

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 11-58—sHB 6308

Insurance and Real Estate Committee

Labor and Public Employees Committee

Planning and Development Committee

Appropriations Committee

Finance, Revenue and Bonding Committee

Government Administration and Elections Committee

AN ACT CONCERNING HEALTHCARE REFORM

SUMMARY: This act:

1. requires the comptroller to offer employee and retiree coverage under “partnership plans” to (a) nonstate public employers beginning January 1, 2012 and (b) nonprofit employers beginning January 1, 2013 (§§ 1-8);
2. requires certain municipal employers that sponsor fully insured group health insurance policies or plans for their active employees and retirees to submit, by October 1 annually, certain information to the comptroller (§ 9);
3. allows municipal employers to give certain claims data they request from health insurers to the comptroller upon his request and requires that the information be kept confidential (§ 10);
4. establishes the (a) Office of Health Reform and Innovation (OHRI) (§ 11) and (b) SustiNet Health Care Cabinet in the lieutenant governor’s office (§ 14);
5. requires OHRI to convene a working group concerning a statewide multipayer data initiative (§ 13);
6. requires (a) hospitals to submit patient-identifiable and emergency department data to the Office of Health Care Access (OHCA) which must keep it confidential, (b) certain facilities providing outpatient services to provide data to OHCA, and (c) OHCA to convene a working group addressing patient-identifiable data reporting in the outpatient setting (§ 12);
7. makes a variety of changes in laws relating to contracts between health care providers and health insurers (§§ 15-19);
8. requires the Insurance Department to license and regulate third-party administrators (TPA) (§§ 20-36);
9. changes various health insurance statutes to conform with the 2010 federal Patient Protection and Affordable Care Act (PPACA), including covering dependents until age 26, not denying coverage to children under age 19 because of preexisting conditions, and eliminating lifetime benefit maximums (§§ 37-53); and
10. revises the health insurance utilization review, grievance, and external appeal statutes to comply with the PPACA (§§ 54-89).

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EFFECTIVE DATE: Various, see below.

§ 1 — DEFINITIONS

The act defines terms used throughout §§ 1-8. It defines “nonstate public employer” as a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library. A municipality and a board of education may be considered separate employers. A “nonstate public employee” is an employee or elected officer of a nonstate public employer.

A “nonprofit employer” is a (1) nonprofit corporation organized under federal law (26 USC 501) that (a) has a purchase of service contract or (b) receives 50% or more of its gross annual revenue from government grants or funding or (2) tax-exempt labor or agricultural organization under federal law (26 USC 501(c)(5)).

A “partnership plan” is a health care benefit plan offered by the comptroller to nonstate public employers or nonprofit employers under the act.

EFFECTIVE DATE: July 1, 2011

§ 2 — PARTNERSHIP PLANS

The act requires the comptroller to offer coverage under a partnership plan to certain employer groups that submit an application that is approved under the act’s provisions. He must offer coverage to:

1. nonstate public employers and their retirees beginning January 1, 2012 and
2. nonprofit employers and their retirees beginning January 1, 2013.

The act specifies that the comptroller does not have to offer coverage from every partnership plan offered to every employer. It allows the comptroller to offer partnership plans on a fully-insured or risk-pooled basis at his discretion. Any insurer, health maintenance organization (HMO), or entity with which he contracts and any fully insured plan offered is subject to state insurance laws.

Coverage Term, Renewal, and Withdrawal

In order for an employer group to participate in a partnership plan, the group must agree to benefit periods lasting at least two years. An employer may apply for renewal before the end of each benefit period.

The act requires the comptroller to develop procedures for an employer group to (1) apply to participate in the plan, (2) apply for renewal, and (3) withdraw from participation. The procedures must include the terms and conditions (1) under which a group can withdraw before the benefit period ends and (2) on how to obtain a refund for any unearned premiums paid or premium equivalent payments made in excess of incurred claims. The procedures must provide that nonstate public employees covered under a collective bargaining agreement must withdraw in accordance with any applicable state collective bargaining laws for municipal employees and teachers.

The act allows the comptroller to collect payments and fees for unreported claims and expenses.

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Open Enrollment

Under the act, initial open enrollment for nonstate public employers must be for coverage that begins July 1, 2012, and subsequent enrollment periods must begin each July 1. Initial open enrollment for nonprofit employers must be for coverage beginning January 1, 2013. Subsequent enrollment periods must begin each July 1 and January 1.

Application Form

The act requires the comptroller to create an application for employer groups seeking coverage under a partnership plan and for renewal of such plans. The employer must disclose in the application whether it will offer any other plan to the employees offered the partnership plan.

Taft-Hartley Exception

The act prohibits an employee from enrolling in a partnership plan if he or she is covered through his or her employer under a health insurance plan or arrangement issued to, or in accordance with, a trust established through collective bargaining under the federal Labor Management Relations Act (i.e., the Taft-Hartley Act).

Status as a Governmental Health Plan Under Federal ERISA

The act requires the comptroller to take any necessary actions to ensure that providing coverage to an employer under a partnership plan will not affect the state employee health plan's status as a "governmental plan" under the federal Employee Retirement Income Security Act (ERISA) (see BACKGROUND). ERISA sets certain fiduciary and disclosure standards for private-sector health plans and exempts governmental plans from these requirements.

The act authorizes the comptroller to cancel an employer's coverage with notice and stop accepting applications from nonprofit employers if he determines that providing this coverage affects the state plan's ERISA status. He must create the form and time frame for the cancellation notice.

The comptroller must resume accepting applications from these employers if he determines that granting them coverage will not affect the state employee plan's ERISA status. The act does not set criteria for these decisions.

The comptroller must publicly announce any decision to discontinue or resume (1) coverage or (2) accepting applications under a partnership plan.

Patient-Centered Medical Homes and Claims Data

The act requires the comptroller to consult with the Health Care Cost Containment Committee (HCCCC) to:

1. develop and implement patient-centered medical homes for the state employee plan and partnership plans that will reduce these plans' costs and
2. review claims data for these plans to target high-cost health care providers and medical conditions and monitor costly trends.

EFFECTIVE DATE: July 1, 2011

§ 3 — EMPLOYER GROUP PARTICIPATION

Permissive and Mandatory Collective Bargaining for Nonstate Public Employers

The act makes a nonstate public employer group's initial and continuing participation in a partnership plan a permissive subject of collective bargaining. If the union and the employer sign a written agreement to bargain over the participation, then the decision to join the plan is subject to binding arbitration.

Application and Decision Process for All Eligible Employers

The act establishes two different processes for determining whether a nonstate public or nonprofit employer group's application for coverage will be accepted, depending on whether the application covers all or some of the employees.

If the application covers all employees, the act requires the comptroller to accept the application for the next enrollment period, based on the partnership plan's applicable terms and conditions. The comptroller must give the employer written notice of when coverage begins, pending the employer's acceptance of the plan's terms and conditions. But if the application covers only some employees or it indicates the employer will offer other health plans to employees offered the partnership plan, the comptroller must forward the application to a health care actuary within five days of receiving it.

Within 60 days of receiving an application from the comptroller, the actuary must determine whether it will shift a significant part of the employer group's medical risks to the partnership plan. (The act does not define the term "significant.") If so, the actuary must provide this in writing to the comptroller and include the specific reasons for the decision and the information relied upon in making it.

Under the act, if the comptroller receives a significant risk shift finding from the actuary, he must deny the application and give the employer and HCCCC written notice that includes specific reasons for denial. If the actuary's finding does not indicate such a shift, the comptroller must accept the application and give the employer written notice of when coverage begins, pending the employer's acceptance of the plan's terms and conditions.

The act requires the comptroller to consult with a health care actuary to develop actuarial standards for (1) assessing the shift in medical risks of an employer's employees and retirees to the partnership plan and (2) determining the administrative and fluctuating reserve fees and the premium amounts or premium equivalent payments needed to cover anticipated claims and claim reserves. The comptroller must present the standards to the HCCCC for its review, evaluation, and approval before the standards are used. (Presumably the comptroller will contract with an actuary for these services although the act does not specify this.)

Exceptions to Actuarial Review

The act prohibits the comptroller from forwarding to the actuary an application that proposes to cover fewer than all employees because (1) the

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employer will not cover temporary, part-time, or durational employees or (2) individual employees decline coverage.

Regulations Regarding Actuarial Review

The act authorizes the comptroller to adopt regulations establishing procedures for the reviews and the standards used in them.

EFFECTIVE DATE: July 1, 2011

§ 4 — RETIREES

Employer groups whose applications for coverage under a partnership plan are accepted also may seek coverage for their retirees. The act states that Sections one to 14 do not diminish any right to retiree health insurance under a collective bargaining agreement or state law.

The act requires the employer to remit premiums for retirees' coverage to the comptroller in accordance with its provisions.

Application and Decision Process

The application process and decision notice requirements with respect to covering an employer's retirees, including actuarial review if the employer proposes to cover fewer than all retirees (even if it covers all employees), is the same as for employees (described in § 3 above).

Exceptions to Actuarial Review

The act prohibits the comptroller from forwarding an application to the actuary when the only retirees an employer excludes from the proposed coverage are those who (1) decline coverage or (2) are Medicare enrollees.

EFFECTIVE DATE: July 1, 2011

§ 5 — PREMIUMS, FEES, COST SHARING, AND PARTNERSHIP ACCOUNT

Premiums

The act requires an employer to pay monthly premiums to the comptroller in an amount he determines for providing coverage for the group's employees and retirees.

It permits an employer to require a covered employee or retiree to pay part of the coverage cost, subject to any applicable collective bargaining agreement.

Administrative Fee, Fluctuating Reserves Fee, and Employee Contribution

The act authorizes the comptroller to charge employers an administrative fee calculated on a per member, per month basis. In addition, the comptroller is authorized to charge a fluctuating reserves fee that he deems necessary to ensure an adequate claims reserve. He must do this in accordance with the actuarial standards developed in consultation with the HCCCC.

Penalties for Late Payment of Premiums

Interest. If an employer does not pay its premiums by the 10th day after the due date, the act requires the employer to pay interest, retroactive to the due date, at the prevailing rate the comptroller determines.

State Money Withheld. If a nonstate public employer fails to make premium or premium equivalent payments, the act authorizes the comptroller to direct the state treasurer, or any state officer who holds state money (i.e., grant, allocation, or appropriation) owed the employer, to withhold payment. The money must be withheld until (1) the employer pays the comptroller the past due premiums or premium equivalents and interest or (2) the treasurer or state officer determines that arrangements, satisfactory to the treasurer, have been made for paying the premiums or premium equivalents and interest.

The act prohibits the treasurer or state officer from withholding state money from the group if doing so impedes receiving any federal grant or aid in connection with it.

Terminate Plan Participation. With respect to a (1) nonstate public employer that is not owed state money or from which money is not withheld and (2) nonprofit employer, the act allows the comptroller to terminate the group's participation in the partnership plan for failure to pay premiums or premium equivalents if he gives it at least 10-days' notice. The group can avoid termination by paying premiums or premium equivalents and interest due in full before the termination effective date.

