



House of Representatives

File No. 868

General Assembly

January Session, 2011

(Reprint of File No. 483)

Substitute House Bill No. 6308
As Amended by House
Amendment Schedules "A" and "D"

Approved by the Legislative Commissioner
May 31, 2011

AN ACT CONCERNING HEALTHCARE REFORM.

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

1 Section 1. (NEW) (*Effective July 1, 2011*) As used in this section and
2 sections 2 to 8, inclusive, of this act:

3 (1) "Health Care Cost Containment Committee" means the
4 committee established in accordance with the ratified agreement
5 between the state and the State Employees Bargaining Agent Coalition
6 pursuant to subsection (f) of section 5-278 of the general statutes.

7 (2) "Nonprofit employee" means any employee of a nonprofit
8 employer.

9 (3) "Nonprofit employer" means (A) a nonprofit corporation,
10 organized under 26 USC 501, as amended from time to time, that (i)
11 has a purchase of service contract, as defined in section 4-70b of the
12 general statutes, or (ii) receives fifty per cent or more of its gross
13 annual revenue from grants or funding from the state, the federal
14 government or a municipality or any combination thereof, or (B) an
15 organization that is tax exempt pursuant to 26 USC 501(c)(5), as

16 amended from time to time.

17 (4) "Nonstate public employee" means any employee or elected
18 officer of a nonstate public employer.

19 (5) "Nonstate public employer" means a municipality or other
20 political subdivision of the state, including a board of education, quasi-
21 public agency or public library. A municipality and a board of
22 education may be considered separate employers.

23 (6) "Partnership plan" means a health care benefit plan offered by
24 the Comptroller to nonstate public employers or nonprofit employers
25 under section 2 of this act.

26 (7) "State employee plan" means a self-insured group health care
27 benefits plan established under subsection (m) of section 5-259 of the
28 general statutes.

29 Sec. 2. (NEW) (*Effective July 1, 2011*) (a) (1) Notwithstanding the
30 provisions of title 38a of the general statutes, the Comptroller shall
31 offer to nonstate public employers and nonprofit employers, and their
32 respective retirees, if applicable, coverage under a partnership plan or
33 plans. Such plan or plans may be offered on a fully-insured or risk-
34 pooled basis at the discretion of the Comptroller. Any health insurer,
35 health care center or other entity that contracts with the Comptroller
36 for the purposes of this section and any fully-insured plan offered by
37 the Comptroller under such contract shall be subject to title 38a of the
38 general statutes. Eligible employers shall submit an application to the
39 Comptroller for coverage under any such plan or plans.

40 (2) Beginning January 1, 2012, the Comptroller shall offer coverage
41 under such plan or plans to nonstate public employers. Beginning
42 January 1, 2013, the Comptroller shall offer coverage under such plan
43 or plans to nonprofit employers.

44 (b) (1) The Comptroller shall require nonstate public employers and
45 nonprofit employers that elect to obtain coverage under a partnership

46 plan to participate in such plan for not less than two-year intervals. An
47 employer may apply for renewal prior to the expiration of each
48 interval.

49 (2) The Comptroller shall develop procedures by which:

50 (A) Such employers may apply to obtain coverage under a
51 partnership plan, including procedures for nonstate public employers
52 that are currently fully insured and procedures for nonstate public
53 employers that are currently self-insured;

54 (B) Employers receiving coverage for their employees pursuant to a
55 partnership plan may (i) apply for renewal, or (ii) withdraw from such
56 coverage, including, but not limited to, the terms and conditions under
57 which such employers may withdraw prior to the expiration of the
58 interval and the procedure by which any premium payments such
59 employers may be entitled to or premium equivalent payments made
60 in excess of incurred claims shall be refunded to such employer. Any
61 such procedures shall provide that nonstate public employees covered
62 by collective bargaining shall withdraw from such coverage in
63 accordance with chapters 113 and 166 of the general statutes; and

64 (C) The Comptroller may collect payments and fees for unreported
65 claims and expenses.

66 (c) (1) The initial open enrollment for nonstate public employers
67 shall be for coverage beginning July 1, 2012. Thereafter, open
68 enrollment for nonstate public employers shall be for coverage periods
69 beginning July first.

