SECTION 5: NOTICE OF INTENT

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

NOTICE OF INTENT TO ADOPT A REGULATION

In accordance with section 4-168(a) of the Connecticut General Statutes, notice is hereby given that the Insurance Commissioner, pursuant to the authority of sections 55, 62 and 66 of Public Act No. 11-58, proposes to adopt a regulation concerning Utilization Review, Grievances and Appeals.

Statement of purpose: To promulgate regulations relating to utilization review, grievances and external appeals that conform to federal and state statutes.

All interested persons are invited to submit written data, views or arguments in connection with the proposed action within thirty days following publication of this notice in the Connecticut Law Journal to the State of Connecticut, Insurance Department, Attention: N. Beth Cook, P.O. Box 816, Hartford, CT 06142-0816.

Copies of the proposed regulation may be obtained by writing to the Insurance Department at the above address or sending an e-mail to Beth.Cook@ct.gov. The proposed regulation may also be viewed by visiting the Insurance Department's Internet Web site at www.ct.gov/cid and clicking on "Proposed Regulations".

Thomas B. Leonardi
Insurance Commissioner

List name(s) and address(es) of center(s):

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SECTION 2. Section 38a-504a-1 to 38a-504a-2, inclusive, of the Regulations of Connecticut State Agencies are repealed.

Statement of purpose: To amend the regulation consistent with federal and state statutory changes which have expanded coverage for routine care expenses to a broader range of clinical trial. The definitions and filing requirements are redundant to the statute and are therefore being repealed; the form is being updated to remove any references to "cancer".

INSURANCE DEPARTMENT

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Thomas B. Leonardi
Insurance Commissioner

Regulations Concerning Utilization Review, Grievances and External Review

SECTION 1.

The Regulations of Connecticut State Agencies are amended by adding section 38a-XXX-1 through 38a-XXX – 11 as follows:

(NEW) Sec. 38a-XXX – 1. Utilization review company licenses

(a) No utilization review company shall conduct utilization review in this state unless it has been licensed by the commissioner in accordance with section 63 of public act 11-58. All requests for licensure shall be made in a manner and on a form prescribed annually by the commissioner.

(b) Applications will not be considered complete and eligible for processing until all required information is provided.

(c) The application fee must be submitted in check form made payable to the Treasurer – State of Connecticut.

(d) All licenses shall be renewed no later than October 1 annually.

(e) The annual license fee will not be pro-rated if issued for a period less than a full year.

(NEW) Sec. 38a-XXX-2. Compensation based on certification denials – prohibited

(a) No staff member, officer or consultant of a utilization review company or a health carrier shall receive any financial incentive based on the number of denials of certifications made.

(b) No utilization review company or health carrier shall receive any financial incentive based on the number of denials of certifications made.

(NEW) Sec. 38a-XXX-3. Confidentiality

(a) Each utilization review company shall comply with the provisions of this section as well as all applicable federal and state laws to protect the confidentiality of patient medical records. Each utilization review company shall:

(1) Secure each case file by assigning case identification numbers to all utilization review requests, and use such numbers in lieu of personally identifiable information, whenever feasible.

(2) Ensure that all paper copies of files are reasonably secured in appropriate storage facilities.

(3) Maintain appropriate written procedures for the requesting, maintenance, and disposition of patient medical records.

(4) Develop and maintain specifications indicating when and by whom the release of patient medical records is permitted.

(5) Ensure that all utilization review business operations are reasonably secured during non-business hours.

(6) Require all employees with access to patient medical records to sign a confidentiality statement, to be maintained on file by the company, in which the employee acknowledges the confidential nature of such information.

(7) Maintain a written policy stipulating sanctions for an employee's unauthorized disclosure of patient medical records, up to and including to termination of employment.

(8) Maintain procedures for limiting access to computer files containing patient medical records through passwords, restricted functions and computer terminal security.

(9) Develop and maintain procedures to address the security of all patient medical records that are transferred by facsimile, which shall include:

(i) A statement in all facsimile transmission cover sheets that such data is confidential and is limited specifically for use by the company in making a utilization review determination; and

(ii) Security procedures governing the use of facsimile transmissions, specifying restricted access to such transmissions, the extent of such information that may be released, and the placement of the facsimile machine in a reasonably secured or isolated area.

(b) Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(NEW) Sec. 38a-XXX-4. Recordkeeping

With respect to all utilization reviews, urgent care or expedited utilization reviews, appeals of adverse determinations, and expedited appeals, each utilization review company shall maintain an audit trail, through a written control log or computer report, clearly evidencing:

(1) the date and time that a request or appeal was received;

(2) the dates, times and reasons for any subsequent requests for additional information required to complete any such review or appeal;

(3) the dates and times of the receipt of the additional information; and

(4) the date and time of notification to the provider of record or the enrollee.

(NEW) Sec. 38a-XXX –5. Statistical reporting to the commissioner

(a) Each health carrier shall file annually with the commissioner, on or before March 1, a summary report of its utilization review program activities in the calendar year immediately preceding and a report that includes for each type of health benefit plan offered by the health carrier the required information set forth in subsection (e)(1)(B) of section 55 of public act 11-58.

(b) Each health carrier shall report the information indicated in a format as specified annually by the commissioner and shall maintain source records adequate to support the accuracy of the information filed.