The act allows the comptroller to ask the attorney general to bring an action in Hartford Superior Court to recover any premiums, premium equivalents, and interest owed, or seek equitable relief from a terminated group.

Partnership Plan Premium Account

The act establishes a separate, nonlapsing partnership plan premium account in the General Fund. The comptroller must (1) deposit the premiums collected from employers, employees, and retirees into this account and (2) administer the account to pay claims and administrative fees to entities providing coverage or services under partnership plans.

EFFECTIVE DATE: July 1, 2011

§ 6 — ADVISORY COMMITTEES

Nonstate Public Health Care Advisory Committee

The act establishes a 12-member Nonstate Public Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for nonstate public employees.

The committee consists of three representatives each of (1) municipal employers, (2) municipal employees, (3) board of education employers, and (4) board of education employees. Of the three representatives in each category, one must represent each of the following types of towns: (1) one with 100,000 or more people, (2) one with at least 20,000 but fewer than 100,000 people, and (3) one with fewer than 20,000 people. The comptroller appoints the committee

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members.

Nonprofit Health Care Advisory Committee

The act establishes a six-member Nonprofit Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for nonprofit employees.

The committee consists of three representatives each of (1) nonprofit employers and (2) nonprofit employees. The comptroller appoints the committee members.

EFFECTIVE DATE: July 1, 2011

§ 7 — REGULATIONS

The act authorizes the comptroller to adopt regulations to implement and administer the partnership plans and allows him to implement policies and procedures to administer the plans while adopting the regulations. He must publish notice of intent to adopt the regulations in the *Connecticut Law Journal* within 20 days of implementation. These policies and procedures are valid until the final regulations are adopted.

EFFECTIVE DATE: July 1, 2011

§ 8 — SEBAC CONSENT

The act prohibits the comptroller from offering coverage under the partnership plan until (1) the HCCCC provides the comptroller written approval of the act's provisions and (2) the State Employees Bargaining Agents Coalition (SEBAC) provides the House and Senate clerks written consent to incorporate the act's terms into its collective bargaining agreement. (Presumably, SEBAC's written consent goes to the clerks for legislative action. By law, if the legislature does not act within 30 days, the agreement is deemed approved (CGS § 5-278(b)).)

It specifies that nothing in the act's partnership plan provisions modifies the state employee health plan without the written consent of SEBAC and the Office of Policy and Management (OPM) secretary.

EFFECTIVE DATE: Upon passage

§ 9 — MUNICIPAL HEALTH PLANS

By October 1, 2011, and annually thereafter, the act requires municipal employers of more than 50 people to electronically submit to the comptroller, in a form he prescribes, information for any fully-insured group health plan they sponsor for active employees or retirees covering (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including coverage under an HMO plan; and (5) single-service ancillary health coverage plans, including dental, vision, and prescription drug plans.

The required information is the percentage increase or decrease in group health insurance policy or plan costs in the immediately preceding two policy

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years. To calculate the percentage change, the employer must divide the total premium costs, including any premiums or contributions the employees or retirees paid, by the total number of covered employees and retirees.

Under the act, the covered employers are towns; cities; boroughs; and school, taxing, and fire districts.

EFFECTIVE DATE: July 1, 2011

§ 10 — HEALTH INSURANCE CLAIMS DATA

By law, insurers, health care centers (i.e., HMOs), hospital or medical service corporations, or other entities that deliver, issue, renew, amend, or continue any group health insurance policy in Connecticut that covers (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan, must provide, at the request of a municipal employer with more than 50 employees sponsoring the policy:

1. complete and accurate medical, dental, and pharmaceutical utilization data, as applicable;
2. total claims paid and claims paid by year, practice type, and service category, for in-network and out-of-network providers;
3. premiums the employer paid by month; and
4. the number of people insured under the policy by month and coverage tier, including single, two-person, and family categories.

The act extends the requirement to insurers and entities that deliver, issue, renew, amend, or continue any group health insurance policy covering single-service ancillary health coverage plans, including dental, vision, and prescription drug plans. It requires all the insurers and entities to provide this and the other information free of charge by October 1 annually.

By law, the information provided (1) can be used only to get competitive quotes for group health insurance or promote employee wellness initiatives and (2) is confidential and not subject to disclosure under the Freedom of Information Act (FOIA). The act allows employers to give the information to the comptroller upon request. The comptroller must keep it confidential.

EFFECTIVE DATE: July 1, 2011

§ 12 — OCHA DATA COLLECTION

Hospital Data

By law, hospitals must provide the Office of Health Care Access (OHCA) division of the Department of Public Health (DPH) with hospital discharge and patient billing data. Prior law required OHCA to keep individual patient and billing data confidential, but permitted it to disclose aggregate reports from which individual patient and physician data cannot be identified.

The act instead requires hospitals to submit patient-identifiable inpatient discharge data and emergency department data to OHCA. "Patient-identifiable data" means any information that identifies, or may reasonably be used as a basis to identify, an individual patient, including data from patient medical abstracts

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and bills.

The act allows an intermediary to submit data to OHCA on behalf of a hospital or outpatient surgical facility. (PA 11-61, § 143 instead allows the data to be submitted through a contractual arrangement with an intermediary. The contractual arrangement must (1) comply with the federal Health Insurance Portability and Accountability Act (HIPAA) and (2) ensure that data is submitted accurately and timely.)

Outpatient Data

The act also requires outpatient surgical facilities, hospitals, or facilities providing outpatient surgical services as part of a hospital's outpatient surgery department to provide OHCA with the following: (1) the facility's name, location, and operating hours; (2) the type of facility and services provided; and (3) the total number of clients, treatments, patient visits, and procedures or scans performed in a calendar year.

The act requires OHCA to convene a working group of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations addressing current obstacles to and proposed requirements for patient-identifiable data reporting in the outpatient setting. By February 1, 2012, the working group must report its findings and recommendations to the Public Health and Insurance and Real Estate committees.

The office must begin reporting additional outpatient data it deems necessary by July 1, 2015. By July 1, 2012, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers must provide a progress report to DPH, until all ambulatory surgery centers comply with the implementation of systems that allow for reporting of outpatient data required by DPH. Until such additional reporting requirements take effect, DPH may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives. But the act specifies that DPH cannot assess penalties for failing to submit the data.

Data Confidentiality

Under the act, patient-identifiable data OHCA receives must be kept confidential and is not considered a public record or file subject to disclosure under FOIA. OHCA may release de-identified patient data or aggregate patient data to the public in a manner consistent with HIPAA privacy provisions. The act defines "de-identified patient data" as any information that meets the requirements for de-identification of protected health information under HIPAA. Any de-identified patient data released by OHCA must exclude provider, physician, and payer organization names or codes and be kept confidential by the recipient. OHCA may not release patient-identifiable data except for medical and scientific research purposes as provided under current law (CGS § 19a-25) and regulations. The act prohibits an individual or entity that receives patient-identifiable data from releasing it in any manner that may result in the identification of an individual patient, physician, provider, or payer. OHCA must impose a reasonable, cost-based fee for any patient data provided to a

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nongovernmental entity.

The act requires OHCA, by October 1, 2011, to enter into a memorandum of understanding with the comptroller to allow him access to this data if he agrees in writing to keep confidential individual patient and physician data identified by name or personal identification code. (PA 11-61, § 143, instead requires the comptroller to keep patient and provider data confidential.)

The DPH commissioner must adopt regulations to carry out these provisions, which must be implemented within available appropriations.

EFFECTIVE DATE: July 1, 2011

§§ 11 & 13 — OFFICE OF HEALTH REFORM AND INNOVATION

The act establishes the Office of Health Reform and Innovation (OHRI) within the Office of the Lieutenant Governor. The special advisor to the governor on healthcare reform must direct its activities.

OHRI must:

1. coordinate and implement the state's responsibilities under state and federal health care reform;
2. identify (a) federal grants and other nonstate funding sources to help implement the PPACA and (b) other measures that enhance health care access, reduce costs, and improve the quality of the state's health care;
3. recommend and advance executive action and legislation to effectively and efficiently implement the PPACA and state health care reform initiatives;
4. design processes to maximize stakeholder and public input and ensure transparency in implementing health care reform;
5. ensure information sharing and coordination of efforts with the General Assembly and state agencies concerning public health and health care reform;
6. report on or after January 1, 2012, and annually thereafter, to the Appropriations, Human Services, Insurance and Real Estate, and Public Health committees on state agencies' progress in implementing the PPACA;
7. ensure coordination of efforts with state agencies on the prevention and management of chronic illnesses;
8. ensure state government structures are working together to effectively implement federal and state health care reform;
9. ensure, in consultation with the Connecticut Health Insurance Exchange and Department of Social Services, necessary coordination between the exchange and Medicaid enrollment planning and coordinated efforts among state agencies in order to prevent and manage chronic illnesses; and
10. maximize private philanthropic support to advance health care reform initiatives.

By August 1, 2011, OHRI must consult with the SustiNet Health Care Cabinet established under the act (see § 14) and convene a consumer advisory board with at least seven members.

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OHRI and the Office of the Healthcare Advocate must provide staff support to the cabinet. OHRI must maintain a central comprehensive health reform web site.

The act directs state agencies to use their best efforts to assist OHRI, within available appropriations.

OHRI, in consultation with the Sustinet Health Care Cabinet, may use any consultants necessary to carry out its statutory responsibilities. The office may retain consultants to conduct feasibility and risk assessments required to implement, as may be practicable, private and public mechanisms to provide adequate health insurance products to individuals, small employers, nonstate public employers, municipal-related employers, and nonprofit employers, beginning on January 1, 2014. Not later than October 1, 2012, OHRI and the cabinet must make recommendations to the governor based on the results of analyses.

Multipayer Data Initiative

Under the act, OHRI must convene a working group to develop a plan implementing a state-wide multipayer data initiative to improve the state's use of health care data from multiple sources to increase efficiency, enhance outcomes, and improve the understanding of health care expenditures in the public and private sectors. The group must include the OPM secretary; comptroller; the commissioners of public health, social services, and insurance; health care providers; representatives of health insurance companies; health insurance purchasers; hospitals; and consumer advocates.

OHRI must report on the initiative plan to the Appropriations, Insurance and Real Estate, and Public Health committees.

EFFECTIVE DATE: Upon passage

§ 14 — SUSTINET HEALTH CARE CABINET

The act establishes, within the Office of the Lieutenant Governor, the Sustinet Health Care Cabinet to advise the governor and OHRI on issues specified.

Members and Appointment Process

The 28-member cabinet consists of the following members who must be appointed by August 1, 2011:

1. five appointed by the governor, (a) two representing the health care industry serving four-year terms, (b) one representing community health centers serving three years, (c) one representing insurance producers serving three years, and (d) one at-large appointment serving three years;
2. one appointed by the Senate president pro tempore who is an oral health specialist engaged in active practice serving four years;
3. one appointed by the Senate majority leader representing labor and serving three years;
4. one appointed by the Senate minority leader who is an advanced practice registered nurse engaged in active practice and serving two years;
5. one consumer advocate appointed by the House speaker serving four

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- years;
6. one appointed by the House majority leader who is a primary care physician engaged in active practice serving four years;
 7. one appointed by the House minority leader representing the health information technology industry and serving three years;
 8. five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one each representing faith communities, small businesses, the home health care industry, hospitals, and an at-large appointment, all of whom serve five-year terms;
 9. the lieutenant governor;
 10. the OPM secretary, the comptroller, the healthcare advocate and the special advisor to the governor on healthcare reform or their designees; the commissioners of Social Services and Public Health, or their designees; all of whom serve as ex-officio voting members; and
 11. the commissioners of Children and Families, Developmental Services, Mental Health and Addiction Services, and Insurance or their designees, and the nonprofit liaison to the governor, or his designee, all of whom serve as ex-officio nonvoting members.