70 (2) The initial open enrollment for nonprofit employers shall be for
71 coverage beginning January 1, 2013. Thereafter, open enrollment for
72 nonprofit employers shall be for coverage periods beginning January
73 first and July first.

74 (d) Nothing in this section or sections 3 and 4 of this act shall require
75 the Comptroller to offer coverage to every employer seeking coverage

76 under sections 3 and 4 of this act from every partnership plan offered
77 by the Comptroller.

78 (e) The Comptroller shall create applications for coverage for the
79 purposes of sections 3 and 4 of this act and for renewal of a
80 partnership plan. Such applications shall require an employer to
81 disclose whether the employer will offer any other health care benefits
82 plan to the employees who are offered a partnership plan.

83 (f) No employee shall be enrolled in a partnership plan if such
84 employee is covered through such employee's employer by health
85 insurance plans or insurance arrangements issued to or in accordance
86 with a trust established pursuant to collective bargaining subject to the
87 federal Labor Management Relations Act.

88 (g) (1) The Comptroller shall take such actions as are necessary to
89 ensure that granting coverage to an employer under sections 3 and 4 of
90 this act will not affect the status of the state employee plan as a
91 governmental plan under the Employee Retirement Income Security
92 Act of 1974, as amended from time to time. Such actions may include,
93 but are not limited to, cancelling coverage, with notice, to such
94 employer and discontinuing the acceptance of applications for
95 coverage from nonprofit employers. The Comptroller shall establish
96 the form and time frame for the notice of cancellation to be provided to
97 such employer.

98 (2) The Comptroller shall resume providing coverage for, or
99 accepting applications for coverage from, nonprofit employers if the
100 Comptroller determines that granting coverage to such employers will
101 not affect the state employee plan's status as a governmental plan
102 under the Employee Retirement Income Security Act of 1974, as
103 amended from time to time.

104 (3) The Comptroller shall make a public announcement of the
105 Comptroller's decision to discontinue or resume coverage or the
106 acceptance of applications for coverage under a partnership plan or
107 plans.

108 (h) The Comptroller, in consultation with the Health Care Cost
109 Containment Committee, shall:

110 (1) Develop and implement patient-centered medical homes for the
111 state employee plan and partnership plans offered under this section,
112 in a manner that will reduce the costs of such plans; and

113 (2) Review claims data of the state employee plan and partnership
114 plans offered under this section, to target high-cost health care
115 providers and medical conditions and monitor costly trends.

116 Sec. 3. (NEW) (*Effective July 1, 2011*) (a) Nonstate public employers
117 and nonprofit employers may apply for coverage under a partnership
118 plan in accordance with this section.

119 (1) Notwithstanding any provision of the general statutes, initial
120 and continuing participation in a partnership plan by a nonstate public
121 employer shall be a permissive subject of collective bargaining and
122 shall be subject to binding interest arbitration only if the collective
123 bargaining agent and the employer mutually agree to bargain over
124 such participation.

125 (2) If a nonstate public employer or a nonprofit employer submits
126 an application for coverage for all of its respective employees, the
127 Comptroller shall accept such application upon the terms and
128 conditions applicable to the partnership plan, for the next open
129 enrollment. The Comptroller shall provide written notification to such
130 employer of such acceptance and the date on which such coverage
131 shall begin, pending acceptance by such employer of the terms and
132 conditions of such plan.

133 (3) (A) Except as specified in subparagraph (D) of this subdivision, if
134 a nonstate public employer or a nonprofit employer submits an
135 application for coverage for less than all of its respective employees, or
136 indicates in the application the employer will offer other health plans
137 to employees who are offered a partnership plan, the Comptroller shall
138 forward such application to a health care actuary not later than five

139 business days after receiving such application. Not later than sixty
140 days after receiving such application, such actuary shall notify the
141 Comptroller whether, as a result of the employees included in such
142 application or other factors, the application will shift a significant part
143 of such employer's employees' medical risks to the partnership plan.
144 Such actuary shall provide, in writing, to the Comptroller the specific
145 reasons for such actuary's finding, including a summary of all
146 information relied upon in making such a finding.

