee shall be two thousand five hundred
2085 dollars and shall be dedicated to the regulation of utilization review,
2086 except that the commissioner shall be authorized to use such funds as

2087 is necessary to implement the provisions of sections 38a-91aa to 38a-
2088 91qq, inclusive.

2089 (c) The request for licensure or renewal shall include the name,
2090 address, telephone number and normal business hours of the
2091 utilization review company, the name and telephone number of a
2092 person for the commissioner to contact. **[**, and evidence of compliance
2093 noted in the provisions of section 38a-226c.**]** Any material changes in
2094 the information filed in accordance with this subsection shall be filed
2095 with the commissioner **[**within**]** not later than thirty days **[**of**]** after the
2096 change.

2097 (d) The commissioner shall receive and investigate all grievances
2098 filed against utilization review companies by an enrollee. The
2099 commissioner shall code, track and review all grievances. The
2100 commissioner may impose such penalties as authorized, in accordance
2101 with section 38a-226b, as amended by this act.

2102 (e) In the absence of any contractual agreement to the contrary, the
2103 enrollee **[**is**]** shall be responsible for requesting certification and for
2104 authorizing the provider to release, in a timely manner, all information
2105 necessary to conduct the review. A utilization review company shall
2106 permit either the enrollee, the enrollee's representative or the provider
2107 of record to assist in fulfilling that responsibility.

2108 **[**(f) If the commissioner determines that additional data from a
2109 utilization review company are necessary to determine compliance
2110 with the provisions of sections 38a-226 to 38a-226d, inclusive, he may
2111 require the utilization review company to provide data relating to
2112 reviews, appeals and denials.**]**

2113 Sec. 16. Section 38a-226b of the general statutes is repealed and the
2114 following is substituted in lieu thereof (*Effective July 1, 2011*):

2115 **[**(1)**]** (a) Whenever the commissioner has reason to believe that a
2116 utilization review company subject to sections **[**38a-226 to 38a-226d**]** 1

2117 to 13, inclusive, of this act has been or is engaging in conduct in
2118 violation of said sections, and that a proceeding by the commissioner
2119 would be in the interest of the public, the commissioner shall issue and
2120 serve upon such company a statement of the charges in that respect
2121 and a notice of a hearing to be held at a time and place fixed in the
2122 notice, which shall not be less than thirty days after the date of service.
2123 At the time and place fixed for such hearing, such company shall have
2124 an opportunity to be heard and to show cause why an order should
2125 not be made by the commissioner requiring such company to cease
2126 and desist from the alleged conduct complained of.

2127 [(2)] (b) If, after such hearing, the commissioner determines that the
2128 utilization review company charged has engaged in a violation of
2129 [sections 38a-226 to 38a-226d, inclusive] section 4, 7 or 8 of this act, the
2130 commissioner shall reduce the findings to writing and shall issue and
2131 cause to be served upon the utilization review company a copy of such
2132 findings and an order requiring such company to cease and desist
2133 from engaging in such violation. The commissioner may order any of
2134 the following:

2135 [(A)] (1) Payment of a civil penalty of not more than one thousand
2136 five hundred dollars for each act or violation, provided such penalty
2137 shall not exceed an aggregate penalty of fifteen thousand dollars
2138 unless the company knew or reasonably should have known it was in
2139 violation of [sections 38a-226 to 38a-226d, inclusive] section 4, 7 or 8 of
2140 this act, in which case the penalty shall be not more than seven
2141 thousand five hundred dollars for each act or violation not to exceed
2142 an aggregate penalty of seventy-five thousand dollars in any six-
2143 month period;

2144 [(B)] (2) Suspension or revocation of the utilization review
2145 company's license to do business in this state if it knew or reasonably
2146 should have known that it was in violation of [sections 38a-226 to 38a-
2147 226d, inclusive] section 4, 7 or 8 of this act; or

2148 [(C)] (3) Payment of such reasonable expenses as may be necessary

2149 to compensate the commissioner in connection with the proceedings
2150 under this [subdivision] subsection, which shall be dedicated
2151 exclusively to the regulation of utilization review.

2152 [(3)] (c) Any company aggrieved by any such order of the
2153 commissioner may appeal therefrom in accordance with the provisions
2154 of section 4-183, except venue for such appeal shall be in the judicial
2155 district of New Britain.

2156 [(4)] (d) Any person who violates a cease and desist order of the
2157 commissioner made pursuant to this section and while such order is in
2158 effect shall, after notice and hearing and upon order of the
2159 commissioner, be subject to the following: [(A)] (1) A civil penalty of
2160 not more than seventy-five thousand dollars; or [(B)] (2) suspension or
2161 revocation of such person's license.

2162 (e) The commissioner may adopt regulations, in accordance with
2163 chapter 54, to carry out the provisions of this section and section 38a-
2164 226a, as amended by this act.

2165 Sec. 17. Section 38a-226c of the general statutes is repealed and the
2166 following is substituted in lieu thereof (*Effective July 1, 2011*):

2167 [(a) All utilization review companies shall meet the following
2168 minimum standards:

2169 (1) Each utilization review company shall maintain and make
2170 available procedures for providing notification of its determinations
2171 regarding certification in accordance with the following:

2172 (A) Notification of any prospective determination by the utilization
2173 review company shall be mailed or otherwise communicated to the
2174 provider of record or the enrollee or other appropriate individual
2175 within two business days of the receipt of all information necessary to
2176 complete the review, provided any determination not to certify an
2177 admission, service, procedure or extension of stay shall be in writing.
2178 After a prospective determination that authorizes an admission,

2179 service, procedure or extension of stay has been communicated to the
2180 appropriate individual, based on accurate information from the
2181 provider, the utilization review company may not reverse such
2182 determination if such admission, service, procedure or extension of
2183 stay has taken place in reliance on such determination.

2184 (B) Notification of a concurrent determination shall be mailed or
2185 otherwise communicated to the provider of record within two business
2186 days of receipt of all information necessary to complete the review or,
2187 provided all information necessary to perform the review has been
2188 received, prior to the end of the current certified period and provided
2189 any determination not to certify an admission, service, procedure or
2190 extension of stay shall be in writing.

2191 (C) The utilization review company shall not make a determination
2192 not to certify based on incomplete information unless it has clearly
2193 indicated, in writing, to the provider of record or the enrollee all the
2194 information that is needed to make such determination.

2195 (D) Notwithstanding subparagraphs (A) to (C), inclusive, of this
2196 subdivision, the utilization review company may give authorization
2197 orally, electronically or communicated other than in writing. If the
2198 determination is an approval for a request, the company shall provide
2199 a confirmation number corresponding to the authorization.

2200 (E) Except as provided in subparagraph (F) of this subdivision with
2201 respect to a final notice, each notice of a determination not to certify an
2202 admission, service, procedure or extension of stay shall include in
2203 writing (i) the principal reasons for the determination, (ii) the
2204 procedures to initiate an appeal of the determination or the name and
2205 telephone number of the person to contact with regard to an appeal
2206 pursuant to the provisions of this section, and (iii) the procedure to
2207 appeal to the commissioner pursuant to section 38a-478n.

2208 (F) Each notice of a final determination not to certify an admission,
2209 service, procedure or extension of stay shall include in writing (i) the

2210 principal reasons for the determination, (ii) a statement that all internal
2211 appeal mechanisms have been exhausted, and (iii) a copy of the
2212 application and procedures prescribed by the commissioner for filing
2213 an appeal to the commissioner pursuant to section 38a-478n.

2214 (2) Each utilization review company shall maintain and make
2215 available a written description of the appeal procedure by which either
2216 the enrollee or the provider of record may seek review of
2217 determinations not to certify an admission, service, procedure or
2218 extension of stay. An appeal by the provider of record shall be deemed
2219 to be made on behalf of the enrollee and with the consent of such
2220 enrollee if the admission, service, procedure or extension of stay has
2221 not yet been provided or if such determination not to certify creates a
2222 financial liability to the enrollee. The procedures for appeals shall
2223 include the following:

2224 (A) Each utilization review company shall notify in writing the
2225 enrollee and provider of record of its determination on the appeal as
2226 soon as practical, but in no case later than thirty days after receiving
2227 the required documentation on the appeal.

2228 (B) On appeal, all determinations not to certify an admission,
2229 service, procedure or extension of stay shall be made by a licensed
2230 practitioner of the healing arts.

2231 (3) The process established by each utilization review company may
2232 include a reasonable period within which an appeal must be filed to be
2233 considered.

2234 (4) Each utilization review company shall also provide for an
2235 expedited appeals process for emergency or life threatening situations.
2236 Each utilization review company shall complete the adjudication of
2237 such expedited appeals within two business days of the date the
2238 appeal is filed and all information necessary to complete the appeal is
2239 received by the utilization review company.

2240 (5) Each utilization review company shall utilize written clinical
2241 criteria and review procedures which are established and periodically
2242 evaluated and updated with appropriate involvement from
2243 practitioners.

2244 (6) Physicians, nurses and other licensed health professionals
2245 making utilization review decisions shall have current licenses from a
2246 state licensing agency in the United States or appropriate certification
2247 from a recognized accreditation agency in the United States, provided,
2248 any final determination not to certify an admission, service, procedure
2249 or extension of stay for an enrollee within this state, except for a claim
2250 brought pursuant to chapter 568, shall be made by a physician, nurse
2251 or other licensed health professional under the authority of a
2252 physician, nurse or other licensed health professional who has a
2253 current Connecticut license from the Department of Public Health.