Subsequent cabinet terms begin on August 1 of the year appointed and last for four years. If an appointing authority does not make an appointment initially or within 90 days of a vacancy, the cabinet must appoint a member by majority vote.

When the initial terms of the five cabinet members appointed by the SustiNet Health Partnership board of directors expire, five successor cabinet members must be appointed as follows: (1) one appointed by the governor; (2) one appointed by the Senate president pro tempore; (3) one appointed by the House speaker; and (4) two appointed by majority board vote. These successor board members are at-large appointments.

The lieutenant governor serves as the cabinet chairperson; the cabinet must hold its first meeting by September 1, 2011.

Cabinet Duties

The cabinet must advise the governor and OHRI on developing an integrated health care system for Connecticut and must:

1. evaluate the means of ensuring an adequate health care workforce in the state;
2. jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option allowed under the PPACA;
3. identify short- and long-range opportunities, issues, and gaps created by the enactment of the PPACA;
4. coordinate with OHRI concerning the effectiveness of delivery system reforms and other efforts to control health care costs, including reforms and efforts implemented by state agencies;
5. develop a business plan for the governor and OHRI that takes into account the OHRI feasibility and risk assessments (see § 13) and evaluates private or public mechanisms that will provide adequate health insurance products

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beginning on January 1, 2014, including for- and non-profit organizations, insurance cooperatives, and self-insurance and submit appropriate implementation recommendations to the governor.

6. advise the governor on the (a) design, implementation, actionable objectives, and evaluation of state and federal health care policies, priorities, and objectives relating to the state's efforts to improve health care access and (b) quality of such care and the affordability and sustainability of the state's health care system.

The cabinet may convene working groups, which can include volunteer health care experts, to make recommendations on developing and implementing service delivery and health care provider payment reforms, including multi-payer initiatives, medical homes, electronic health records, and evidenced-based health care quality improvement.

EFFECTIVE DATE: Upon passage

§ 15 — CLAIM PAYMENT REQUIREMENTS

Prior law required health insurers to pay claims within 45 days of receiving them. The act increases the time an insurer has to pay claims submitted on paper and decreases the time it has to pay claims submitted electronically.

Paper Claims

The act requires insurers to pay paper claims within 60 days of receiving them. As under existing law, if the claim does not include all required information, the insurer must send written notice to the claimant requesting the information be sent within 30 days. Upon receiving the requested information, the insurer must pay the claim within 30 days.

Electronic Claims

The act requires insurers to pay electronic claims within 20 days of receiving them. If the claim does not include all required information, the insurer must send written notice to the claimant requesting the information be sent within 10 days. Upon receiving the requested information, the insurer must pay the claim within 10 days.

Claims Paid Late

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

EFFECTIVE DATE: January 1, 2012

§ 16 — NEW INSURANCE PRODUCTS

The act permits a contracting health organization (e.g., insurer or HMO) to

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introduce new insurance products to health care providers at any time as long as it gives the provider at least 60 days advance notice if the new product makes material changes to the administrative requirements or fee schedule portions of the provider's contract. The advance notice must allow the provider at least 30 days to decide whether to participate in the new insurance product. The provider may decline participation.

EFFECTIVE DATE: January 1, 2012

§ 17 — PROVIDER NETWORK ADEQUACY

The act requires each insurer that contracts with licensed health care providers to maintain a provider network that is consistent with the National Committee for Quality Assurance's (NCQA's) network adequacy requirements or URAC's provider network access and availability standards.

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

NCQA and URAC are nonprofit organizations that accredit and certify a wide range of health care organizations. (URAC was previously known as the Utilization Review Accreditation Commission.)

EFFECTIVE DATE: January 1, 2012

§ 18 — PRIOR AUTHORIZATIONS

The act prohibits insurers and utilization review companies that grant prior authorizations for admissions, services, procedures, or extensions of hospital stays on or after January 1, 2012 from reversing or rescinding the authorization or refusing to pay for the admission, service, procedure, or extension of stay if:

1. the insurer or company did not notify the health care provider at least three business days before the scheduled date of the admission, service, procedure, or extension of stay that it was reversed or rescinded due to medical necessity, fraud, or lack of coverage and
2. the admission, service, procedure, or extension of stay took place in reliance on the prior authorizations.

The act specifies that this applies regardless of whether the preauthorization is required or requested by an insured's health care provider. It also specifies that a preauthorization is effective for at least 60 days from when it is issued, unless it is reversed or rescinded.

These provisions are not to be construed as authorizing benefits or services in excess of those provided for in the policy or contract.

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

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§ 19 — DENTIST CHARGES

Under the act, a provider contract between an insurer and a licensed dentist entered into, renewed, or amended on or after January 1, 2012 cannot require the dentist to accept as payment an amount the insurer sets for services or procedures that are not covered benefits under the dental plan.

The act prohibits a dentist from charging more than his or her usual and customary rate for such noncovered services or procedures.

It requires each evidence of coverage for an individual or group dental plan to include the following statement:

“IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.”

The act requires dentists to post, in a conspicuous place, a notice stating that services or procedures that are not covered benefits under an insurance policy or plan might not be offered at a discounted rate.

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

This section does not apply to a self-insured plan or collectively bargained agreement.

EFFECTIVE DATE: January 1, 2012

§ 20 — THIRD PARTY-ADMINISTRATOR DEFINITIONS

Third-Party Administrator

With certain exceptions, a third-party administrator (TPA) is one who directly or indirectly (1) underwrites; (2) collects charges or premiums; or (3) adjusts or settles claims on Connecticut residents with respect to life, annuity, or health coverage offered or provided by an insurer.

The act excludes from the definition of TPA:

1. an employer administering its employee benefit plan or that of an affiliated employer under common management and control;
2. a union administering a benefit plan on its members' behalf;
3. an insurer licensed in Connecticut or acting as an authorized insurer with respect to insurance lawfully issued to cover a Connecticut resident, and its sales representatives;
4. an insurance producer licensed to sell life, annuity, or health coverage in Connecticut, who just sells insurance;

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5. a creditor acting on its debtors' behalf with respect to insurance covering a debt between the creditor and its debtors;
6. a trust and its trustees and agents acting pursuant to a trust established under federal law that restricts financial transactions with labor organizations;
7. a tax-exempt trust and its trustees, or a custodian and the custodian's agents acting pursuant to an account meeting federal requirements for custodial accounts and contracts treated as qualified trusts;
8. a mortgage lender, credit union, or financial institution subject to supervision or examination by federal or state banking authorities, when collecting or remitting premiums to licensed insurance producers, limited lines producers, or authorized insurers in connection with loan payments;
9. a credit card company advancing or collecting insurance premiums or charges from its credit card holders who have authorized collection;
10. an attorney adjusting or settling claims in the normal course of his or her practice or employment who does not collect charges or premiums in connection with life, annuity, or health coverage;
11. an insurance adjuster whose activities are limited to adjusting claims;
12. an insurance producer licensed in Connecticut and acting as a managing general agent whose activities are limited to those specified in law;
13. a business entity affiliated with an insurer licensed in Connecticut that undertakes activities as a TPA only for the direct and assumed insurance business of the affiliated insurer;
14. a consortium of state-funded federally qualified health centers that provide services only to recipients of programs administered by the Department of Social Services;
15. a pharmacy benefits manager registered with the insurance commissioner;
16. an entity providing administrative services to the Health Reinsurance Association; and
17. a nonprofit association or one of its direct subsidiaries that provides access to insurance as part of the benefits or services the association or subsidiary makes available to its members.

Underwriting

The act defines "underwriting" as (1) accepting applications from employers or individuals for coverage in accordance with the written rules of the insurer or self-funded plan and (2) the overall planning and coordination of a benefits program.

Adjuster

The act defines "adjuster" as an independent or contracted person who investigates or settles claims, excluding an insurer's employee who investigates or settles claims incurred under insurance contracts the insurer or an affiliated insurer writes.

Insurer

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The act defines an “insurer” as a person or people doing insurance business, including a captive insurer, a licensed insurance company, a medical or hospital service corporation, an HMO, or a consumer dental plan, that provides employee welfare benefits on a self-funded basis. It excludes a fraternal benefit society.

EFFECTIVE DATE: October 1, 2011

§ 21 — TPA LICENSE REQUIREMENT

The act prohibits a person (including an entity) from offering to act as a TPA in Connecticut unless licensed or exempt from licensure. This prohibition does not apply to a TPA’s employee to the extent that his or her activities are under the TPA’s supervision and control. But, the act does not exempt a TPA’s employees from the licensing requirements regarding public adjusters, casualty adjusters, motor vehicle physical damage appraisers, certified insurance consultants, surplus lines brokers, or any other insurance-related occupation for which the commissioner deems a license necessary. (See TPA Licensing Process below for more details.)

Certain entities that are exempt from TPA licensure but that perform similar services must register annually with the insurance commissioner.

License Exemption

A licensed insurer that underwrites, collects premiums or charges, or adjusts or settles claims, except for its policyholders, subscribers, and certificate holders, is exempt from the act’s requirements. These insurers must (1) be subject to the Connecticut Unfair Insurance Practices Act, (2) respond to all complaint inquiries received from the Insurance Department within 10 days of receiving them, and (3) obtain a customer’s prior written consent for advertising mentioning the customer.

ERISA Plans

The act specifies that it does not authorize the commissioner to regulate a self-insured plan subject to the federal Employee Retirement Income Security Act (ERISA). The commissioner is authorized to regulate activities an insurer undertakes for such plans that do not relate to the benefit plan and that comport with his authority under ERISA to regulate the business of insurance.

Written Agreement

Under the act, a TPA must have a written agreement with the insurer (hereafter, insurer includes another person using the TPA’s services). The agreement must be kept as part of the official records of both the TPA and the insurer until five years after the contract ends. The agreement must contain all of the following provisions, except those that do not apply to the functions the TPA performs:

1. a statement of activities that the TPA must perform on the insurer’s behalf;
2. the lines, classes, or types of insurance the TPA may administer;
3. a requirement that the TPA render an accounting, on an agreed frequency, detailing all transactions it performs pertaining to the insurer’s

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- underwritten businesses;
4. the procedures for any withdrawals to be made, including remittance, deposits, transfers to and deposits in a claims-paying account, payment to a group policyholder, payment to the TPA for commissions, fees, or charges, and remittance of return premiums;
 5. procedures and requirements for required disclosures; and
 6. termination and dispute resolution procedures.