147 (B) If the Comptroller determines that, based on such finding, the
148 application will shift a significant part of such employer's employees'
149 medical risks to the partnership plan, the Comptroller shall not
150 provide coverage to such employer and shall provide written
151 notification and the specific reasons for such denial to such employer
152 and the Health Care Cost Containment Committee.

153 (C) If the Comptroller determines that, based on such finding, the
154 application will not shift a significant part of such employer's
155 employees' medical risks to the partnership plan, the Comptroller shall
156 accept such application for the next open enrollment. The Comptroller
157 shall provide written notification to such employer of such acceptance
158 and the date on which such coverage shall begin, pending acceptance
159 by such employer of the terms and conditions of such plan.

160 (D) If an employer included less than all of its employees in its
161 application for coverage because of (i) the decision by individual
162 employees to decline coverage from their employer for themselves or
163 their dependents, or (ii) the employer's decision not to offer coverage
164 to temporary, part-time or durational employees, the Comptroller shall
165 not forward such employer's application to a health care actuary.

166 (b) The Comptroller shall consult with a health care actuary who
167 shall develop:

168 (1) Actuarial standards to assess the shift in medical risks of an
169 employer's employees to a partnership plan. The Comptroller shall
170 present such standards to the Health Care Cost Containment

171 Committee for its review, evaluation and approval prior to the use of
172 such standards; and

173 (2) Actuarial standards to determine the administrative fees and
174 fluctuating reserves fees set forth in section 5 of this act and the
175 amount of premiums or premium equivalent payments to cover
176 anticipated claims and claim reserves. The Comptroller shall present
177 such standards to the Health Care Cost Containment Committee for its
178 review, evaluation and approval prior to the use of such standards.

179 (c) The Comptroller may adopt regulations, in accordance with
180 chapter 54 of the general statutes, to establish the procedures and
181 criteria for any reviews or evaluations performed by the Health Care
182 Cost Containment Committee pursuant to subsection (b) of this section
183 or subsection (c) of section 4 of this act.

184 Sec. 4. (NEW) (*Effective July 1, 2011*) (a) Employers whose
185 applications for coverage for their employees under a partnership
186 plan, pursuant to section 3 of this act, have been accepted may seek
187 such coverage for their retirees in accordance with this section.
188 Premium payments for such coverage shall be remitted by the
189 employer to the Comptroller in accordance with section 5 of this act.

190 (b) (1) If an employer seeks coverage for all of such employer's
191 retirees in accordance with this section and all of such employer's
192 employees in accordance with section 3 of this act, the Comptroller
193 shall accept such application upon the terms and conditions applicable
194 to the partnership plan, for the next open enrollment. The Comptroller
195 shall provide written notification to such employer of such acceptance
196 and the date on which such coverage shall begin, pending acceptance
197 by such employer of the terms and conditions of such plan.

198 (2) Except as specified in subdivision (5) of this subsection, if a
199 nonstate public employer or a nonprofit employer seeks coverage for
200 less than all of its respective retirees, regardless of whether the
201 employer is seeking coverage for all of such employer's active
202 employees, the Comptroller shall forward such application to a health

203 care actuary not later than five business days after receiving such
204 application. Not later than sixty days after receiving such application,
205 such actuary shall notify the Comptroller whether, as a result of the
206 retirees included in such application or other factors, the application
207 will shift a significant part of such employer's retirees' medical risks to
208 the partnership plan. Such actuary shall provide, in writing, to the
209 Comptroller the specific reasons for such actuary's finding, including a
210 summary of all information relied upon in making such a finding.

211 (3) If the Comptroller determines that, based on such finding, the
212 application will shift a significant part of such employer's retirees'
213 medical risks to the partnership plan, the Comptroller shall not
214 provide coverage to such employer and shall provide written
215 notification and the specific reasons for such denial to such employer
216 and the Health Care Cost Containment Committee.