2254 (7) In cases where an appeal to reverse a determination not to certify
2255 is unsuccessful, each utilization review company shall assure that a
2256 practitioner in a specialty related to the condition is reasonably
2257 available to review the case. When the reason for the determination not
2258 to certify is based on medical necessity, including whether a treatment
2259 is experimental or investigational, each utilization review company
2260 shall have the case reviewed by a physician who is a specialist in the
2261 field related to the condition that is the subject of the appeal. Any such
2262 review, except for a claim brought pursuant to chapter 568, that
2263 upholds a final determination not to certify in the case of an enrollee
2264 within this state shall be conducted by such practitioner or physician
2265 under the authority of a practitioner or physician who has a current
2266 Connecticut license from the Department of Public Health. The review
2267 shall be completed within thirty days of the request for review. The
2268 utilization review company shall be financially responsible for the
2269 review and shall maintain, for the commissioner's verification,
2270 documentation of the review, including the name of the reviewing
2271 physician.

2272 (8) Except as provided in subsection (e) of this section, each
2273 utilization review company shall make review staff available by toll-
2274 free telephone, at least forty hours per week during normal business
2275 hours.

2276 (9) Each utilization review company shall comply with all
2277 applicable federal and state laws to protect the confidentiality of
2278 individual medical records. Summary and aggregate data shall not be
2279 considered confidential if it does not provide sufficient information to
2280 allow identification of individual patients.

2281 (10) Each utilization review company shall allow a minimum of
2282 twenty-four hours following an emergency admission, service or
2283 procedure for an enrollee or his representative to notify the utilization
2284 review company and request certification or continuing treatment for
2285 that condition.

2286 (11) No utilization review company may give an employee any
2287 financial incentive based on the number of denials of certification such
2288 employee makes.

2289 (12) Each utilization review company shall annually file with the
2290 commissioner:

2291 (A) The names of all managed care organizations, as defined in
2292 section 38a-478, that the utilization review company services in
2293 Connecticut;

2294 (B) Any utilization review services for which the utilization review
2295 company has contracted out for services and the name of such
2296 company providing the services;

2297 (C) The number of utilization review determinations not to certify
2298 an admission, service, procedure or extension of stay and the outcome
2299 of such determination upon appeal within the utilization review
2300 company. Determinations related to mental or nervous conditions, as
2301 defined in section 38a-514, shall be reported separately from all other

2302 determinations reported under this subdivision; and

2303 (D) The following information relative to requests for utilization
2304 review of mental health services for enrollees of fully insured health
2305 benefit plans or self-insured or self-funded employee health benefit
2306 plans, separately and by category: (i) The reason for the request,
2307 including, but not limited to, an inpatient admission, service,
2308 procedure or extension of inpatient stay or an outpatient treatment, (ii)
2309 the number of requests denied by type of request, and (iii) whether the
2310 request was denied or partially denied.

2311 (13) Any utilization review decision to initially deny services shall
2312 be made by a licensed health professional.

2313 (b) Unless there is a contrary written agreement between the
2314 utilization review company and the hospital, all hospitals in this state
2315 shall permit each licensed utilization review company to conduct
2316 reviews on the premises. Each utilization review company shall
2317 conduct its telephone, on-site information gathering reviews and
2318 hospital communications during the hospitals' and practitioners'
2319 reasonable and normal business hours, unless other arrangements are
2320 mutually agreed upon. Each utilization review company's staff shall
2321 identify themselves by name and by the name of their organization
2322 and, for on-site reviews, shall carry photographic identification and the
2323 utilization review company's company identification card.

2324 (c) The provider of record shall provide to each utilization review
2325 company, within a reasonable period of time, all relevant information
2326 necessary for the utilization review company to certify the admission,
2327 procedure, treatment or length of stay. Failure of the provider to
2328 provide such documentation for review shall be grounds for a denial
2329 of certification in accordance with the policy of the utilization review
2330 company or the health benefit plan.

2331 (d) No provider, enrollee or agent thereof may provide to any
2332 utilization review company information which is fraudulent or

2333 misleading. If fraudulent or misleading statements have occurred, the
2334 commissioner shall provide notice of the alleged violation and
2335 opportunity to request a hearing in accordance with chapter 54 to said
2336 provider, enrollee or agent thereof. If a hearing is not requested or if
2337 after a hearing the commissioner finds that a violation has in fact
2338 occurred, the commissioner may impose a civil penalty (1) of not more
2339 than seven thousand five hundred dollars, or (2) commensurate with
2340 the value of services provided which were certified as a result of said
2341 fraudulent or misleading information. In addition, any allegation or
2342 denial made without reasonable cause and found untrue shall subject
2343 the party pleading the same to the payment of such reasonable
2344 expenses as may be necessary to compensate the department for
2345 expenses incurred due to such untrue pleading. All such payments to
2346 the department shall be dedicated exclusively to the regulation of
2347 utilization review.

2348 (e) On or after November 1, 1997, if an enrollee has been admitted to
2349 an acute care hospital and the attending physician determines that the
2350 enrollee's life will be endangered or other serious injury or illness
2351 could occur if the patient is discharged or if treatment is delayed, the
2352 attending physician may transmit, pursuant to the standardized
2353 process developed pursuant to section 38a-478p, a request for an
2354 expedited review to the utilization review company. If such attending
2355 physician receives no response, in the standardized process developed
2356 pursuant to section 38a-478p, from the utilization review company
2357 after three hours have passed since the provider sent the request and
2358 all information needed to complete the review, the request shall be
2359 deemed approved. Each utilization review company shall make review
2360 staff available from 8:00 a.m. to 9:00 p.m. to process requests pursuant
2361 to this subsection.

2362 (f) The Insurance Commissioner, after consultation with the
2363 Commissioner of Public Health, shall adopt regulations, in accordance
2364 with chapter 54, as he deems necessary to clarify or supplement the
2365 standards set forth in this section. The regulations shall include

2366 standards, which may be based on the national standards of the
2367 American Accreditation Health Care Commission, concerning the
2368 confidentiality of patient medical records.]

2369 (a) (1) The commissioner shall approve independent review
2370 organizations eligible to be assigned to conduct external reviews under
2371 sections 9 to 11, inclusive, of this act.

2372 (2) The commissioner shall (A) develop an application form for the
2373 initial approval and for the reapproval of independent review
2374 organizations, and (B) maintain and periodically update a list of
2375 approved independent review organizations.

2376 (b) (1) Any independent review organization seeking to conduct
2377 external reviews under sections 9 to 11, inclusive, of this act shall
2378 submit the application form for approval or reapproval, as applicable,
2379 to the commissioner and shall include all documentation and
2380 information necessary for the commissioner to determine if the
2381 independent review organization satisfies the minimum qualifications
2382 established under this section.

2383 (2) An approval or reapproval shall be effective for two years,
2384 unless the commissioner determines before the expiration of such
2385 approval or reapproval that the independent review organization no
2386 longer satisfies the minimum qualifications established under this
2387 section.

2388 (3) Whenever the commissioner determines that an independent
2389 review organization has lost its accreditation or no longer satisfies the
2390 minimum requirements established under this section, the
2391 commissioner shall terminate the approval of the independent review
2392 organization and remove the independent review organization from
2393 the list of approved independent review organizations specified in
2394 subdivision (2) of subsection (a) of this section.

2395 (c) To be eligible for approval by the commissioner, an independent

2396 review organization shall:

2397 (1) Have and maintain written policies and procedures that govern
2398 all aspects of both the standard external review process and the
2399 expedited external review process set forth in sections 9 to 11,
2400 inclusive, of this act that include, at a minimum:

2401 (A) A quality assurance mechanism in place that ensures:

2402 (i) That external reviews are conducted within the specified time
2403 frames and required notices are provided in a timely manner;

2404 (ii) (I) The selection of qualified and impartial clinical peers to
2405 conduct external reviews on behalf of the independent review
2406 organization and the suitable matching of such peers to specific cases,
2407 and (II) employs or contracts with an adequate number of clinical
2408 peers to meet this objective;

2409 (iii) The confidentiality of medical and treatment records and
2410 clinical review criteria;

2411 (iv) That any person employed by or under contract with the
2412 independent review organization adheres to the requirements of
2413 sections 9 to 11, inclusive, of this act; and

2414 (B) A toll-free telephone number to receive information twenty-four
2415 hours a day, seven days a week, related to external reviews and that is
2416 capable of accepting, recording or providing appropriate instruction to
2417 incoming telephone callers during other than normal business hours;

2418 (2) Agree to maintain and provide to the commissioner the
2419 information set forth in section 38a-226d, as amended by this act;

2420 (3) Not own or control, be a subsidiary of, be owned or controlled in
2421 any way by, or exercise control with a health benefit plan, a national,
2422 state or local trade association of health benefit plans, or a national,
2423 state or local trade association of health care providers; and

2424 (4) Assign as a clinical peer a physician or other appropriate health
2425 care provider who meets the following minimum qualifications:

2426 (A) Is an expert in the treatment of the covered person's medical
2427 condition that is the subject of the external review;

2428 (B) Is knowledgeable about the recommended health care service or
2429 treatment through recent or current actual clinical experience treating
2430 patients with the same or similar medical condition of the covered
2431 person;

2432 (C) Holds a nonrestricted license in a state of the United States and,
2433 for physicians, a current certification by a recognized American
2434 medical specialty board in the area or areas appropriate to the subject
2435 of the external review; and

2436 (D) Has no history of disciplinary actions or sanctions, including
2437 loss of staff privileges or participation restrictions, that have been
2438 taken or are pending by any hospital, governmental agency or unit or
2439 regulatory body that raise a substantial question as to the clinical
2440 peer's physical, mental or professional competence or moral character.

2441 (d) (1) An independent review organization that is accredited by a
2442 nationally recognized private accrediting entity that has independent
2443 review accreditation standards that the commissioner has determined
2444 are equivalent to or exceed the minimum qualifications of this section
2445 shall be presumed to be in compliance with this section.