Termination and Disputes Regarding Lawful Obligations

A TPA or insurer may, with written notice, terminate the written agreement for cause as provided in the agreement. The insurer may also suspend the TPA's underwriting authority while the termination is pending. In a dispute between the TPA and the insurer regarding the fulfillment of a lawful obligation with respect to a policy or plan subject to the written agreement, the insurer must fulfill the obligation.

EFFECTIVE DATE: October 1, 2011

§ 22 — PAYMENTS TO INSURERS

The act specifies that insurance premiums or charges paid to a TPA by an insured party or on its behalf are deemed to have been received by the insurer. "Return premium" or claim payments the insurer forwards to the TPA are not deemed to have been paid to the insured party or claimant until the insured party or claimant receives them. The act specifies that it does not limit an insurer's rights to sue the TPA for its failure to pay the insurer, insured parties, or claimants.

EFFECTIVE DATE: October 1, 2011

§ 23 — BOOKS AND RECORDS OF TRANSACTIONS PERFORMED ON PAYOR'S BEHALF

The act requires a TPA to maintain and make available to an insurer with which it contracts complete books and records of all transactions performed on the insurer's behalf. The TPA must maintain the books and records (1) in accordance with prudent standards of insurance recordkeeping and (2) for at least five years after they were created.

Under the act, the insurer owns any records the TPA generates pertaining to the insurer. But the TPA retains the right to access the books and records to fulfill its contractual obligations to insured parties, claimants, and the insurer.

If a written agreement is terminated, the TPA may, by a separate written agreement with the insurer, transfer all books and records to a new TPA. The new TPA must acknowledge to the insurer, in writing, that it is responsible for retaining the books and records of the prior TPA.

Insurers Affiliated with Certain Business Entities

An insurer that is affiliated with a business entity (i.e., a for-profit or nonprofit

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corporation, a limited liability company, or similar form of business organization) is responsible for the acts of that business entity to the extent of the entity's activities as a TPA for such insurer. Upon the commissioner's request, the insurer is responsible for furnishing the books and records of all transactions performed on behalf of the insurer to the commissioner.

Access to Books and Records

The commissioner must have access to examine, audit, and inspect books and records maintained by a TPA. Any documents, materials, or other information in the possession or control of the commissioner obtained from a TPA, insurer, insurance producer, or employee or agent acting on their behalf, in an investigation, examination or audit are (1) confidential by law and privileged, (2) not subject to disclosure under the Freedom of Information Act, (3) not subject to subpoena, and (4) not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may use these documents, materials, or other information in any regulatory or legal action brought as a part of the commissioner's official duties.

Neither the commissioner nor anyone who receives documents, materials, or other information may testify or be required to testify in any private civil action concerning them.

The commissioner may share and receive documents, materials, or other information deemed confidential and privileged with other state, federal, and international regulatory agencies; the National Association of Insurance Commissioners (NAIC) or its affiliates or subsidiaries; and state, federal, and international law enforcement authorities, provided the recipient of such documents, materials, or other information agrees to maintain their confidentiality and privileged status. He may also enter into agreements governing the sharing and use of information.

Disclosures to the commissioner do not waive any applicable privilege or claim of confidentiality. The act does not prohibit the commissioner from releasing final, adjudicated actions, including terminated TPA licenses, to a database or other clearinghouse service maintained by the NAIC or its affiliates or subsidiaries.

EFFECTIVE DATE: October 1, 2011

§ 24 — ADVERTISING BY A TPA

The act requires a TPA who advertises on an insurer's behalf to use only advertising that the insurer approves, beforehand, in writing. A TPA that mentions any customer in its advertising must obtain the customer's prior written consent.

EFFECTIVE DATE: October 1, 2011

§ 25 — ADMINISTRATION OF BENEFITS

Each insurer is responsible for determining the benefits, premium rates, underwriting criteria, and claims payment procedures for the lines, classes, or types of insurance the TPA is authorized to administer, and for securing

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reinsurance. The insurer must provide to the TPA, in writing, administration procedures for benefits, premium rates, underwriting criteria, and claims payment. Each insurer is responsible for the competent administration of its benefit and service programs.

If the TPA administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer must conduct a review of the TPA's operations at least semiannually. At least one such review must be an on-site audit.

EFFECTIVE DATE: October 1, 2011

§ 26 — FIDUCIARY CAPACITY

The act requires the TPA to hold in a fiduciary capacity (1) all insurance charges and premiums it collects on behalf of or for an insurer and (2) return premiums received from an insurer.

The act requires TPAs to (1) immediately return funds to the person entitled to them or (2) deposit them promptly in a fiduciary account the TPA establishes and maintains in a federally insured financial institution. The TPA must provide a periodic accounting to the insurer, detailing all transactions it performed pertaining to the insurer's business.

Record Maintenance

The act requires the TPA to keep clear records of deposits and withdrawals and copies of all records of any fiduciary account it maintains or controls on an insurer's behalf and, at an insurer's request, give the insurer copies of the deposit and withdrawal records.

Paying Claims

The act prohibits a TPA from paying any claim by withdrawing funds from a fiduciary account in which premiums or charges are deposited. Withdrawals from such an account must be made as provided in the TPA's written agreement.

The act requires that all claims a TPA pays from funds collected on behalf of or for an insurer must be paid only by drafts or checks of, and as authorized by, the insurer.

EFFECTIVE DATE: October 1, 2011

§ 27 — COMPENSATION

The act prohibits a TPA from entering into an agreement or understanding with an insurer that makes or has the effect of making the TPA's commissions, fees, or charges contingent upon savings achieved by the adjustment, settlement, or payment of losses covered by the insurer's obligations. This prohibition does not prevent a TPA from receiving performance-based compensation for providing auditing services. It also does not prevent a TPA's compensation from being based on premiums or charges collected or the number of claims paid or processed.

EFFECTIVE DATE: October 1, 2011

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§ 28 — NOTICE AND DISCLOSURE

The act requires that when a TPA's services are used, the TPA must give each insured a benefits identification card that discloses the TPA's identity and its relationship with the policyholder and insurer.

The act requires a TPA, when it collects premiums, charges, or fees, to inform the insured person of the reasons for each. Additional charges are prohibited to the extent the insurer has paid for the services.

The act requires the TPA to disclose to the insurer all charges, fees, and commissions that it receives for services it provides the insurer, including any fees or commissions paid by insurers providing reinsurance or stop loss coverage.

EFFECTIVE DATE: October 1, 2011

§ 29 — PROMPTLY DELIVER WRITTEN COMMUNICATIONS

The act requires a TPA to promptly deliver written communications on the insurer's behalf. The TPA must deliver, promptly after receiving instructions from the insurer, any policies, certificates, booklets, termination notices, or other written communications the insurer delivers to the TPA for delivery to insured parties or covered individuals.

EFFECTIVE DATE: October 1, 2011

§ 30 — TPA LICENSING PROCESS

Surety Bond Requirement

The act requires a TPA applicant to execute a surety bond in an amount to be determined by the commissioner, but (1) sufficient to protect insurers or others using the TPA's services and (2) not less than \$500,000. A TPA must maintain the bond as a condition for license renewal.

The commissioner may waive the bond requirement if the TPA applicant submits audited annual financial statements for the two most recent fiscal years that prove the TPA has a positive net worth. An audited annual financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that must be filed with the report and include (1) amounts shown on the consolidated audited financial report, (2) amounts for each entity stated separately, and (3) explanations of consolidating and eliminating entries. A TPA who has submitted such statements in lieu of executing a surety bond and who is renewing its license must submit the most recent audited annual financial statement.

Application

The act requires a TPA applying for a license to (1) submit a completed application to the commissioner (by using the current version of the "NAIC's Uniform Application for Third Party Administrators") and (2) pay the required fee (see § 36).

The application must include or be accompanied by the following information

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and documents:

1. the applicant's basic organizational documents, including any articles of incorporation or association; partnership, trust, or shareholder agreement; trade name certificate; and other applicable documents;
2. the bylaws, rules, regulations, or similar documents regulating the applicant's internal affairs;
3. a NAIC biographical affidavit for the people responsible for the applicant's affairs, including (a) all members of the board of directors, board of trustees, executive committee, or other governing board or committee; (b) the principal officers in the case of a corporation, or the partners or members in the case of a partnership, association, or limited liability company; (c) any shareholder or member directly or indirectly holding 10% or more of its stock, securities, or interest; and (d) any other person who exercises control or influence over the applicant's affairs;
4. evidence of the required surety bond;
5. a statement describing the business plan, including (a) information on staffing levels and activities proposed in Connecticut and nationwide and (b) details of the applicant's ability to provide a sufficient number of experienced and qualified personnel for claims processing, recordkeeping, and underwriting; and
6. other pertinent information the commissioner may require.

Access to Records

The act requires a TPA applying for a license to provide for the commissioner's inspection copies of all contracts with insurers or others using the TPA's services. The TPA must produce its accounts, records, and files for examination and make its officers available to give information concerning its affairs, as often as the commissioner reasonably requires.

License Refusal

The commissioner may refuse to issue a license if he determines that:

1. the TPA or any individual responsible for conducting its affairs is not competent, trustworthy, financially responsible, or of good personal and business reputation;
2. the TPA has had an insurance or a TPA certificate of authority or license denied or revoked for cause by any jurisdiction; or
3. any of the grounds relating to the act's enforcement requirements exist with respect to the TPA.

Miscellaneous Requirements

A license issued to a TPA is in force until September 30th in each year, unless revoked or suspended before that date. The commissioner, at his discretion, may renew a TPA license upon receiving payment of the required fee without having the TPA reapply.

A TPA licensed or applying for a license must immediately notify the commissioner of any material change in its ownership, control, or other fact or

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circumstance affecting its qualification for a license.

In addition to the surety bond described above, a licensed TPA or applicant that administers or will administer self-insured government or church plans must execute and maintain a surety bond, for use by the commissioner and the insurance regulatory authority of any other state in which the TPA is authorized to conduct business, to cover people who have remitted premiums, insurance charges, or other money to the TPA in the course of the TPA's business. The bond must be equal to the greater of (1) \$100,000 or (2) 10% of the aggregate total amount of self-funded coverage under government or church plans handled in Connecticut and all additional states in which the TPA is authorized to conduct business.

EFFECTIVE DATE: October 1, 2011

§ 31 — REGISTRATION REQUIREMENT

A person who is not required to be licensed as a TPA but who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims for Connecticut residents in connection with a self-insured life, annuity, or health coverage plan must annually register with the commissioner by October 1 on a form he designates. This does not apply if the self-insured plan is a government or church plan.

EFFECTIVE DATE: October 1, 2011

§ 32 — ANNUAL REPORT

The act requires each licensed TPA to file an annual report with the commissioner for the preceding calendar year by July 1 each year or within a time extension the commissioner grants for good cause. The annual report must be in the form and contain the information the commissioner prescribes, including evidence that the required surety bonds, as applicable, remain in force. The information contained in the report must be verified by at least two of the TPA's officers.

The annual report must include the complete names and addresses of all insurers with which the TPA had agreements during the preceding fiscal year. The TPA must pay the required filing fee when it files the annual report.

The act requires the commissioner to review each TPA's most recently filed annual report by September 1. After the review, the commissioner must issue a certification to the TPA, or update the NAIC's electronic database, indicating (1) that it is currently licensed and in good standing or (2) any deficiencies found in the annual report or financial statements.