(c) The information required in subsection (a) of this section shall also be provided on an aggregate basis with respect to utilization review activities conducted nationwide.

(NEW) Sec. 38a-XXX-6. Examinations

(a) The commissioner shall, at his discretion, undertake a compliance examination of any utilization review company licensed and conducting business in this state. In conducting the examination, the commissioner or his designee may examine the offices of such utilization review company, its books, records, procedures and any other information deemed to be relevant to the examination.

(b) Upon completing the compliance examination, the commissioner or his designee shall issue a report of the examination. The report shall include any corrective or remedial actions deemed necessary to be taken by the utilization review company in order to assure compliance with the requirements of Connecticut law.

(NEW) Sec. 38a-XXX-7. Grievance procedures

(a) Each health carrier shall file with the commissioner a copy of the written procedures, including all forms used to process requests, for (1) the review of grievances of adverse determinations that were based, in whole or in part, on medical necessity, (2) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility, and (3) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(b) Each health carrier shall file with the commissioner an initial copy of such procedures, including all forms used to process requests no later than June 2012 and any subsequent material modifications to such procedures no later than one month following implementation of the modification.

(NEW) Sec. 38a-XXX-8. Notice to enrollees

(a) Each health carrier required to submit notices to a covered person or the covered person's authorized representative pursuant to sections 57 of public act 11-58, including adverse determinations that involve a rescission, shall include with

the Notice of Adverse Determination a description of the health carrier's procedures for initiating an internal grievance of an adverse determination including the procedures for an expedited request. Such notification shall also include the procedures for filing an external review or an expedited external review.

(b) Each health carrier required to submit notices to a covered person or the covered person's authorized representative pursuant to sections 58 of public act 11-58 shall include with the Notice of a Grievance Decision that upholds the Adverse Determination a description of the health carrier's procedures for initiating any remaining internal grievance rights including the procedures for an expedited request. If the Notice of a Grievance Decision that upholds the Adverse Determination is the final adverse determination, or if the notice is issued due to the health carrier's failure to strictly adhere to the requirements of section 58 (f)(1) of public act 11-58, the notice must also include a statement that all internal appeals have been exhausted. Such notice shall include the procedure for filing an external review or an expedited external review, as well as a copy of the external review application and consumer guide. The external review application and consumer guide containing the procedure and application to appeal to the commissioner pursuant to section 60 of public act 11-58 shall be made available to the health carrier by the commissioner for use with this notification requirement. A copy of the external review application and consumer guide shall also be made available from the health carrier to the covered person or the covered person's authorized representative, upon request.

(c) For purposes of triggering any internal or external review periods, notice shall be deemed to have been given to the covered person or the covered person's authorized representative three (3) calendar days after the notice is put into the possession of the postal service.

(NEW) Sec. 38a-XXX-9. Rescission notice

Group health plans, or health insurance issuers offering group or individual health insurance coverage, shall provide advance written notice, consistent with 45 C.F.R. 136, to each individual market participant, primary subscriber who would be affected before coverage may be rescinded regardless of whether the rescission applies to an entire group or only to an individual within the group. Rescissions and eligibility denials shall be considered to be adverse determinations for purposes of internal and external claim review.

(NEW) Sec. 38a-XXX-10. Independent review organizations

(a) The commissioner shall enter into agreements for external review services with as many independent review organizations as he deems necessary. The agreements shall set forth all terms which the commissioner deems necessary to assure a full and fair review of appeals. Selection of an independent review organization shall include, but not be limited to the criteria set forth in section 65 of public act 11-58 and be in accordance with all applicable state contracting laws.

(b) After entering into an agreement with the commissioner, the independent review organization shall report changes in its ownership, or its operational or administrative status to the commissioner not later than thirty (30) days after the effective date of such change. If the commissioner determines that the reported change(s) may negatively impact the effectiveness or objectivity of the independent review organization, the commissioner reserves the right to terminate the agreement.

(NEW) Sec. 38a-XXX-11. Severability

If any provision of sections 38a-XXX-1 to 38a-XXX-11, inclusive, of the regulations of Connecticut State Agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the provisions

of said regulations, and the application of such provision to other persons or circumstances shall not be affected thereby.

SECTION 2

Sections 38a-226-1 to section 38a-226-10, inclusive, of the Regulations of Connecticut State Agencies are repealed.

SECTION 3

Section 38a-478m-1 of the Regulations of Connecticut State Agencies is repealed.

SECTION 4

Sections 38a-478n-1 to section 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies are repealed.

Statement of purpose: To promulgate regulations relating to utilization review, grievances and external appeals that conform to federal and state statutes.

CONNECTICUT HOUSING FINANCE AUTHORITY

Notice of Intent to Amend Procedures

Statement of purpose: To amend the Housing Tax Credit Contribution Program Procedures of the Authority.

Summary of proposed procedures: The Procedures are being amended to implement amendments to the Connecticut General Statutes.

Copies of the proposed Procedures may be obtained by calling (860) 571-4349. All interested persons may submit written data, views and arguments in connection with the above-stated proposed procedures to the President-Executive Director, Connecticut Housing Finance Authority, 999 West Street, Rocky Hill, Connecticut 06067, no later than 30 days after publication of this notice.