2446 (2) The commissioner shall initially review and periodically review
2447 the independent review organization accreditation standards of a
2448 nationally recognized private accrediting entity to determine whether
2449 such entity's standards are, and continue to be, equivalent to or exceed
2450 the minimum qualifications established under this section. The
2451 commissioner may accept a review conducted by the National
2452 Association of Insurance Commissioners for the purpose of the
2453 determination under this subdivision.

2454 (3) Upon request, a nationally recognized private accrediting entity
2455 shall make its current independent review organization accreditation
2456 standards available to the commissioner or the National Association of
2457 Insurance Commissioners in order for the commissioner to determine
2458 if such entity's standards are equivalent to or exceed the minimum
2459 qualifications established under this section. The commissioner may
2460 exclude any private accrediting entity that is not reviewed by the
2461 National Association of Insurance Commissioners.

2462 Sec. 18. Section 38a-226d of the general statutes is repealed and the
2463 following is substituted in lieu thereof (*Effective July 1, 2011*):

2464 **[**The commissioner may find that the standards in section 38a-226c
2465 have been met if each utilization review company has received
2466 approval or accreditation by a utilization review accreditation
2467 organization, or otherwise demonstrates to the commissioner that it
2468 adheres to standards which are substantially similar to the standards
2469 in said section 38a-226c, provided such approval, accreditation or
2470 standards do not provide less protection to enrollees than is provided
2471 under said section 38a-226c.**]**

2472 (a) The commissioner shall not assign an independent review
2473 organization, and no independent review organization shall assign a
2474 clinical peer, to conduct an external review of a specified case if such
2475 organization or clinical peer has a material professional, familial or
2476 financial conflict of interest with any of the following:

2477 (1) The health carrier that is the subject of the external review;

2478 (2) The covered person whose treatment is the subject of the external
2479 review or the covered person's authorized representative;

2480 (3) Any officer, director or management employee of the health
2481 carrier that is the subject of the external review;

2482 (4) The health care provider, the health care provider's medical
2483 group or independent practice association recommending the health

2484 care service or treatment that is the subject of the external review;

2485 (5) The facility at which the recommended health care service or
2486 treatment would be provided; or

2487 (6) The developer or manufacturer of the principal drug, device,
2488 procedure or other therapy being recommended for the covered
2489 person whose treatment is the subject of the external review.

2490 (b) To determine whether an independent review organization or a
2491 clinical peer of the independent review organization has a material
2492 professional, familial or financial conflict of interest for purposes of
2493 subsection (a) of this section, the commissioner shall consider
2494 situations in which the independent review organization to be
2495 assigned to conduct an external review of a specified case or a clinical
2496 peer to be assigned by the independent review organization to conduct
2497 an external review of a specified case may have an apparent
2498 professional, familial or financial relationship or connection with a
2499 person described in subsection (a) of this section, but the
2500 characteristics of such relationship or connection are such that they are
2501 not a material professional, familial or financial conflict of interest that
2502 results in the disapproval of the independent review organization or
2503 the clinical peer from conducting such external review.

2504 (c) An independent review organization shall be unbiased. In
2505 addition to any other written procedures required under section 38a-
2506 226c, as amended by this act, an independent review organization shall
2507 establish and maintain written procedures to ensure that it is unbiased.

2508 (d) No independent review organization or clinical peer working on
2509 behalf of an independent review organization or an employee, agent or
2510 contractor of an independent review organization shall be liable in
2511 damages to any person for any opinions rendered or acts or omissions
2512 performed within the scope of the organization's or person's duties
2513 during or upon completion of an external review conducted pursuant
2514 to sections 9 to 11, inclusive, of this act, unless such opinion was

2515 rendered or act or omission performed in bad faith or involved gross
2516 negligence.

2517 (e) (1) Each independent review organization assigned by the
2518 commissioner to conduct an external review pursuant to sections 9 to
2519 11, inclusive, of this act shall maintain written records, in the aggregate
2520 by state where the covered person requesting the external review
2521 resides and by health carrier, on all external reviews such organization
2522 conducted during a calendar year and shall, upon request, submit a
2523 report to the commissioner, in a format prescribed by the
2524 commissioner.

2525 (2) Such report shall include, in the aggregate by state where the
2526 covered person requesting the external review resides and by health
2527 carrier:

2528 (A) The total number of requests for an external review;

2529 (B) The number of such requests resolved and, of those resolved, the
2530 number resolved upholding the adverse determination or final adverse
2531 determination and the number resolved reversing the adverse
2532 determination or final adverse determination;

2533 (C) The average length of time for resolution;

2534 (D) A summary of the types of coverages or cases for which an
2535 external review was sought;

2536 (E) The number of external reviews that were terminated as a result
2537 of reconsideration by the health carrier of its adverse determination or
2538 final adverse determination after the receipt of additional information
2539 from the covered person or the covered person's authorized
2540 representative; and

2541 (F) Any other information the commissioner may request or require.

2542 (3) Each independent review organization shall retain the written

2543 records required pursuant to subdivision (1) of this subsection for not
2544 less than six years after the assignment of an external review.

2545 (f) The commissioner may adopt regulations, in accordance with
2546 chapter 54, to carry out the provisions of this section and section 38a-
2547 226c, as amended by this act.

2548 Sec. 19. Subsection (a) of section 38a-11 of the general statutes is
2549 repealed and the following is substituted in lieu thereof (*Effective July*
2550 *1, 2011*):

2551 (a) The commissioner shall demand and receive the following fees:
2552 (1) For the annual fee for each license issued to a domestic insurance
2553 company, two hundred dollars; (2) for receiving and filing annual
2554 reports of domestic insurance companies, fifty dollars; (3) for filing all
2555 documents prerequisite to the issuance of a license to an insurance
2556 company, two hundred twenty dollars, except that the fee for such
2557 filings by any health care center, as defined in section 38a-175, shall be
2558 one thousand three hundred fifty dollars; (4) for filing any additional
2559 paper required by law, thirty dollars; (5) for each certificate of
2560 valuation, organization, reciprocity or compliance, forty dollars; (6) for
2561 each certified copy of a license to a company, forty dollars; (7) for each
2562 certified copy of a report or certificate of condition of a company to be
2563 filed in any other state, forty dollars; (8) for amending a certificate of
2564 authority, two hundred dollars; (9) for each license issued to a rating
2565 organization, two hundred dollars. In addition, insurance companies
2566 shall pay any fees imposed under section 12-211; (10) a filing fee of
2567 fifty dollars for each initial application for a license made pursuant to
2568 section 38a-769; (11) with respect to insurance agents' appointments:
2569 (A) A filing fee of fifty dollars for each request for any agent
2570 appointment, except that no filing fee shall be payable for a request for
2571 agent appointment by an insurance company domiciled in a state or
2572 foreign country which does not require any filing fee for a request for
2573 agent appointment for a Connecticut insurance company; (B) a fee of
2574 one hundred dollars for each appointment issued to an agent of a

2575 domestic insurance company or for each appointment continued; and
2576 (C) a fee of eighty dollars for each appointment issued to an agent of
2577 any other insurance company or for each appointment continued,
2578 except that (i) no fee shall be payable for an appointment issued to an
2579 agent of an insurance company domiciled in a state or foreign country
2580 which does not require any fee for an appointment issued to an agent
2581 of a Connecticut insurance company, and (ii) the fee shall be twenty
2582 dollars for each appointment issued or continued to an agent of an
2583 insurance company domiciled in a state or foreign country with a
2584 premium tax rate below Connecticut's premium tax rate; (12) with
2585 respect to insurance producers: (A) An examination fee of fifteen
2586 dollars for each examination taken, except when a testing service is
2587 used, the testing service shall pay a fee of fifteen dollars to the
2588 commissioner for each examination taken by an applicant; (B) a fee of
2589 eighty dollars for each license issued; (C) a fee of eighty dollars per
2590 year, or any portion thereof, for each license renewed; and (D) a fee of
2591 eighty dollars for any license renewed under the transitional process
2592 established in section 38a-784; (13) with respect to public adjusters: (A)
2593 An examination fee of fifteen dollars for each examination taken,
2594 except when a testing service is used, the testing service shall pay a fee
2595 of fifteen dollars to the commissioner for each examination taken by an
2596 applicant; and (B) a fee of two hundred fifty dollars for each license
2597 issued or renewed; (14) with respect to casualty adjusters: (A) An
2598 examination fee of twenty dollars for each examination taken, except
2599 when a testing service is used, the testing service shall pay a fee of
2600 twenty dollars to the commissioner for each examination taken by an
2601 applicant; (B) a fee of eighty dollars for each license issued or renewed;
2602 and (C) the expense of any examination administered outside the state
2603 shall be the responsibility of the entity making the request and such
2604 entity shall pay to the commissioner two hundred dollars for such
2605 examination and the actual traveling expenses of the examination
2606 administrator to administer such examination; (15) with respect to
2607 motor vehicle physical damage appraisers: (A) An examination fee of
2608 eighty dollars for each examination taken, except when a testing