EFFECTIVE DATE: October 1, 2011

§ 33 — ENFORCEMENT

The act requires the commissioner to suspend or revoke a TPA's license or issue a cease and desist order if the TPA does not have a license, after notice and hearing, if he finds that the TPA:

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1. is financially unsound;
2. is using methods or business practices that render its further business in Connecticut hazardous or injurious to insured persons or the public; or
3. failed to pay any judgment rendered against it in Connecticut within 60 days after the judgment became final.

The act authorizes the commissioner to suspend or revoke a TPA's license or issue a cease and desist order if the TPA does not have a license, after notice and hearing, if he finds that the TPA:

1. violated any (a) lawful rule or order of the commissioner or (b) provision of applicable Connecticut insurance laws;
2. refused to be examined or produce its accounts, records, and files, or any individual responsible for its affairs for examination;
3. without just cause, (a) refused to pay proper claims or perform its contractual services or (b) caused covered individuals to accept less than the amount due or employ attorneys or bring suit against the TPA to secure full payment or settlement of the claims;
4. failed at any time to meet any license qualification that would have been grounds for the commissioner to refuse to issue a license;
5. had a person responsible for its affairs who has been convicted of or pled guilty or no contest to a felony, without regard to whether adjudication was withheld;
6. is under license suspension or revocation in another state; or
7. failed to file an annual report in a timely manner.

The commissioner may, without advance notice and before a hearing, issue an order immediately suspending a TPA's license, or a cease and desist order if the TPA does not have a license, if he finds that:

1. the TPA is insolvent or impaired;
2. another state has started a proceeding for receivership, conservatorship, rehabilitation, or other delinquency proceeding regarding the TPA; or
3. the TPA's financial condition or business practices pose an imminent threat to the public health, safety, or welfare of Connecticut residents.

When the commissioner issues an order suspending a license or a cease and desist order, he must notify the TPA that it may request a hearing within 10 business days of receiving the order. If a hearing is requested, the commissioner must schedule it within 10 business days after receiving the request. If a hearing is not requested and the commissioner does not choose to hold one, the order remains in effect until the commissioner modifies or vacates it.

EFFECTIVE DATE: October 1, 2011

§ 34 — ADOPTION OF REGULATIONS

The act authorizes the insurance commissioner to adopt regulations relating to TPAs.

EFFECTIVE DATE: October 1, 2011

§ 35 — MARKET CONDUCT EXAMINATION

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The act authorizes the commissioner, as often as he deems it expedient, to examine the market conduct of any TPA doing business in Connecticut. He already has this authority with respect to insurance companies, HMOs, and fraternal benefit societies.

EFFECTIVE DATE: October 1, 2011

§ 36 — FEES

The act establishes the following fees that the insurance commissioner must collect from a TPA:

1. \$500 for each license issued,
2. \$350 for each license renewal, and
3. \$100 for each annual report filed.

EFFECTIVE DATE: October 1, 2011

§§ 37 - 40 — DEPENDENTS COVERED TO AGE 26

Under PPACA, children may stay on a parent's health insurance plan until age 26. The act revises various insurance statutes to comply with this requirement. Prior state law restricted a child's coverage based on his or her marriage or residency status.

EFFECTIVE DATE: Upon passage

§§ 41 & 46 — PREEXISTING CONDITIONS

Under PPACA, insurers cannot impose a preexisting condition limitation that excludes coverage for children under age 19. The act revises various insurance statutes to comply with this requirement. It specifies that no insurer can refuse to issue an individual health insurance plan to a child under age 19 solely on the basis that the child has a preexisting condition.

EFFECTIVE DATE: Upon passage

§§ 42 & 43 — LIFETIME LIMITS

Under PPACA, health benefit plans cannot impose lifetime limits on the dollar value of "essential health benefits," to be defined by the U.S. Department of Health and Human Services. To conform to the federal requirement, the act prohibits individual and group comprehensive health care plans from imposing such a lifetime limit. It specifies that a plan may include a lifetime limit of at least \$1 million on benefits that are not essential health care benefits as defined by PPACA and related regulations.

EFFECTIVE DATE: Upon passage

§§ 44 & 45 — CONTINUATION OF COVERAGE

As under prior law, the act requires health insurers to provide continuation of coverage to individuals under specified circumstances.

EFFECTIVE DATE: Upon passage

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§§ 47, 48, & 69 — RESCISSIONS

PPACA limits policy rescissions (e.g., retrospective policy cancellations) to instances of fraud and intentional material misrepresentation.

Under state law, an insurer or HMO must obtain the insurance commissioner's approval for a policy rescission, cancellation, or limitation. The act requires the commissioner to approve a request for rescission or limitation when the insured or the insured's representative (1) submitted fraudulent (rather than false) information on an insurance application, (2) intentionally (rather than knowingly) misrepresented material information on the application, or (3) intentionally (rather than knowingly) omitted material information from the application. He must approve a cancellation in accordance with federal law, which requires prior notice to the insured.

EFFECTIVE DATE: Upon passage

§§ 49-52 — MEDICAL LOSS RATIO

The Insurance Department publishes an annual Consumer Report Card on Health Insurance Carriers in Connecticut. By law, the report card must include each insurer's and HMO's medical loss ratio. The act refers to that medical loss ratio as the "state medical loss ratio" and specifies that the report card also include the federal medical loss ratio, as defined in PPACA. "Medical loss ratio" is generally the percentage of premium dollars that an insurer or HMO spends on providing health care and health care quality improvement activities, compared to how much is spent on administrative and overhead costs.

By law, an insurer or HMO must include a written notice with each application for individual or group health insurance coverage that discloses the medical loss ratio. The act requires disclosure of both the state and federal medical loss ratios.

The act requires a managed care organization to report both medical loss ratios to (1) the insurance commissioner and (2) enrollees.

EFFECTIVE DATE: January 1, 2012

§ 53 — PPACA COMPLIANCE AND REGULATIONS

The act requires insurers to comply with PPACA. It authorizes the insurance commissioner to adopt regulations.

It specifies that state law provisions concerning PPACA are not to be construed to supersede any state law that provides greater protection to an insured, unless it prevents the application of PPACA.

EFFECTIVE DATE: Upon passage

§ 54 — DEFINITIONS

The act defines numerous terms regarding utilization review, grievance, and external review processes used throughout §§ 55 to 66.

The act expands the definition of "adverse determination." Under prior law,

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“adverse determination” meant a decision by a managed care organization, health insurer, or utilization review company to deny, reduce, or end payment for a covered admission, service, procedure, or extension of stay because it did not meet that entity’s requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. Under the act, “adverse determination” includes a health carrier’s denial, reduction, termination, or failure to pay for a requested benefit because the benefit (1) does not meet the carrier’s requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness or (2) is determined to be experimental or investigational. It includes any adverse prospective, concurrent, or retrospective review determinations and coverage rescissions.

Under prior law, “utilization review” meant a prospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources given to or proposed for a person. The act (1) redefines the term to mean formal techniques used to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings and (2) expands it to include retrospective reviews in addition to prospective or concurrent reviews.

EFFECTIVE DATE: July 1, 2011

§ 55 — GENERAL REQUIREMENTS

Prior law gave the insurance commissioner the authority to regulate utilization review companies. It contained licensing requirements, minimum standards, and appeal and enforcement procedures. The act makes changes to the utilization review process to conform it to federal PPACA requirements.

Health Carriers

The act applies to (1) health carriers offering a health benefit plan and performing utilization review, including prospective, concurrent, or retrospective review benefit determinations, and (2) utilization review companies or a health carrier’s designee that performs utilization review. A “health carrier” is an entity that (1) is subject to Connecticut’s insurance laws and regulations or the insurance commissioner’s jurisdiction and (2) contracts to provide, deliver, arrange for, pay, or reimburse the costs of health care services. It includes insurers, health care centers (i.e., HMOs), managed care organizations, hospital or medical service corporations, or any other entity that provides health insurance, health benefits, or health care services.

A health carrier must (1) monitor all utilization review activities carried out by or on behalf of it and (2) ensure that any utilization review company or other entity it contracts with to perform utilization review complies with the act and any related regulations. A health carrier must ensure that appropriate personnel have operational responsibility for the activities of the health carrier’s utilization review program.

Utilization Review Program

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A health carrier that requires utilization review must implement a program and develop a written document that describes all utilization review activities and procedures for (1) filing benefit requests, (2) notifying covered persons of utilization review and benefit determinations, and (3) reviewing adverse determinations (e.g., benefit denials) and grievances. The document must include:

1. procedures to evaluate the medical necessity, appropriateness, health care setting, level of care, or effectiveness of health care services;
2. data sources and clinical review criteria used in making determinations;
3. procedures to ensure consistent application of clinical review criteria and compatible determinations;
4. data collection processes and analytical methods used to assess utilization of health care services;
5. provisions to ensure the confidentiality of clinical, proprietary, and protected health information;
6. the health carrier's organizational mechanism, such as a utilization review or quality assurance committee, that periodically assesses the health carrier's utilization review program and reports to the health carrier's governing body; and
7. the health carrier's staff position responsible for managing the utilization review program.

A health carrier must include in the insurance policy, coverage certificate, or handbook provided to those covered a description of the procedures for utilization review and benefit determinations, grievances, and external reviews in a format the insurance commissioner prescribes. The description must include the following statements:

1. the subscriber or other covered person may file a request for an external review of an initial or final adverse determination with the commissioner when the determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness (the disclosure document must include the commissioner's contact information);
2. the covered person must authorize the release of related medical records when filing a request for an external review (i.e., a review conducted by an independent third party);
3. the rights and responsibilities of covered persons with respect to utilization review and benefit determinations, grievances, and external reviews; and
4. a covered person has the right to contact the commissioner or the healthcare advocate at any time for assistance (the disclosure document must include the contact information for both offices).

A health carrier must also:

1. inform people it covers, at initial enrollment and annually thereafter, of its grievance procedures;
2. inform a covered person and his or her health care professional (i.e., a licensed health care practitioner) of the grievance procedures whenever the health carrier denies a benefit requested by the health care professional;

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3. include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons;
4. print on its membership or identification cards a toll-free telephone number for utilization review and benefit determinations;
5. maintain records of all benefit requests, claims, and notices related to utilization review and benefit determinations for at least six years and make the records available upon request to the commissioner and federal oversight agencies; and
6. maintain records of all grievances received in accordance with the act and make the records available upon request to (a) covered persons, if the records can be disclosed under law, (b) the commissioner, and (c) federal oversight agencies.

Annual Reporting

By March first annually, a health carrier must file with the commissioner a (1) summary report of its utilization review program activities in the prior calendar year and (2) report that includes for each type of health benefit plan offered:

1. a certificate of compliance certifying that the utilization review program complies with all applicable state and federal laws concerning confidentiality and reporting requirements,
2. the number of lives covered,
3. the total number of grievances received,
4. the number of grievances resolved at each level and their resolution,
5. the number of grievances known to have been appealed to the commissioner,
6. the number of grievances referred to alternative dispute resolution procedures or resulting in litigation, and
7. actions being taken to correct any identified problems.