2609 service is used, the testing service shall pay a fee of eighty dollars to
2610 the commissioner for each examination taken by an applicant; (B) a fee
2611 of eighty dollars for each license issued or renewed; and (C) the
2612 expense of any examination administered outside the state shall be the
2613 responsibility of the entity making the request and such entity shall
2614 pay to the commissioner two hundred dollars for such examination
2615 and the actual traveling expenses of the examination administrator to
2616 administer such examination; (16) with respect to certified insurance
2617 consultants: (A) An examination fee of twenty-six dollars for each
2618 examination taken, except when a testing service is used, the testing
2619 service shall pay a fee of twenty-six dollars to the commissioner for
2620 each examination taken by an applicant; (B) a fee of two hundred fifty
2621 dollars for each license issued; and (C) a fee of two hundred fifty
2622 dollars for each license renewed; (17) with respect to surplus lines
2623 brokers: (A) An examination fee of twenty dollars for each
2624 examination taken, except when a testing service is used, the testing
2625 service shall pay a fee of twenty dollars to the commissioner for each
2626 examination taken by an applicant; and (B) a fee of six hundred
2627 twenty-five dollars for each license issued or renewed; (18) with
2628 respect to fraternal agents, a fee of eighty dollars for each license
2629 issued or renewed; (19) a fee of twenty-six dollars for each license
2630 certificate requested, whether or not a license has been issued; (20)
2631 with respect to domestic and foreign benefit societies shall pay: (A) For
2632 service of process, fifty dollars for each person or insurer to be served;
2633 (B) for filing a certified copy of its charter or articles of association,
2634 fifteen dollars; (C) for filing the annual report, twenty dollars; and (D)
2635 for filing any additional paper required by law, fifteen dollars; (21)
2636 with respect to foreign benefit societies: (A) For each certificate of
2637 organization or compliance, fifteen dollars; (B) for each certified copy
2638 of permit, fifteen dollars; and (C) for each copy of a report or certificate
2639 of condition of a society to be filed in any other state, fifteen dollars;
2640 (22) with respect to reinsurance intermediaries: A fee of six hundred
2641 twenty-five dollars for each license issued or renewed; (23) with
2642 respect to life settlement providers: (A) A filing fee of twenty-six

2643 dollars for each initial application for a license made pursuant to
2644 section 38a-465a; and (B) a fee of forty dollars for each license issued or
2645 renewed; (24) with respect to life settlement brokers: (A) A filing fee of
2646 twenty-six dollars for each initial application for a license made
2647 pursuant to section 38a-465a; and (B) a fee of forty dollars for each
2648 license issued or renewed; (25) with respect to preferred provider
2649 networks, a fee of two thousand seven hundred fifty dollars for each
2650 license issued or renewed; (26) with respect to rental companies, as
2651 defined in section 38a-799, a fee of eighty dollars for each permit
2652 issued or renewed; (27) with respect to medical discount plan
2653 organizations licensed under section 38a-479rr, a fee of six hundred
2654 twenty-five dollars for each license issued or renewed; (28) with
2655 respect to pharmacy benefits managers, an application fee of one
2656 hundred dollars for each registration issued or renewed; (29) with
2657 respect to captive insurance companies, as defined in section 38a-91aa,
2658 a fee of three hundred seventy-five dollars for each license issued or
2659 renewed; **[**and**]** (30) with respect to each duplicate license issued a fee
2660 of fifty dollars for each license issued; and (31) for each request for an
2661 external review of an adverse determination or a final adverse
2662 determination pursuant to sections 9 to 11, inclusive, of this act,
2663 twenty-five dollars.

2664 Sec. 20. Section 38a-478 of the general statutes is repealed and the
2665 following is substituted in lieu thereof (*Effective July 1, 2011*):

2666 As used in this section, sections **[**38a-478**]** 38a-478a to 38a-478o,
2667 inclusive, and subsection (a) of section 38a-478s, as amended by this
2668 act:

2669 **[**(1) "Adverse determination" means a determination by a managed
2670 care organization, health insurer or utilization review company that an
2671 admission, service, procedure or extension of stay that is a covered
2672 benefit has been reviewed and, based upon the information provided,
2673 does not meet the managed care organization's, health insurer's or
2674 utilization review company's requirements for medical necessity,

2675 appropriateness, health care setting, level of care or effectiveness, and
2676 such requested admission, service, procedure or extension of stay, or
2677 payment for such admission, service, procedure or extension of stay
2678 has been denied, reduced or terminated.]

2679 [(2)] (1) "Commissioner" means the Insurance Commissioner.

2680 [(3)] (2) "Covered benefit" or "benefit" means a health care service to
2681 which an enrollee is entitled under the terms of a health benefit plan.

2682 [(4)] (3) [Except as provided in sections 38a-478m and 38a-478n,
2683 "enrollee"] "Enrollee" means a person who has contracted for or who
2684 participates in a managed care plan for such person or such person's
2685 eligible dependents.

2686 [(5)] (4) "Health care services" means services for the diagnosis,
2687 prevention, treatment, cure or relief of a health condition, illness,
2688 injury or disease.

2689 [(6)] (5) "Managed care organization" means an insurer, health care
2690 center, hospital or medical service corporation or other organization
2691 delivering, issuing for delivery, renewing, amending or continuing any
2692 individual or group health managed care plan in this state.

2693 [(7)] (6) "Managed care plan" means a product offered by a managed
2694 care organization that provides for the financing or delivery of health
2695 care services to persons enrolled in the plan through: (A)
2696 Arrangements with selected providers to furnish health care services;
2697 (B) explicit standards for the selection of participating providers; (C)
2698 financial incentives for enrollees to use the participating providers and
2699 procedures provided for by the plan; or (D) arrangements that share
2700 risks with providers, provided the organization offering a plan
2701 described under subparagraph (A), (B), (C) or (D) of this subdivision is
2702 licensed by the Insurance Department pursuant to chapter 698, 698a or
2703 700 and the plan includes utilization review, [pursuant to sections 38a-
2704 226 to 38a-226d, inclusive] as defined in section 38a-226, as amended

2705 by this act.

2706 [(8)] (7) "Preferred provider network" has the same meaning as
2707 provided in section 38a-479aa, as amended by this act.

2708 [(9)] (8) "Provider" or "health care provider" means a person licensed
2709 to provide health care services under chapters 370 to 373, inclusive, 375
2710 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

2711 [(10) "Review entity" means an entity that conducts independent
2712 external reviews of adverse determinations. Such review entities
2713 include, but are not limited to, medical peer review organizations,
2714 independent utilization review companies, provided such
2715 organizations or companies are not related to or associated with any
2716 managed care organization or health insurer, and nationally
2717 recognized health experts or institutions approved by the Insurance
2718 Commissioner.]

2719 [(11)] (9) "Utilization review" has the same meaning as provided in
2720 section 38a-226, as amended by this act.

2721 [(12)] (10) "Utilization review company" has the same meaning as
2722 provided in section 38a-226, as amended by this act.

2723 Sec. 21. Subsection (c) of section 38a-19 of the general statutes is
2724 repealed and the following is substituted in lieu thereof (*Effective July*
2725 *1, 2011*):

2726 (c) The provisions of this section shall not apply to an order or
2727 decision of the commissioner made pursuant to section 38a-477b or
2728 [38a-478n] sections 9 to 11, inclusive, of this act.

2729 Sec. 22. Subsection (b) of section 38a-477b of the general statutes is
2730 repealed and the following is substituted in lieu thereof (*Effective July*
2731 *1, 2011*):

2732 (b) An insurer or health care center shall apply for approval of such

2733 rescission, cancellation or limitation by submitting such written
2734 information to the Insurance Commissioner on an application in such
2735 form as the commissioner prescribes. Such insurer or health care center
2736 shall provide a copy of the application for such approval to the insured
2737 or the insured's representative. Not later than seven business days
2738 after receipt of the application for such approval, the insured or the
2739 insured's representative shall have an opportunity to review such
2740 application and respond and submit relevant information to the
2741 commissioner with respect to such application. Not later than fifteen
2742 business days after the submission of information by the insured or the
2743 insured's representative, the commissioner shall issue a written
2744 decision on such application. The commissioner [may] shall only
2745 approve: [such rescission, cancellation]

2746 (1) Such rescission or limitation if the commissioner finds that [(1)]
2747 (A) the insured or such insured's representative submitted the written
2748 information [submitted] on or with the insurance application that was
2749 [false] fraudulent at the time such application was made, [and] (B) the
2750 insured or such insured's representative [knew or should have known
2751 of the falsity] intentionally misrepresented information therein [,] and
2752 such [submission] misrepresentation materially affects the risk or the
2753 hazard assumed by the insurer or health care center, or [(2)] (C) the
2754 information omitted from the insurance application was [knowingly]
2755 intentionally omitted by the insured or such insured's representative [,
2756 or the insured or such insured's representative should have known of
2757 such omission,] and such omission materially affects the risk or the
2758 hazard assumed by the insurer or health care center. Such decision
2759 shall be mailed to the insured, the insured's representative, if any, and
2760 the insurer or health care center; and

2761 (2) Such cancellation in accordance with the provisions set forth in
2762 the Public Health Service Act, 42 USC 300gg et seq., as amended from
2763 time to time.

2764 Sec. 23. Section 38a-478a of the general statutes is repealed and the

2765 following is substituted in lieu thereof (*Effective July 1, 2011*):

2766 On March [1, 1999, and] first annually, [thereafter,] the Insurance
2767 Commissioner shall submit a report [,] to the Governor and to the joint
2768 standing committees of the General Assembly having cognizance of
2769 matters relating to public health and [relating to] insurance,
2770 concerning the commissioner's responsibilities under the provisions of
2771 sections [38a-226 to 38a-226d, inclusive] 38a-226a and 38a-226b, as
2772 amended by this act, sections 1 to 13, inclusive, of this act, 38a-478 to
2773 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by
2774 this act, and 38a-993. The report shall include: (1) A summary of the
2775 quality assurance plans submitted by managed care organizations
2776 pursuant to section 38a-478c along with suggested changes to improve
2777 such plans; (2) suggested modifications to the consumer report card
2778 developed under the provisions of section 38a-478*l*; (3) a summary of
2779 the commissioner's procedures and activities in conducting market
2780 conduct examinations of utilization review companies and preferred
2781 provider networks, including, but not limited to: (A) The number of
2782 desk and field audits completed during the previous calendar year; (B)
2783 a summary of findings of the desk and field audits, including any
2784 recommendations made for improvements or modifications; (C) a
2785 description of complaints concerning managed care companies, and
2786 any preferred provider network that provides services to enrollees on
2787 behalf of the managed care organization, including a summary and
2788 analysis of any trends or similarities found in the managed care
2789 complaints filed by enrollees; (4) a summary of the complaints
2790 concerning managed care companies received by the Insurance
2791 Department's Consumer Affairs Division and the commissioner under
2792 [section 38a-478n] sections 9 to 11, inclusive, of this act, including a
2793 summary and analysis of any trends or similarities found in the
2794 complaints received; (5) a summary of any violations the commissioner
2795 has found against any managed care organization or any preferred
2796 provider network that provides services to enrollees on behalf of the
2797 managed care organization; and (6) a summary of the issues discussed
2798 related to health care or managed care organizations at the Insurance

2799 Department's quarterly forums throughout the state.

2800 Sec. 24. Section 38a-478b of the general statutes is repealed and the
2801 following is substituted in lieu thereof (*Effective July 1, 2011*):

2802 (a) Each managed care organization, as defined in section 38a-478,
2803 that fails to file the data, reports or information required by sections
2804 **[**38a-226 to 38a-226d**]** 1 to 13, inclusive, of this act, 38a-478 to 38a-478u,
2805 inclusive, as amended by this act, 38a-479aa, as amended by this act,
2806 and 38a-993 shall pay a late fee of one hundred dollars per day for each
2807 day from the due date of such data, reports or information to the date
2808 of filing. Each managed care organization that files incomplete data,
2809 reports or information shall be so informed by the commissioner, shall
2810 be given a date by which to remedy such incomplete filing and shall
2811 pay said late fee commencing from the new due date.

2812 (b) On June **[**1, 1998, and**]** first annually, **[**thereafter,**]** the
2813 commissioner shall submit **[**,**]** to the Governor and to the joint standing
2814 committees of the General Assembly having cognizance of matters
2815 relating to public health and **[**matters relating to**]** insurance, a list of
2816 those managed care organizations that have failed to file any data,
2817 report or information required by sections **[**38a-226 to 38a-226d**]** 1 to
2818 13, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by
2819 this act, 38a-479aa, as amended by this act, and 38a-993.

2820 Sec. 25. Section 38a-478h of the general statutes is repealed and the
2821 following is substituted in lieu thereof (*Effective July 1, 2011*):

2822 (a) Each contract delivered, issued for delivery, renewed, amended
2823 or continued in this state **[**on and after October 1, 1997,**]** between a
2824 managed care organization and a participating provider shall require
2825 the provider to give at least sixty days' advance written notice to the
2826 managed care organization and shall require the managed care
2827 organization to give at least sixty days' advance written notice to the
2828 provider in order to withdraw from or terminate the agreement.

2829 (b) The provisions of this section shall not apply: (1) When lack of
2830 such notice is necessary for the health or safety of the enrollees; (2)
2831 when a provider has entered into a contract with a managed care
2832 organization that is found to be based on fraud or material
2833 misrepresentation; or (3) when a provider engages in any fraudulent
2834 activity related to the terms of his contract with the managed care
2835 organization.

2836 (c) No managed care organization shall take or threaten to take any
2837 action against any provider in retaliation for such provider's assistance
2838 to an enrollee under the provisions of **[**subsection (e) of section 38a-
2839 226c or section 38a-478n**]** sections 9 to 11, inclusive, of this act.

2840 Sec. 26. Subsection (d) of section 38a-478r of the general statutes is
2841 repealed and the following is substituted in lieu thereof (*Effective July*
2842 *1, 2011*):

2843 (d) The Insurance Commissioner **[**, after consultation with the
2844 working group convened pursuant to section 38a-478p,**]** may develop
2845 and disseminate to hospitals in this state a claims form system that will
2846 ensure that all hospitals consistently code for the presenting and
2847 diagnosis symptoms on all emergency claims.

2848 Sec. 27. Section 38a-478s of the general statutes is repealed and the
2849 following is substituted in lieu thereof (*Effective July 1, 2011*):

2850 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended
2851 by this act, or sections 1 to 13, inclusive, of this act shall be construed to
2852 apply to the arrangements of managed care organizations or health
2853 insurers offered to individuals covered under self-insured employee
2854 welfare benefit plans established pursuant to the federal Employee
2855 Retirement Income Security Act of 1974.

2856 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, as
2857 amended by this act, and sections 1 to 13, inclusive, of this act shall not
2858 apply to any plan that provides for the financing or delivery of health

2859 care services solely for the purposes of workers' compensation benefits
2860 pursuant to chapter 568.

2861 Sec. 28. Section 38a-478t of the general statutes is repealed and the
2862 following is substituted in lieu thereof (*Effective July 1, 2011*):

2863 The Commissioner of Public Health may request and shall receive
2864 any data, report or information filed with the Insurance Commissioner
2865 pursuant to the provisions of sections **[**38a-226 to 38a-226d, inclusive**]**
2866 38a-226a and 38a-226b, as amended by this act, 38a-478 to 38a-478u,
2867 inclusive, as amended by this act, 38a-479aa, as amended by this act,
2868 and 38a-993.

2869 Sec. 29. Section 38a-478u of the general statutes is repealed and the
2870 following is substituted in lieu thereof (*Effective July 1, 2011*):

2871 The Insurance Commissioner may adopt regulations in accordance
2872 with the provisions of chapter 54 to implement the provisions of
2873 sections **[**38a-226 to 38a-226d, inclusive,**]** 38a-478 to 38a-478u, inclusive,
2874 as amended by this act, 38a-479aa, as amended by this act, and 38a-
2875 993.

2876 Sec. 30. Section 38a-479aa of the general statutes is repealed and the
2877 following is substituted in lieu thereof (*Effective July 1, 2011*):

2878 (a) As used in this part and subsection (b) of section 20-138b:

2879 (1) "Covered benefits" means health care services to which an
2880 enrollee is entitled under the terms of a managed care plan;

2881 (2) "Enrollee" means an individual who is eligible to receive health
2882 care services through a preferred provider network;

2883 (3) "Health care services" means health care related services or
2884 products rendered or sold by a provider within the scope of the
2885 provider's license or legal authorization, and includes hospital,
2886 medical, surgical, dental, vision and pharmaceutical services or

2887 products;

2888 (4) "Managed care organization" means (A) a managed care
2889 organization, as defined in section 38a-478, (B) any other health
2890 insurer, or (C) a reinsurer with respect to health insurance;

2891 (5) "Managed care plan" means a managed care plan, as defined in
2892 section 38a-478;

2893 (6) "Person" means an individual, agency, political subdivision,
2894 partnership, corporation, limited liability company, association or any
2895 other entity;

2896 (7) "Preferred provider network" means a person, which is not a
2897 managed care organization, but which pays claims for the delivery of
2898 health care services, accepts financial risk for the delivery of health
2899 care services and establishes, operates or maintains an arrangement or
2900 contract with providers relating to (A) the health care services
2901 rendered by the providers, and (B) the amounts to be paid to the
2902 providers for such services. "Preferred provider network" does not
2903 include (i) a workers' compensation preferred provider organization
2904 established pursuant to section 31-279-10 of the regulations of
2905 Connecticut state agencies, (ii) an independent practice association or
2906 physician hospital organization whose primary function is to contract
2907 with insurers and provide services to providers, (iii) a clinical
2908 laboratory, licensed pursuant to section 19a-30, whose primary
2909 payments for any contracted or referred services are made to other
2910 licensed clinical laboratories or for associated pathology services, or
2911 (iv) a pharmacy benefits manager responsible for administering
2912 pharmacy claims whose primary function is to administer the
2913 pharmacy benefit on behalf of a health benefit plan;

2914 (8) "Provider" means an individual or entity duly licensed or legally
2915 authorized to provide health care services; and

2916 (9) "Commissioner" means the Insurance Commissioner.

2917 (b) On and after May 1, 2004, no preferred provider network may
2918 enter into or renew a contractual relationship with a managed care
2919 organization unless the preferred provider network is licensed by the
2920 commissioner. On and after May 1, 2005, no preferred provider
2921 network may conduct business in this state unless it is licensed by the
2922 commissioner. Any person seeking to obtain or renew a license shall
2923 submit an application to the commissioner, on such form as the
2924 commissioner may prescribe, and shall include the filing described in
2925 this subsection, except that a person seeking to renew a license may
2926 submit only the information necessary to update its previous filing.
2927 Applications shall be submitted by March first of each year in order to
2928 qualify for the May first license issue or renewal date. The filing
2929 required from such preferred provider network shall include the
2930 following information: (1) The identity of the preferred provider
2931 network and any company or organization controlling the operation of
2932 the preferred provider network, including the name, business address,
2933 contact person, a description of the controlling company or
2934 organization and, where applicable, the following: (A) A certificate
2935 from the Secretary of the State regarding the preferred provider
2936 network's and the controlling company's or organization's good
2937 standing to do business in the state; (B) a copy of the preferred
2938 provider network's and the controlling company's or organization's
2939 financial statement completed in accordance with sections 38a-53 and
2940 38a-54, as applicable, for the end of its most recently concluded fiscal
2941 year, along with the name and address of any public accounting firm
2942 or internal accountant which prepared or assisted in the preparation of
2943 such financial statement; (C) a list of the names, official positions and
2944 occupations of members of the preferred provider network's and the
2945 controlling company's or organization's board of directors or other
2946 policy-making body and of those executive officers who are
2947 responsible for the preferred provider network's and controlling
2948 company's or organization's activities with respect to the health care
2949 services network; (D) a list of the preferred provider network's and the
2950 controlling company's or organization's principal owners; (E) in the