The act requires the commissioner to adopt regulations to establish the form and content of the annual reports.

EFFECTIVE DATE: July 1, 2011

§ 56 — OVERSIGHT OF UTILIZATION REVIEW PROGRAM

The act requires a health carrier to contract with (1) health care professionals to administer its utilization review program and oversee utilization review determinations and (2) clinical peers to evaluate the clinical appropriateness of an adverse determination. A “clinical peer” is a licensed physician or other health care professional in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.

Each utilization review program must use documented clinical review criteria based on sound clinical evidence and evaluated periodically by the health carrier’s organizational mechanism to assure the program’s effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors the commissioner approves. Each health carrier must make its clinical review criteria available upon request to authorized

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government agencies.

A health carrier must:

1. have procedures in place to ensure that the health care professionals administering the utilization review program are applying the clinical review criteria consistently;
2. have data systems that support utilization review program activities and generate management reports to enable the health carrier to monitor and manage health care services effectively;
3. provide covered persons and participating providers access to its utilization review staff through a toll-free telephone number or electronically;
4. coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, member satisfaction assessment, and risk management; and
5. routinely assess the effectiveness and efficiency of its utilization review program.

Delegation

If a health carrier delegates any utilization review activities to a utilization review company, the health carrier must maintain adequate oversight, including (1) a written description of the utilization review company's activities and responsibilities, (2) evidence of the health carrier's formal approval of the company, and (3) a process by which the health carrier evaluates the company's performance.

Necessary Information Only

When conducting utilization review, the health carrier must (1) collect only the information needed, including pertinent clinical information, to make the utilization review or benefit determination and (2) ensure that the review is conducted in a way that ensures the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

Personnel Decisions

A health carrier cannot make decisions regarding the hiring, compensation, termination, promotion, or other similar matters of individuals involved in making utilization review or benefit determinations based on the likelihood that the individuals will support benefit denials.

EFFECTIVE DATE: July 1, 2011

§ 57 — UTILIZATION REVIEW AND BENEFIT DETERMINATIONS

Written Procedures

The act requires a health carrier to maintain written procedures for (1)

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utilization review and benefit determinations, (2) expedited utilization review and benefit determinations relating to prospective and concurrent urgent care requests, and (3) notifying covered persons of its determinations. (Hereafter, “covered persons” includes their authorized representatives.)

Prudent Layperson

When determining if a benefit request is an urgent care request, the health carrier must apply the judgment of a prudent layperson with an average knowledge of health and medicine. However, a request must be considered urgent if a health care professional with knowledge of the covered person’s medical condition determines that it is.

Urgent Care Review Request

Unless the covered person has failed to provide information necessary for the health carrier to make a determination, the carrier must determine whether or not to certify the benefit and notify the covered person within 72 hours after receiving the request. For a concurrent urgent care review request, the carrier must make a determination within 24 hours before the current course of treatment expires.

If the covered person failed to provide information necessary for the health carrier to make a determination, the carrier must notify the person as soon as possible but within 24 hours after receiving the request. In all cases, the carrier must provide the person at least 48 hours to submit the information.

A health carrier must notify the covered person of its determination as soon as possible but within 48 hours after the earlier of (1) the date the person provides the information or (2) the date the information was to have been submitted.

Non-Urgent Care Review Request

For a prospective or concurrent non-urgent review request, a health carrier must determine whether or not to certify the benefit and notify the covered person within 15 days after receiving the request. For a retrospective review request, the health carrier must make a determination within 30 days after receiving the request.

The health carrier may extend either time period once for up to 15 days if it (1) determines an extension is necessary due to circumstances beyond its control and (2) notifies the covered person before the initial time period ends of the circumstances requiring the extension and the date by which the health carrier expects to make a determination.

If the extension is needed because the covered person failed to submit information necessary to reach a determination, the health carrier must (1) specifically describe in the extension notice the information necessary to complete the request and (2) give the covered person at least 45 days to provide this information. If the covered person fails to submit the information before the end of the extension period, the health carrier may deny the requested benefit.

Procedural Failure

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Whenever a health carrier receives a review request from a covered person that fails to meet the carrier's filing procedures, the carrier must notify the covered person of the failure. The carrier must send the notice within five days after receiving the request for a non-urgent request or within 24 hours for an urgent care request. The health carrier may provide the notice orally if it provides written confirmation within five days after providing the oral notice.

Notice of Adverse Determination

A health carrier must provide promptly to a covered person an adverse determination notice, either in writing or electronically. It must include, in a way the covered person can understand:

1. sufficient information to identify the benefit request or claim involved, including the date of service, health care professional, and claim amount;
2. the specific reason for the adverse determination and a description of the health carrier's standard used in deciding to issue the denial;
3. reference to the specific health benefit plan provisions on which the determination is based;
4. a description of any additional material or information the covered person needs to complete the benefit request or claim, including an explanation of why the material or information is necessary;
5. a description of the health carrier's internal grievance process, including expedited review procedures, applicable time limits, and contact information;
6. a statement that the person may, pursuant to the requirements of the carrier's internal grievance process, (a) submit written material relating to the request and (b) receive, free of charge upon request, reasonable access to and copies of all information relevant to his or her request;
7. if the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (a) the specific rule, guideline, protocol, or other similar criterion or (b) a statement that one of these was relied upon to make the adverse determination and that a copy will be provided to the covered person free of charge on request, with instructions for requesting a copy;
8. if the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of that scientific or clinical rationale and (a) an explanation of the rationale that applies the terms of the health benefit plan to the covered person's medical circumstances or (b) a statement that an explanation will be provided to the covered person free of charge on request and instructions for requesting a copy; and
9. a statement explaining the covered person's right to (a) contact the insurance commissioner or Office of Healthcare Advocate at any time for assistance and contact information or (b) file, upon completion of the health carrier's internal grievance process, a civil suit in a court of competent jurisdiction.

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Rescission

If the adverse determination is a rescission (i.e., retroactively cancelling insurance after a policyholder becomes sick or is injured), the health carrier must include with the advance notice of the rescission application a written statement that includes:

1. clear identification of the alleged fraudulent act, practice, or omission or intentional misrepresentation of material fact;
2. an explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
3. a disclosure that the covered person may immediately file a grievance with the health carrier to request a review of the adverse determination to rescind coverage;
4. a description of the health carrier's grievance procedures, including any applicable time limits; and
5. the date the advance notice of the proposed rescission ends and the date to which the coverage will be retroactively rescinded.

Strict Adherence Required

Whenever a health carrier fails to strictly adhere to the utilization review and benefit determination requirements, the covered person is deemed to have exhausted the health carrier's internal grievance process and may file for an external review, regardless of whether the health carrier asserts substantial compliance or *de minimis* error.

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

EFFECTIVE DATE: July 1, 2011

§§ 58 & 59 — INTERNAL GRIEVANCE PROCESS

Prior law required managed care organizations and health insurers to have an internal grievance procedure for enrollees to seek a review of grievances arising from the entity's actions or inaction. The act expands upon existing law to conform it to the federal PPACA.

Written Procedures Required

A health carrier must establish and maintain written procedures for (1) reviewing grievances of adverse determinations that were based on medical necessity, (2) the expedited review of grievances of adverse determinations of urgent care requests, and (3) notifying covered persons of its adverse determinations.

Filing Required

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A health carrier must file with the commissioner a copy of the procedures, including all forms used to process requests and any subsequent material modifications to the procedures.

A health carrier also must file annually with the commissioner, as part of its annual report described above, a certificate of compliance stating that it has established and maintains grievance procedures that fully comply with the act's provisions for each of its health benefit plans.

Grievance of Adverse Determination Based on Medical Necessity

A covered person may file a grievance of an adverse determination that was based, in whole or in part, on medical necessity with the health carrier within 180 days after the covered person receives the adverse determination notice. For prospective or concurrent urgent care requests, a person can request an expedited review orally or in writing.

The health carrier must ensure that an adverse determination review is conducted in a manner that ensures the independence and impartiality of the individuals involved in making the review decision.

Clinical Peer. If the adverse determination involves utilization review, the health carrier must designate one or more appropriate clinical peers to review the determination. The clinical peers cannot have been involved in the initial adverse determination.

The individuals conducting a grievance review must consider all comments, documents, records, and other information the covered person submits relevant to his or her benefit request that is the subject of the adverse determination under review, regardless of whether such information was submitted or considered in making the initial adverse determination.

New or Additional Evidence. Before issuing a decision, the health carrier must provide free of charge to the covered person any new or additional evidence relied upon or scientific or clinical rationale used in connection with the grievance. The carrier must provide the evidence and rationale sufficiently in advance of the carrier's determination date to allow the person a reasonable opportunity to respond before then.

Transmitting Information and Decision. For an expedited review, the health carrier must transmit all information, including its decision, to the covered person by telephone, fax, electronically, or other expeditious method.

Treatment During Concurrent Review. For an expedited review of a grievance involving an adverse determination of a concurrent review urgent care request, treatment must be continued without liability to the covered person until the person has been notified of the review decision.

Decision Time Period. The health carrier must notify the covered person in writing or electronically of its decision within specified time periods. A time period begins on the date the health carrier receives the grievance, regardless of whether all of the information necessary to make the decision accompanies the filing. (Under prior law, grievances had to be resolved within 60 days.)

For a grievance of an adverse determination involving an expedited review request, the health carrier must decide and notify the covered person of the

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decision within 72 hours after receiving it.

For a grievance of an adverse determination involving a prospective or concurrent review request, the health carrier must decide and notify the covered person of the decision within 30 days after receiving it.

For a grievance of an adverse determination involving a retrospective review request, the health carrier must decide and notify the covered person of the decision within 60 days after receiving it.

Decision Notice. The health carrier's notice must include, in a way the covered person can understand:

1. the titles and qualifying credentials of the individuals participating in the review process;
2. enough information to identify the claim involved, including the date of service, health care professional, and claim amount;
3. a statement of the reviewers' understanding of the grievance;
4. the reviewers' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for the decision in sufficient detail for the covered person to respond further to the health carrier's position;
5. reference to the evidence or documentation used as the basis for the decision;
6. if applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner"; and
7. a statement disclosing the covered person's right to contact the commissioner or the healthcare advocate at any time and the contact information.

If a decision upholds the adverse determination, the notice must contain:

1. the specific reason for the final adverse determination, including the denial code and its corresponding meaning and a description of the health carrier's standard used in reaching the denial;
2. a reference to the specific health benefit plan provisions on which the decision is based;
3. a statement that the covered person may receive from the health carrier, free of charge and on request, reasonable access to and copies of all relevant documents, records, and other information;
4. if the final adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (a) the specific rule, guideline, protocol, or other similar criterion or (b) a statement that one of these was relied upon to make the final adverse determination and that a copy of it will be provided to the covered person free of charge on request, with instructions for requesting such copy;
5. if the final adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, a written statement of the scientific or clinical rationale for the final adverse determination and (a) an explanation of the rationale used to make the determination that applies the terms of the health benefit plan to the

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- covered person's medical circumstances or (b) a statement that an explanation will be provided to the covered person free of charge on request, with instructions for requesting a copy of the explanation; and
6. the procedures for obtaining an external review.