2951 case of an out-of-state preferred provider network, controlling
2952 company or organization, a certificate that such preferred provider
2953 network, company or organization is in good standing in its state of
2954 organization; (F) in the case of a Connecticut or out-of-state preferred
2955 provider network, controlling company or organization, a report of the
2956 details of any suspension, sanction or other disciplinary action relating
2957 to such preferred provider network, or controlling company or
2958 organization in this state or in any other state; and (G) the identity,
2959 address and current relationship of any related or predecessor
2960 controlling company or organization. For purposes of this
2961 subparagraph, "related" means that a substantial number of the board
2962 or policy-making body members, executive officers or principal
2963 owners of both companies are the same; (2) a general description of the
2964 preferred provider network and participation in the preferred provider
2965 network, including: (A) The geographical service area of and the
2966 names of the hospitals included in the preferred provider network; (B)
2967 the primary care physicians, the specialty physicians, any other
2968 contracting providers and the number and percentage of each group's
2969 capacity to accept new patients; (C) a list of all entities on whose behalf
2970 the preferred provider network has contracts or agreements to provide
2971 health care services; (D) a table listing all major categories of health
2972 care services provided by the preferred provider network; (E) an
2973 approximate number of total enrollees served in all of the preferred
2974 provider network's contracts or agreements; (F) a list of subcontractors
2975 of the preferred provider network, not including individual
2976 participating providers, that assume financial risk from the preferred
2977 provider network and to what extent each subcontractor assumes
2978 financial risk; (G) a contingency plan describing how contracted health
2979 care services will be provided in the event of insolvency; and (H) any
2980 other information requested by the commissioner; and (3) the name
2981 and address of the person to whom applications may be made for
2982 participation.

2983 (c) Any person developing a preferred provider network, or
2984 expanding a preferred provider network into a new county, pursuant

2985 to this section and subsection (b) of section 20-138b, shall publish a
2986 notice, in at least one newspaper having a substantial circulation in the
2987 service area in which the preferred provider network operates or will
2988 operate, indicating such planned development or expansion. Such
2989 notice shall include the medical specialties included in the preferred
2990 provider network, the name and address of the person to whom
2991 applications may be made for participation and a time frame for
2992 making application. The preferred provider network shall provide the
2993 applicant with written acknowledgment of receipt of the application.
2994 Each complete application shall be considered by the preferred
2995 provider network in a timely manner.

2996 (d) (1) Each preferred provider network shall file with the
2997 commissioner and make available upon request from a provider the
2998 general criteria for its selection or termination of providers. Disclosure
2999 shall not be required of criteria deemed by the preferred provider
3000 network to be of a proprietary or competitive nature that would hurt
3001 the preferred provider network's ability to compete or to manage
3002 health care services. For purposes of this section, criteria is of a
3003 proprietary or competitive nature if it has the tendency to cause
3004 providers to alter their practice pattern in a manner that would
3005 circumvent efforts to contain health care costs and criteria is of a
3006 proprietary nature if revealing the criteria would cause the preferred
3007 provider network's competitors to obtain valuable business
3008 information.

3009 (2) If a preferred provider network uses criteria that have not been
3010 filed pursuant to subdivision (1) of this subsection to judge the quality
3011 and cost-effectiveness of a provider's practice under any specific
3012 program within the preferred provider network, the preferred
3013 provider network may not reject or terminate the provider
3014 participating in that program based upon such criteria until the
3015 provider has been informed of the criteria that the provider's practice
3016 fails to meet.

3017 (e) Each preferred provider network shall permit the Insurance
3018 Commissioner to inspect its books and records.

3019 (f) Each preferred provider network shall permit the commissioner
3020 to examine, under oath, any officer or agent of the preferred provider
3021 network or controlling company or organization with respect to the
3022 use of the funds of the preferred provider network, company or
3023 organization, and compliance with (1) the provisions of this part, and
3024 (2) the terms and conditions of its contracts to provide health care
3025 services.

3026 (g) Each preferred provider network shall file with the
3027 commissioner a notice of any material modification of any matter or
3028 document furnished pursuant to this part, and shall include such
3029 supporting documents as are necessary to explain the modification.

3030 (h) Each preferred provider network shall maintain a minimum net
3031 worth of either (1) the greater of (A) two hundred fifty thousand
3032 dollars, or (B) an amount equal to eight per cent of its annual
3033 expenditures as reported on its most recent financial statement
3034 completed and filed with the commissioner in accordance with
3035 sections 38a-53 and 38a-54, as applicable, or (2) another amount
3036 determined by the commissioner.

3037 (i) Each preferred provider network shall maintain or arrange for a
3038 letter of credit, bond, surety, reinsurance, reserve or other financial
3039 security acceptable to the commissioner for the exclusive use of paying
3040 any outstanding amounts owed participating providers in the event of
3041 insolvency or nonpayment except that any remaining security may be
3042 used for the purpose of reimbursing managed care organizations in
3043 accordance with subsection (b) of section 38a-479bb. Such outstanding
3044 amount shall be at least an amount equal to the greater of (1) an
3045 amount sufficient to make payments to participating providers for two
3046 months determined on the basis of the two months within the past
3047 year with the greatest amounts owed by the preferred provider
3048 network to participating providers, (2) the actual outstanding amount

3049 owed by the preferred provider network to participating providers, or
3050 (3) another amount determined by the commissioner. Such amount
3051 may be credited against the preferred provider network's minimum
3052 net worth requirements set forth in subsection (h) of this section. The
3053 commissioner shall review such security amount and calculation on a
3054 quarterly basis.

3055 (j) Each preferred provider network shall pay the applicable license
3056 or renewal fee specified in section 38a-11. The commissioner shall use
3057 the amount of such fees solely for the purpose of regulating preferred
3058 provider networks.

3059 (k) In no event, including, but not limited to, nonpayment by the
3060 managed care organization, insolvency of the managed care
3061 organization, or breach of contract between the managed care
3062 organization and the preferred provider network, shall a preferred
3063 provider network bill, charge, collect a deposit from, seek
3064 compensation, remuneration or reimbursement from, or have any
3065 recourse against an enrollee or an enrollee's designee, other than the
3066 managed care organization, for covered benefits provided, except that
3067 the preferred provider network may collect any copayments,
3068 deductibles or other out-of-pocket expenses that the enrollee is
3069 required to pay pursuant to the managed care plan.

3070 (l) Each contract or agreement between a preferred provider
3071 network and a participating provider shall contain a provision that if
3072 the preferred provider network fails to pay for health care services as
3073 set forth in the contract, the enrollee shall not be liable to the
3074 participating provider for any sums owed by the preferred provider
3075 network or any sums owed by the managed care organization because
3076 of nonpayment by the managed care organization, insolvency of the
3077 managed care organization or breach of contract between the managed
3078 care organization and the preferred provider network.

3079 **[**(m) Each utilization review determination made by or on behalf of
3080 a preferred provider network shall be made in accordance with

3081 sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of
3082 a determination not to certify an admission, service, procedure or
3083 extension of stay shall be conducted in accordance with subdivision (7)
3084 of subsection (a) of section 38a-226c, and any subsequent appeal shall
3085 be referred to the managed care organization on whose behalf the
3086 preferred provider network provides services. The managed care
3087 organization shall conduct the subsequent appeal in accordance with
3088 said subdivision.**]**

3089 **[**(n)**]** (m) The requirements of subsections (h) and (i) of this section
3090 shall not apply to a consortium of federally qualified health centers
3091 funded by the state, providing services only to recipients of programs
3092 administered by the Department of Social Services. The Commissioner
3093 of Social Services shall adopt regulations, in accordance with chapter
3094 54, to establish criteria to certify any such federally qualified health
3095 center, including, but not limited to, minimum reserve fund
3096 requirements.

3097 Sec. 31. Subsection (d) of section 38a-479bb of the general statutes is
3098 repealed and the following is substituted in lieu thereof (*Effective July*
3099 *1, 2011*):

3100 (d) Each managed care organization shall ensure that any contract it
3101 has with a preferred provider network includes:

3102 (1) A provision that requires the preferred provider network to
3103 provide to the managed care organization at the time a contract is
3104 entered into, annually, and upon request of the managed care
3105 organization, (A) the financial statement completed in accordance with
3106 sections 38a-53 and 38a-54, as applicable, and section 38a-479aa; (B)
3107 documentation that satisfies the managed care organization that the
3108 preferred provider network has sufficient ability to accept financial
3109 risk; (C) documentation that satisfies the managed care organization
3110 that the preferred provider network has appropriate management
3111 expertise and infrastructure; (D) documentation that satisfies the
3112 managed care organization that the preferred provider network has an

3113 adequate provider network taking into account the geographic
3114 distribution of enrollees and participating providers and whether
3115 participating providers are accepting new patients; (E) an accurate list
3116 of participating providers; and (F) documentation that satisfies the
3117 managed care organization that the preferred provider network has
3118 the ability to ensure the delivery of health care services as set forth in
3119 the contract;

3120 (2) A provision that requires the preferred provider network to
3121 provide to the managed care organization a quarterly status report that
3122 includes (A) information updating the financial statement completed
3123 in accordance with sections 38a-53 and 38a-54, as applicable, and
3124 section 38a-479aa; (B) a report showing amounts paid to those
3125 providers who provide health care services on behalf of the managed
3126 care organization; (C) an estimate of payments due providers but not
3127 yet reported by providers; (D) amounts owed to providers for that
3128 quarter; and (E) the number of utilization review determinations not to
3129 certify an admission, service, procedure or extension of stay made by
3130 or on behalf of the preferred provider network and the outcome of
3131 such determination on appeal;

3132 (3) A provision that requires the preferred provider network to
3133 provide notice to the managed care organization not later than five
3134 business days after (A) any change involving the ownership structure
3135 of the preferred provider network; (B) financial or operational
3136 concerns arise regarding the financial viability of the preferred
3137 provider network; or (C) the preferred provider network's loss of a
3138 license in this or any other state;

3139 (4) A provision that if the managed care organization fails to pay for
3140 health care services as set forth in the contract, the enrollee will not be
3141 liable to the provider or preferred provider network for any sums
3142 owed by the managed care organization or preferred provider
3143 network;

3144 (5) A provision that the preferred provider network shall include in

3145 all contracts between the preferred provider network and participating
3146 providers a provision that if the preferred provider network fails to
3147 pay for health care services as set forth in the contract, for any reason,
3148 the enrollee shall not be liable to the participating provider or
3149 preferred provider network for any sums owed by the preferred
3150 provider network or any sums owed by the managed care
3151 organization because of nonpayment by the managed care
3152 organization, insolvency of the managed care organization or breach of
3153 contract between the managed care organization and the preferred
3154 provider network;

3155 (6) A provision requiring the preferred provider network to provide
3156 information to the managed care organization, satisfactory to the
3157 managed care organization, regarding the preferred provider
3158 network's reserves for financial risk;

3159 (7) A provision that (A) the preferred provider network or managed
3160 care organization shall post and maintain a letter of credit, bond,
3161 surety, reinsurance, reserve or other financial security acceptable to the
3162 commissioner, in order to satisfy the risk accepted by the preferred
3163 provider network pursuant to the contract, in an amount calculated in
3164 accordance with subsection (i) of section 38a-479aa, (B) the managed
3165 care organization shall determine who posts and maintains the
3166 security required under subparagraph (A) of this subdivision, and (C)
3167 in the event of insolvency or nonpayment, such security shall be used
3168 by the preferred provider network, or other entity designated by the
3169 commissioner, solely for the purpose of paying any outstanding
3170 amounts owed participating providers, except that any remaining
3171 security may be used for the purpose of reimbursing the managed care
3172 organization for any payments made by the managed care
3173 organization to participating providers on behalf of the preferred
3174 provider network;

3175 (8) A provision under which the managed care organization is
3176 permitted, at the discretion of the managed care organization, to pay

3177 participating providers directly and in lieu of the preferred provider
3178 network in the event of insolvency or mismanagement by the
3179 preferred provider network and that payments made pursuant to this
3180 subdivision may be made or reimbursed from the security posted
3181 pursuant to subsection (b) of this section;

3182 (9) A provision transferring and assigning contracts between the
3183 preferred provider network and participating providers to the
3184 managed care organization for the provision of future services by
3185 participating providers to enrollees, at the discretion of the managed
3186 care organization, in the event the preferred provider network (A)
3187 becomes insolvent, (B) otherwise ceases to conduct business, as
3188 determined by the commissioner, or (C) demonstrates a pattern of
3189 nonpayment of authorized claims, as determined by the commissioner,
3190 for a period in excess of ninety days;

3191 (10) A provision that each contract or agreement between the
3192 preferred provider network and participating providers shall include a
3193 provision transferring and assigning contracts between the preferred
3194 provider network and participating providers to the managed care
3195 organization for the provision of future health care 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; and

3202 (11) A provision that the preferred provider network shall pay for
3203 the delivery of health care services and operate or maintain
3204 arrangements or contracts with providers in a manner consistent with
3205 the provisions of law that apply to the managed care organization's
3206 contracts with enrollees and providers. **[**; and**]**

3207 **[**(12) A provision that the preferred provider network shall ensure
3208 that utilization review determinations are made in accordance with

3209 sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of
3210 a determination not to certify an admission, service, procedure or
3211 extension of stay shall be made in accordance with subdivision (7) of
3212 subsection (a) of section 38a-226c. In cases where an appeal to reverse a
3213 determination not to certify is unsuccessful, the preferred provider
3214 network shall refer the case to the managed care organization which
3215 shall conduct the subsequent appeal, if any, in accordance with said
3216 subdivision.**]**

3217 Sec. 32. Section 38a-479ee of the general statutes is repealed and the
3218 following is substituted in lieu thereof (*Effective July 1, 2011*):

3219 (a) If the Insurance Commissioner determines that a preferred
3220 provider network or managed care organization, or both, has not
3221 complied with any applicable provision of this part **[**, sections 38a-226
3222 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as
3223 amended by this act, the commissioner may (1) order the preferred
3224 provider network or managed care organization, or both if both have
3225 not complied, to cease and desist all operations in violation of this part
3226 or said sections; (2) terminate or suspend the preferred provider
3227 network's license; (3) institute a corrective action against the preferred
3228 provider network or managed care organization, or both if both have
3229 not complied; (4) order the payment of a civil penalty by the preferred
3230 provider network or managed care organization, or both if both have
3231 not complied, of not more than one thousand dollars for each and
3232 every act or violation; (5) order the payment of such reasonable
3233 expenses as may be necessary to compensate the commissioner in
3234 conjunction with any proceedings held to investigate or enforce
3235 violations of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or
3236 sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6)
3237 use any of the commissioner's other enforcement powers to obtain
3238 compliance with this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or
3239 sections 38a-815 to 38a-819, inclusive, as amended by this act. The
3240 commissioner may hold a hearing concerning any matter governed by
3241 this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815

3242 to 38a-819, inclusive, as amended by this act, in accordance with
3243 section 38a-16. Subject to the same confidentiality and liability
3244 protections set forth in subsections (c) and (k) of section 38a-14, the
3245 commissioner may engage the services of attorneys, appraisers,
3246 independent actuaries, independent certified public accountants or
3247 other professionals and specialists to assist the commissioner in
3248 conducting an investigation under this section, the cost of which shall
3249 be borne by the managed care organization or preferred provider
3250 network, or both, that is the subject of the investigation.

3251 (b) If a preferred provider network fails to comply with any
3252 applicable provision of this part [, sections 38a-226 to 38a-226d,
3253 inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended by this
3254 act, the commissioner may assign or require the preferred provider
3255 network to assign its rights and obligations under any contract with
3256 participating providers in order to ensure that covered benefits are
3257 provided.

3258 (c) The commissioner shall receive and investigate (1) any grievance
3259 filed against a preferred provider network or managed care
3260 organization, or both, by an enrollee or an enrollee's designee
3261 concerning matters governed by this part [, sections 38a-226 to 38a-
3262 226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended
3263 by this act, or (2) any referral from the Office of the Healthcare
3264 Advocate pursuant to section 38a-1041. The commissioner shall code,
3265 track and review such grievances and referrals. The preferred provider
3266 network or managed care organization, or both, shall provide the
3267 commissioner with all information necessary for the commissioner to
3268 investigate such grievances and referrals. The information collected by
3269 the commissioner pursuant to this section shall be maintained as
3270 confidential and shall not be disclosed to any person except (A) to the
3271 extent necessary to carry out the purposes of this part [, sections 38a-
3272 226 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
3273 amended by this act, (B) as allowed under this title, (C) to the
3274 Healthcare Advocate, and (D) information concerning the nature of

3275 any grievance or referral and the commissioner's final determination
3276 shall be a public record, as defined in section 1-200, provided no
3277 personal information, as defined in section 38a-975, shall be disclosed.
3278 The commissioner shall report to the Healthcare Advocate on the
3279 resolution of any matter referred to the commissioner by the
3280 Healthcare Advocate.

3281 Sec. 33. Section 38a-479ff of the general statutes is repealed and the
3282 following is substituted in lieu thereof (*Effective July 1, 2011*):

3283 No health insurer, health care center, utilization review company, as
3284 defined in section 38a-226, as amended by this act, or preferred
3285 provider network, as defined in section 38a-479aa, as amended by this
3286 act, shall take or threaten to take any adverse personnel or coverage-
3287 related action against any enrollee, provider or employee in retaliation
3288 for such enrollee, provider or employee (1) filing a complaint with the
3289 Insurance Commissioner or the Office of the Healthcare Advocate, or
3290 (2) disclosing information to the Insurance Commissioner concerning
3291 any violation of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or
3292 sections 38a-815 to 38a-819, inclusive, as amended by this act, unless
3293 such disclosure violates the provisions of chapter 705 or the privacy
3294 provisions of the federal Health Insurance Portability and
3295 Accountability Act of 1996, **[**(P.L. 104-191) (HIPAA)**]** P.L. 104-191, as
3296 amended from time to time, or regulations adopted thereunder. Any
3297 enrollee, provider or employee who is aggrieved by a violation of this
3298 section may bring a civil action in the Superior Court to recover
3299 damages and attorneys' fees and costs.

3300 Sec. 34. Section 38a-483c of the general statutes is repealed and the
3301 following is substituted in lieu thereof (*Effective July 1, 2011*):

3302 (a) Each individual health insurance policy delivered, issued for
3303 delivery, renewed, amended or continued in this state on or after
3304 January 1, 2000, shall define the extent to which it provides coverage
3305 for experimental treatments.

3306 (b) No such health insurance policy may deny a procedure,
3307 treatment or the use of any drug as experimental if such procedure,
3308 treatment or drug, for the illness or condition being treated, or for the
3309 diagnosis for which it is being prescribed, has successfully completed a
3310 phase III clinical trial of the federal Food and Drug Administration.

3311 (c) Any person who has been diagnosed with a condition that
3312 creates a life expectancy in that person of less than two years and who
3313 has been denied an otherwise covered procedure, treatment or drug
3314 on the grounds that it is experimental may request an expedited
3315 appeal as provided in **[**section 38a-226c**]** sections 7 and 8 of this act and
3316 may appeal a denial thereof to the Insurance Commissioner in
3317 accordance with the procedures established in **[**section 38a-478n**]**
3318 sections 9 to 11, inclusive, of this act.