Strict Adherence Required

Whenever a health carrier fails to strictly adhere to the grievance requirements, the covered person is deemed to have exhausted the carrier's internal grievance process and may file an external review, regardless of whether the carrier asserts substantial compliance or *de minimis* error.

A covered person who has exhausted the health carrier's internal grievance process may, in addition to filing an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

Grievance of Adverse Determination Not Based on Medical Necessity

A covered person may file a grievance of an adverse determination that was not based on medical necessity with the health carrier within 180 days after the covered person receives the adverse determination notice.

Written Procedures. A health carrier must establish and maintain written procedures for (1) reviewing grievances of adverse determinations that were not based on medical necessity and (2) notifying covered persons of its adverse determinations.

Notice Required. A health carrier must, within three business days of receiving a grievance, notify a covered person that he or she may submit written material for consideration by the individuals designated by the health carrier to conduct the grievance review.

Upon receiving a grievance, a health carrier must designate individuals to conduct a grievance review. The health carrier cannot designate the same individuals who denied the claim or handled the matter that is the subject of the grievance.

A health carrier must give the covered person the name, address, and telephone number of the person or organizational unit designated to coordinate the review on the health carrier's behalf.

Decision Time Period. A health carrier must notify the covered person in writing of its decision within 20 business days after receiving the grievance.

If the health carrier is unable to meet the 20-day deadline due to circumstances beyond its control, it may extend the time period for up to 10 business days, provided that before the initial 20-day period ends, the health carrier provides written notice to the covered person of the extension and the reasons for the delay.

Decision Notice. The written decision notice must include:

1. the titles and qualifying credentials of the individuals participating in the review process,
2. a statement of the individuals' understanding of the grievance,

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3. the individuals' decision in clear terms and the health benefit plan contract basis for the decision in sufficient detail for the covered person to respond further to the health carrier's position, and
4. reference to the evidence or documentation used as the basis for the decision.

EFFECTIVE DATE: July 1, 2011

§ 60 — EXTERNAL REVIEW PROCESS

Under prior law, enrollees who exhausted the internal grievance process could appeal a claim denial to the insurance commissioner, who would assign the review to an independent third party. The act expands upon existing law to conform it to the federal PPACA.

Written Request

A covered person may file with the commissioner a written request for a standard or expedited external review of an adverse determination or a final adverse determination. The commissioner may prescribe the form and content of such review requests.

Filing Fee

By law, a covered person requesting an external review has to pay a \$25 filing fee. But the act specifies that no one will have to pay more than \$75 in any calendar year. By law, if the commissioner finds the covered person is indigent or unable to pay the fee, the commissioner must waive the fee. All fees are deposited in the Insurance Fund.

The commissioner must refund any paid filing fee if the adverse determination or final adverse determination that is the subject of the standard or expedited external review is reversed or revised.

Health Carrier Pays for the Review

The health carrier that issued the adverse determination or final adverse determination that is the subject of the external review request must pay the independent review organization for the cost of conducting the external review, whether the review is standard or expedited.

Decision is Binding

An external review decision, whether standard or expedited, is binding on the health carrier or self-insured government plan and the covered person, except to the extent they have other remedies under federal or state law.

A covered person cannot file a subsequent request for a standard or expedited external review that involves the same adverse determination or final adverse determination for which he or she already received a standard or expedited external review decision.

Written Records Required

Health carriers and independent review organizations must maintain written records of external reviews.

Exhaustion of Internal Grievance Process and Waiver

A covered person cannot request a standard or expedited external review until he or she has exhausted the health carrier's internal grievance process. However, a covered person can request an external review before exhausting the internal grievance process if the health carrier agrees to waive the exhaustion requirement.

Written Disclosure of External Review

When a health carrier sends a covered person an adverse determination notice or a final adverse determination, it must include a written disclosure of his or her right to request an external review. The written notice must include:

1. the following or substantially similar statement: "We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested;"
2. for a notice related to an adverse determination, a statement informing the covered person that (a) if the person has a medical condition for which the time period for completing an expedited internal review of a grievance involving an adverse determination would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function, the covered person may file a request for an expedited external review and (b) the request for expedited external review may be filed at the same time the person files a request for an expedited internal review of a grievance involving an adverse determination, except that the independent review organization assigned to conduct the expedited external review determines whether the covered person must complete the expedited internal review of the grievance before it performs the expedited external review;
3. for a notice related to a final adverse determination, a statement informing the covered person that he or she may file for an expedited external review if (a) the covered person has a medical condition for which the time period for completion of an external review would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function or (b) the final adverse determination concerns (i) an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility or (ii) a denial of coverage based on a determination that the requested health care treatment is experimental or investigational and the covered person's treating health care professional certifies in writing

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- that the requested treatment would be significantly less effective if not promptly initiated;
4. a copy of the description of both the standard and expedited external review procedures, highlighting external review procedures that give the covered person the opportunity to submit additional information and including any forms used to process a standard or expedited external review; and
 5. a medical records release authorization form approved by the commissioner that complies with federal regulations.

Expedited External Review

A covered person may file a request for an expedited external review of an adverse determination or a final adverse determination with the commissioner; an expedited external review is not available for a retrospective review request.

The covered person may file an expedited external review request when he or she receives:

1. an adverse determination, if the covered person has (a) a medical condition for which the time period for completing an expedited internal review of the adverse determination would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function or (b) been denied coverage on the basis that the service or treatment is experimental or investigational and the person's treating health care professional certifies in writing that the service or treatment would be significantly less effective if not promptly started, and the person filed a request for an expedited internal review of an adverse determination; or
2. a final adverse determination, if (a) the covered person has a medical condition for which the time period for completing a standard external review would seriously jeopardize his or her life or health or jeopardize his or her ability to regain maximum function, (b) the determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility, or (c) the coverage was denied on the basis that the service or treatment is experimental or investigational and the person's treating health care professional certifies in writing that the service or treatment would be significantly less effective if not started promptly.

The covered person is not required to file a standard external review request before or at the same time as filing an expedited external review request. If the expedited external review request is ineligible for review, the covered person can still file a standard external review request.

External Review Process and Time Periods

Covered Person. A covered person may file with the commissioner a written request for a standard or expedited external review of an adverse determination or a final adverse determination within 120 days of receiving notice of the determination. Under prior law, a person had 60 days to file an expedited review.

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Commissioner. Within one business day after receiving the request, the commissioner must send a copy of it to the health carrier whose determination is the subject of the request.

Health Carrier. Within five business days after receiving a copy of a standard external review request or one calendar day after receiving a copy of an expedited external review request, the health carrier must complete a preliminary review to determine whether:

1. the individual was a covered person under the health benefit plan at the time the health care service was requested or provided;
2. the involved health care service is a covered service under the covered person's health benefit plan except for the health carrier's determination that it does not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
3. the covered person has exhausted the health carrier's internal grievance process or filed an expedited external review request; and
4. the covered person has provided all the information and forms required to process a standard or expedited external review.

If the service or treatment is experimental or investigational, the health carrier must also determine whether:

1. the requested health care treatment that is the subject of the determination (a) is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational and (b) is not explicitly excluded under the covered person's health benefit plan;
2. the covered person's treating health care professional has certified that (a) standard health care treatments have not been effective in improving the covered person's medical condition, (b) standard health care treatments are not medically appropriate for the person, or (c) there is no available standard health care treatment covered by the health carrier that is more beneficial than the requested health care treatment; and
3. the covered person's treating health care professional (a) has recommended a health care treatment that he or she certifies, in writing, is likely to be more beneficial to the covered person than any available standard health care treatments or (b) is a licensed, board certified, or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified, in writing, that scientifically valid studies using accepted protocols demonstrate that the health care treatment the covered person requested is likely to be more beneficial than any available standard health care treatments.

Initial Determination Notice. The health carrier must notify the commissioner and covered person in writing on whether the request is complete and eligible for external review within one business day after completing the preliminary review for a standard external review request or on the day the preliminary report is completed for an expedited external review request. The commissioner may specify the form for the health carrier's initial determination notice.

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If the request is not complete, the health carrier's notice must specify the information needed to perfect the request. If the request is not eligible for standard or expedited external review, the notice must include the reasons for its ineligibility. The notice must include a statement informing the covered person that he or she can appeal an initial determination of ineligibility to the commissioner.

Regardless of a health carrier's initial determination that a request for a standard or expedited external review is ineligible for review, the commissioner may determine, pursuant to the terms of the covered person's health benefit plan, that the request is eligible and assign an independent review organization to conduct it.

Assignment of Independent Review Organization. Within one business day, for a standard external review request, or one calendar day, for an expedited external review request, of receiving notice that a request is eligible for review, the commissioner must (1) assign an independent review organization to conduct the review (randomly from among qualified organizations), (2) notify the health carrier of the organization's name, and (3) notify the covered person in writing of the request's eligibility and acceptance for review.

The written notice must include (1) a statement that the covered person may submit, within five business days after receiving the notice, additional information in writing to the organization for consideration and (2) where and how such additional information must be submitted. If additional information is submitted later than five business days after the covered person received the notice, the organization may, but is not required to, accept and consider it.

Health Carrier Must Provide Information. Within five business days for a standard external review and one calendar day for an expedited external review after receiving the name of the assigned independent review organization, the health carrier or its designated utilization review company must provide the organization any information it considered in making the determination under review.

If the carrier or utilization review company fails to timely provide the information, the organization (1) must not delay performing the review and (2) may terminate the review and make a decision to reverse the determination.

Within one business day after terminating the review and deciding to reverse the determination, the organization must notify the commissioner, health carrier, and covered person in writing.

Independent Review Organization. The organization must review all the information received from the covered person and health carrier. In reaching a decision, the organization is not bound by any decisions reached during the health carrier's utilization review process.

Upon receiving any information from the covered person, the organization has one business day to forward it to the health carrier.

Health Carrier Reconsideration. Upon receiving the covered person's information from the organization, the health carrier may reconsider the adverse determination that is the subject of the external review. The organization must terminate the external review if the health carrier decides to reverse its

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determination.

Within one business day after making the decision to reverse its determination, the health carrier must notify the commissioner, organization, and covered person in writing.

Other Information the Organization Must Consider. In reaching its decision, the organization also must consider, to the extent they are available and appropriate, the following:

1. the covered person's medical records;
2. the attending health care professional's recommendation;
3. consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, or the treating health care professional;
4. the covered person's health benefit plan's coverage terms to ensure the organization's decision is not contrary to those terms;
5. the most appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, or associations;
6. any applicable clinical review criteria the health carrier or its designee utilization review company developed and used; and
7. after considering the above items, the opinion of the organization's clinical peers who conducted the review.

Decision Time Period. After receiving a review assignment from the commissioner, the organization must notify the commissioner, health carrier, and covered person in writing of its decision to uphold, reverse, or revise the determination that is the subject of the review, within:

1. for standard external reviews, 45 days;
2. for standard external reviews involving an experimental or investigational treatment or service, 20 days;
3. for expedited external reviews, 72 hours; and
4. for expedited external reviews involving an experimental or investigational treatment or service, five days.

Decision Notice. The written notice must include:

1. the reason for the requested review;
2. the dates the organization received the assignment, performed the review, and made its decision;
3. the rationale and principal reasons for its decision, including the applicable evidence-based standards used as a basis for its decision; and
4. reference to the evidence or documentation, including any evidence-based standards, the organization considered in reaching its decision.

For a review involving an experimental or investigational treatment or service, the notice must also include:

1. the covered person's medical condition;
2. the indicators relevant to determining whether there is sufficient evidence to demonstrate that (a) the requested treatment is likely to be more beneficial to the covered person than any available standard treatments

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- and (b) the adverse risks of the requested treatment would not be substantially increased over those of available standard treatments;
3. a description and analysis of any (a) medical or scientific evidence considered in reaching the opinion and (b) evidence-based standard; and
 4. information on whether the clinical peer's rationale for the opinion is based on the other information a clinical peer must consider in developing an opinion.

Health Carrier Action. Upon receiving a decision notice from the organization that reverses the health carrier's determination, the health carrier must immediately approve the coverage that was the subject of the determination.

EFFECTIVE DATE: July 1, 2011

§ 61 — RECORD RETENTION AND REPORTING REQUIREMENTS

Grievance Records

The act requires a health carrier to maintain written records documenting all grievances of adverse determinations it receives, including the notices and claims associated with the grievances, during a calendar year. It must maintain the records for at least six years from the date it provided a covered person an adverse determination notice.

A health carrier must make grievance records available upon request to covered persons if the records are subject to disclosure under law, the commissioner, and appropriate federal oversight agencies. It must maintain the records in a way that is reasonably clear and accessible to the commissioner.

For each grievance, the record must include at least the (1) reason for the grievance, (2) date the health carrier received the grievance, (3) date of each review or review meeting of the grievance, (4) resolution and resolution date at each grievance level, and (5) covered person's name.

Annual Report

A health carrier must submit an annual grievance report to the commissioner by March 1.

External Review Records

A health carrier must maintain written records, in the aggregate, by state where the covered person requesting an external review resides and by each type of health benefit plan the health carrier offers, on all external review requests received during a calendar year. It must retain the records for at least six years after receiving the external review request.

The carrier must, upon request, report to the commissioner on the external reviews in a format the commissioner prescribes. The report must include, in the aggregate by state where the covered person requesting the external review resides and by each type of health benefit plan (1) the total number of external review requests, whether standard or expedited; (2) the number of requests determined eligible for an external review, whether standard or expedited; and (3) any other information the commissioner requests.

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EFFECTIVE DATE: July 1, 2011

§§ 62 & 66 — REGULATIONS

The act requires the commissioner to adopt implementing regulations.

EFFECTIVE DATE: July 1, 2011

§ 63 – UTILIZATION REVIEW LICENSE FEE

By law, a utilization review company must be licensed by the commissioner to do business here. Under prior law, the annual license fee was \$2,500. The act increases this fee to \$3,000.

The act authorizes the commissioner to use the license fees to contract with the UConn School of Medicine to provide medical consultations needed to carry out the commissioner's responsibilities under Title 38a with respect to consumer and market conduct matters. By law, the commissioner may already use the license fees to implement the captive insurance company requirements in CGS §§ 38a-91aa to 38a-91qq.

EFFECTIVE DATE: July 1, 2011

§§ 65 & 66 — INDEPENDENT REVIEW ORGANIZATIONS

Prior law established minimum requirements for independent review entities. The act expands upon these requirements to conform to federal PPACA requirements.

Under the act, the commissioner must (1) approve independent review organizations as eligible to conduct standard and expedited external reviews, (2) develop an application form for initial approvals and reapprovals of organizations, and (3) maintain and periodically update a list of approved organizations.

An organization seeking to conduct external reviews must apply for approval or reapproval, as applicable, to the commissioner, and include all information necessary for the commissioner to determine if the organization satisfies the minimum qualifications.

An approval or reapproval is effective for two years, unless the commissioner determines before its expiration that the organization no longer satisfies the minimum qualifications. When the commissioner determines that an organization has lost its accreditation or no longer satisfies the minimum requirements, the commissioner must remove the organization from the list of approved organizations.

Minimum Qualifications

As under prior law, to be eligible for the commissioner's approval, an organization must maintain written policies and procedures that govern all aspects of both the standard and expedited external review processes. The act requires it to maintain at a minimum:

1. a toll-free telephone number to receive information 24 hours a day, seven

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days a week, related to standard and expedited external reviews and that is capable of accepting, recording, or providing appropriate instruction to callers during other-than-normal business hours and

2. a quality assurance mechanism that ensures:
 - (a) that reviews are conducted within the specified time frames and required notices are provided in a timely manner,
 - (b) the selection of qualified and impartial clinical peers to conduct reviews on the organization's behalf and the suitable matching of peers to specific cases,
 - (c) the organization employs or contracts with an adequate number of clinical peers,
 - (d) the confidentiality of medical and treatment records and clinical review criteria, and
 - (e) that any person employed by or under contract with the organization adheres to the act's requirements.

The organization must also:

1. agree to maintain and provide to the commissioner the information required by the act;
2. not own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care professionals; and
3. assign as a clinical peer a health care professional who meets the following minimum qualifications:
 - (a) is an expert in the treatment of the covered person's medical condition that is the subject of the external review;
 - (b) is knowledgeable about the recommended treatment through recent or current actual clinical experience treating patients with the same or similar medical condition;
 - (c) holds a nonrestricted license in the United States and, for physicians, a current certification by a recognized American medical specialty board in the area appropriate to the subject of the external review; and
 - (d) has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency, or unit or regulatory body that raise a substantial question as to his or her physical, mental, or professional competence or moral character.

National Accreditation. An organization is presumed to meet the minimum qualifications if it is accredited by a nationally recognized private accrediting entity that has independent review organization accreditation standards that the commissioner determines are equivalent to or exceed the minimum qualifications. The commissioner must initially and periodically review the independent review organization accreditation standards of the nationally recognized private accrediting entity to determine whether the standards are, and continue to be, equivalent to or exceed the required minimum qualifications. The commissioner may accept a review conducted by the National Association of Insurance

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Commissioners (NAIC) for this purpose.

Upon request, a nationally recognized private accrediting entity must provide its current independent review organization accreditation standards to the commissioner or NAIC. The commissioner may exclude any private accrediting entity that is not reviewed by NAIC.

Conflict of Interests

The commissioner cannot assign an organization, and no organization can assign a clinical peer, to conduct a standard or expedited external review if the organization or clinical peer has a material professional, familial, or financial conflict of interest with:

1. the health carrier or any of its officers, directors, or managers;
2. the covered person or his or her authorized representative;
3. the health care provider, the provider's medical group, or independent practice association recommending the treatment;
4. the facility at which the treatment would be provided; or
5. the developer or manufacturer of the drug, device, procedure, or other therapy being recommended.

To determine whether an organization or clinical peer has a material professional, familial, or financial conflict of interest, the commissioner must consider situations in which the organization or a clinical peer may have an apparent relationship or connection with a person described above, but the characteristics of the relationship or connection are not material.

Organization Must Be Unbiased

An organization must be unbiased and must, in addition to any other written procedures the act requires, establish and maintain written procedures to ensure that it is unbiased.

Limited Immunity

An organization; clinical peer; or an organization's employee, agent, or contractor is not liable for damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Record Retention and Reporting Requirements

An organization assigned to conduct a standard or expedited external review must maintain written records, in the aggregate by state where the covered person requesting the review resides and by health carrier, on all reviews it conducted during a calendar year. It must retain the records for at least six years after receiving the review assignment.

Upon request, the organization must report to the commissioner in a format he prescribes. The report must include, in the aggregate by state where the covered person requesting the external review resides and by health carrier:

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1. the total number of requests for review, whether standard or expedited;
 2. the number of requests resolved and, of those resolved, the numbers upholding and reversing the adverse determination;
 3. the average time for resolution;
 4. a summary of the coverage or case types for which an external review was sought;
 5. the number of external reviews that were terminated as a result of a health carrier's reconsideration of its determination after receiving additional information from the covered person; and
 6. any other information the commissioner requires.
- EFFECTIVE DATE: July 1, 2011

§ 88 — TEMPORARY PROCEDURE FOR FORM FILINGS

By law, health carriers must file their policy and certificate forms for the commissioner's approval before use. The act allows health carriers to temporarily follow a "file and use" method of filing for policy forms or endorsements relating to utilization review, grievance process, or external review procedures for use on or after July 1, 2011. Health carriers must file their policy forms or endorsements with a certification to the commissioner that the policy forms meet the requirements of law. The carriers can then use the forms until and unless the commissioner disapproves their use. Health carriers can use this temporary procedure until June 30, 2012.

EFFECTIVE DATE: July 1, 2011

§§ 63, 64, 67, 68, 70 - 87, & 89 — TECHNICAL AND CONFORMING CHANGES; REPEALED SECTIONS

These sections make technical and conforming changes, including repealing the existing utilization review, grievance, and external appeals process. But the act recodifies some of the repealed sections, including penalties for a utilization review company that violates the act's provisions.

EFFECTIVE DATE: July 1, 2011

§ 90 — REPEALED SECTIONS

The act repeals the prior SustiNet law.

EFFECTIVE DATE: September 1, 2011

BACKGROUND

ERISA

The federal Employee Retirement Income Security Act (ERISA, U.S. Code Title 29) governs certain activities of most private employers who maintain employee welfare benefit plans and preempts many state laws in this area.

ERISA-covered welfare benefit plans must meet a wide range of (1) fiduciary, reporting, and disclosure requirements and (2) benefit requirements (including

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benefits required under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability and Accountability Act (HIPAA), Mental Health Parity Act, Newborns' and Mothers' Health Protection Act, and Women's Health and Cancer Rights Act).

ERISA does not apply to a "governmental plan," which it defines as "a plan established or maintained for its employees by the government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing." If the state plan permits private-sector employers to join, it may lose its status as a governmental plan, thereby subjecting it to the full requirements of ERISA, including federal oversight.

U.S. DOL Opinion Concerning ERISA Applicability

In 1999, the California School and Legal College Services of the Sonoma County Office of Education (the office) requested an advisory opinion from the U.S. Department of Labor (DOL) concerning the applicability of ERISA. Specifically, it asked if allowing 28 private-sector employees to participate in the California Public Employees' Retirement System (CalPERS) would adversely affect CalPERS' status as a "governmental plan" within the meaning of ERISA.

In its opinion, DOL stated that "governmental plan status is not affected by participation of a *de minimis* number of private sector employees. However, if a benefit arrangement is extended to cover more than a *de minimis* number of private sector employees, the Department may not consider it a governmental plan" under ERISA (U.S. DOL Advisory Opinion 1999-10A, July 26, 1999). DOL further noted that its opinion related solely to the application of ERISA's provisions and "is not determinative of any particular tax treatment under the Internal Revenue Code." It advised the office to contact the IRS to clarify tax treatment of the proposed arrangement.

OLR Tracking: JLK/ND/JK: KM/JKL/JH:Pf: df