3319 **[**(d) For the purposes of conducting an appeal pursuant to section
3320 38a-478n on the grounds that an otherwise covered procedure,
3321 treatment or drug is experimental, the basis of such an appeal shall be
3322 the medical efficacy of such procedure, treatment or drug. The entity
3323 conducting the review may consider whether the procedure, treatment
3324 or drug (1) has been approved by the National Institute of Health or
3325 the American Medical Association, (2) is listed in the United States
3326 Pharmacopoeia Drug Information Guide for Health Care Professionals
3327 (USP-DI), the American Medical Association Drug Evaluations (AMA-
3328 DE), or the American Society of Hospital Pharmacists' American
3329 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
3330 currently in a phase III clinical trial of the federal Food and Drug
3331 Administration.**]**

3332 Sec. 35. Section 38a-513b of the general statutes is repealed and the
3333 following is substituted in lieu thereof (*Effective July 1, 2011*):

3334 (a) Each group health insurance policy delivered, issued for
3335 delivery, renewed, amended or continued in this state on or after
3336 January 1, 2000, shall define the extent to which it provides coverage
3337 for experimental treatments.

3338 (b) No such health insurance policy may deny a procedure,
3339 treatment or the use of any drug as experimental if such procedure,
3340 treatment or drug, for the illness or condition being treated, or for the
3341 diagnosis for which it is being prescribed, has successfully completed a
3342 phase III clinical trial of the federal Food and Drug Administration.

3343 (c) Any person who has been diagnosed with a condition that
3344 creates a life expectancy in that person of less than two years and who
3345 has been denied an otherwise covered procedure, treatment or drug on
3346 the grounds that it is experimental may request an expedited appeal as
3347 provided in **[**section 38a-226c**]** sections 7 and 8 of this act and may
3348 appeal a denial thereof to the Insurance Commissioner in accordance
3349 with the procedures established in **[**section 38a-478n**]** sections 9 to 11,
3350 inclusive, of this act.

3351 **[**(d) For the purposes of conducting an appeal pursuant to section
3352 38a-478n on the grounds that an otherwise covered procedure,
3353 treatment or drug is experimental, the basis of such an appeal shall be
3354 the medical efficacy of such procedure, treatment or drug. The entity
3355 conducting the review may consider whether the procedure, treatment
3356 or drug (1) has been approved by the National Institute of Health or
3357 the American Medical Association, (2) is listed in the United States
3358 Pharmacopoeia Drug Information Guide for Health Care Professionals
3359 (USP-DI), the American Medical Association Drug Evaluations (AMA-
3360 DE), or the American Society of Hospital Pharmacists' American
3361 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
3362 currently in a phase III clinical trial of the federal Food and Drug
3363 Administration.**]**

3364 Sec. 36. Subsection (c) of section 38a-504f of the general statutes is
3365 repealed and the following is substituted in lieu thereof (*Effective July*
3366 *1, 2011*):

3367 (c) The insured, or the provider with the insured's written consent,
3368 may appeal any denial of coverage for medical necessity to an external,
3369 independent review pursuant to **[**section 38a-478n**]** sections 9 to 11,

3370 inclusive, of this act. Such external review shall be conducted by a
3371 properly qualified review agent whom the department has determined
3372 does not have a conflict of interest regarding the cancer clinical trial.

3373 Sec. 37. Subsection (c) of section 38a-542f of the general statutes is
3374 repealed and the following is substituted in lieu thereof (*Effective July*
3375 *1, 2011*):

3376 (c) The insured, or the provider with the insured's written consent,
3377 may appeal any denial of coverage for medical necessity to an external,
3378 independent review pursuant to **[**section 38a-478n**]** sections 9 to 11,
3379 inclusive, of this act. Such external review shall be conducted by a
3380 properly qualified review agent whom the department has determined
3381 does not have a conflict of interest regarding the cancer clinical trial.

3382 Sec. 38. Subdivision (22) of section 38a-816 of the general statutes is
3383 repealed and the following is substituted in lieu thereof (*Effective July*
3384 *1, 2011*):

3385 (22) Any violation of **[**section 38a-478m**]** sections 5 to 8, inclusive, of
3386 this act.

3387 Sec. 39. Subdivision (3) of section 38a-1040 of the general statutes is
3388 repealed and the following is substituted in lieu thereof (*Effective July*
3389 *1, 2011*):

3390 (3) "Managed care plan" means a product offered by a managed care
3391 organization that provides for the financing or delivery of health care
3392 services to persons enrolled in the plan through: (A) Arrangements
3393 with selected providers to furnish health care services; (B) explicit
3394 standards for the selection of participating providers; (C) financial
3395 incentives for enrollees to use the participating providers and
3396 procedures provided for by the plan; or (D) arrangements that share
3397 risks with providers, provided the organization offering a plan
3398 described under subparagraph (A), (B), (C) or (D) of this subdivision is
3399 licensed by the Insurance Department pursuant to chapter 698, 698a or

3400 700 and that the plan includes utilization review, [pursuant to sections
3401 38a-226 to 38a-226d, inclusive] as defined in section 38a-226, as
3402 amended by this act.

3403 Sec. 40. Subsections (b) and (c) of section 38a-1041 of the general
3404 statutes are repealed and the following is substituted in lieu thereof
3405 (*Effective July 1, 2011*):

3406 (b) The Office of the Healthcare Advocate may:

3407 (1) Assist health insurance consumers with managed care plan
3408 selection by providing information, referral and assistance to
3409 individuals about means of obtaining health insurance coverage and
3410 services;

3411 (2) Assist health insurance consumers to understand their rights and
3412 responsibilities under managed care plans;

3413 (3) Provide information to the public, agencies, legislators and
3414 others regarding problems and concerns of health insurance
3415 consumers and make recommendations for resolving those problems
3416 and concerns;

3417 (4) Assist consumers with the filing of complaints and appeals,
3418 including filing appeals with a managed care organization's internal
3419 appeal or grievance process and the external appeal process
3420 established under [section 38a-478n] sections 5 to 11, inclusive, of this
3421 act;

3422 (5) Analyze and monitor the development and implementation of
3423 federal, state and local laws, regulations and policies relating to health
3424 insurance consumers and recommend changes it deems necessary;

3425 (6) Facilitate public comment on laws, regulations and policies,
3426 including policies and actions of health insurers;

3427 (7) Ensure that health insurance consumers have timely access to the

3428 services provided by the office;

3429 (8) Review the health insurance records of a consumer who has
3430 provided written consent for such review;

3431 (9) Create and make available to employers a notice, suitable for
3432 posting in the workplace, concerning the services that the Healthcare
3433 Advocate provides;

3434 (10) Establish a toll-free number, or any other free calling option, to
3435 allow customer access to the services provided by the Healthcare
3436 Advocate;

3437 (11) Pursue administrative remedies on behalf of and with the
3438 consent of any health insurance consumers;

3439 (12) Adopt regulations, pursuant to chapter 54, to carry out the
3440 provisions of sections 38a-1040 to 38a-1050, inclusive; and

3441 (13) Take any other actions necessary to fulfill the purposes of
3442 sections 38a-1040 to 38a-1050, inclusive.

3443 (c) The Office of the Healthcare Advocate shall make a referral to
3444 the Insurance Commissioner if the Healthcare Advocate finds that a
3445 preferred provider network may have engaged in a pattern or practice
3446 that may be in violation of sections **[**38a-226 to 38a-226d, inclusive,**]**
3447 38a-479aa to 38a-479gg, inclusive, <u>as amended by this act,</u> or 38a-815 to
3448 38a-819, inclusive<u>, as amended by this act</u>.

3449 Sec. 41. Sections 38a-478m, 38a-478n and 38a-478p of the general
3450 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	*July 1, 2011*	New section
Sec. 7	*July 1, 2011*	New section
Sec. 8	*July 1, 2011*	New section
Sec. 9	*July 1, 2011*	New section
Sec. 10	*July 1, 2011*	New section
Sec. 11	*July 1, 2011*	New section
Sec. 12	*July 1, 2011*	New section
Sec. 13	*July 1, 2011*	New section
Sec. 14	*July 1, 2011*	38a-226
Sec. 15	*July 1, 2011*	38a-226a
Sec. 16	*July 1, 2011*	38a-226b
Sec. 17	*July 1, 2011*	38a-226c
Sec. 18	*July 1, 2011*	38a-226d
Sec. 19	*July 1, 2011*	38a-11(a)
Sec. 20	*July 1, 2011*	38a-478
Sec. 21	*July 1, 2011*	38a-19(c)
Sec. 22	*July 1, 2011*	38a-477b(b)
Sec. 23	*July 1, 2011*	38a-478a
Sec. 24	*July 1, 2011*	38a-478b
Sec. 25	*July 1, 2011*	38a-478h
Sec. 26	*July 1, 2011*	38a-478r(d)
Sec. 27	*July 1, 2011*	38a-478s
Sec. 28	*July 1, 2011*	38a-478t
Sec. 29	*July 1, 2011*	38a-478u
Sec. 30	*July 1, 2011*	38a-479aa
Sec. 31	*July 1, 2011*	38a-479bb(d)
Sec. 32	*July 1, 2011*	38a-479ee
Sec. 33	*July 1, 2011*	38a-479ff
Sec. 34	*July 1, 2011*	38a-483c
Sec. 35	*July 1, 2011*	38a-513b
Sec. 36	*July 1, 2011*	38a-504f(c)
Sec. 37	*July 1, 2011*	38a-542f(c)
Sec. 38	*July 1, 2011*	38a-816(22)
Sec. 39	*July 1, 2011*	38a-1040(3)
Sec. 40	*July 1, 2011*	38a-1041(b) and (c)
Sec. 41	*July 1, 2011*	Repealer section

INS	*Joint Favorable Subst.-LCO*
JUD	*Joint Favorable*