217 (4) If the Comptroller determines that, based on such finding, the
218 application will not shift a significant part of such employer's retirees'
219 medical risks to the partnership plan, the Comptroller shall accept
220 such application for the next open enrollment. The Comptroller shall
221 provide written notification to such employer of such acceptance and
222 the date on which such coverage shall begin, pending acceptance by
223 such employer of the terms and conditions of such plan.

224 (5) If an employer included less than all of its retirees in its
225 application for coverage because of (A) the decision by individual
226 retirees to decline health benefits or health insurance coverage from
227 their employer for themselves or their dependents, or (B) the retiree's
228 enrollment in Medicare, the Comptroller shall not forward such
229 employer's application to a health care actuary.

230 (c) The Comptroller shall consult with a health care actuary who
231 shall develop actuarial standards to be used to assess the shift in
232 medical risks of an employer's retirees to a partnership plan. The
233 Comptroller shall present such standards to the Health Care Cost
234 Containment Committee for its review, evaluation and approval prior

235 to the use of such standards.

236 (d) Nothing in sections 1 to 14, inclusive, of this act shall diminish
237 any right to retiree health insurance pursuant to a collective bargaining
238 agreement or any other provision of the general statutes.

239 Sec. 5. (NEW) (*Effective July 1, 2011*) (a) There is established an
240 account to be known as the "partnership plan premium account",
241 which shall be a separate, nonlapsing account within the General
242 Fund. All premiums paid by employers and their respective
243 employees and retirees for coverage under a partnership plan
244 pursuant to sections 2 to 4, inclusive, of this act shall be deposited into
245 said account. The account shall be administered by the Comptroller for
246 payment of claims and administrative fees to entities providing
247 coverage or services under partnership plans.

248 (b) The Comptroller may charge each employer participating in a
249 partnership plan an administrative fee calculated on a per member per
250 month basis, in accordance with the actuarial standards developed
251 under subsection (b) of section 3 of this act and subsection (c) of section
252 4 of this act. In addition, the Comptroller may charge a fluctuating
253 reserves fee the Comptroller deems necessary and in accordance with
254 the actuarial standards developed under subsection (b) of section 3 of
255 this act and subsection (c) of section 4 of this act to ensure adequate
256 claims reserves.

257 (c) Each employer shall pay monthly the amount determined by the
258 Comptroller, pursuant to this section, for coverage of its employees or
259 its employees and retirees, as appropriate, under a partnership plan.
260 An employer may require each covered employee to contribute a
261 portion of the cost of such employee's coverage under the plan, subject
262 to any collective bargaining obligation applicable to such employer.

263 (d) If any payment due by an employer under this section is not
264 submitted to the Comptroller by the tenth day after the date such
265 payment is due, interest to be paid by such employer shall be added,
266 retroactive to the date such payment was due, at the prevailing rate of

267 interest as determined by the Comptroller.

268 (1) The Comptroller may terminate participation in the partnership
269 plan by a nonprofit employer on the basis of nonpayment of premium
270 or premium equivalent, provided at least ten days' advance notice is
271 given to such employer, which may continue the coverage and avoid
272 the effect of the termination by remitting payment in full at any time
273 prior to the effective date of termination.

274 (2) (A) If a nonstate public employer fails to make premium
275 payments or premium equivalent payments as required by this
276 section, the Comptroller may direct the State Treasurer, or any other
277 officer of the state who is the custodian of any moneys made available
278 by grant, allocation or appropriation payable to such nonstate public
279 employer, to withhold the payment of such moneys until the amount
280 of the premium or premium equivalent or interest due has been paid
281 to the Comptroller, or until the State Treasurer or such custodial officer
282 determines that arrangements have been made, to the satisfaction of
283 the State Treasurer, for the payment of such premium or premium
284 equivalent and interest. Such moneys shall not be withheld if such
285 withholding will adversely affect the receipt of any federal grant or aid
286 in connection with such moneys.

287 (B) If no grant, allocation or appropriation is payable to such
288 nonstate public employer or is not withheld, pursuant to
289 subparagraph (A) of this subdivision, the Comptroller may terminate
290 participation in a partnership plan by a nonstate public employer on
291 the basis of nonpayment of premium or premium equivalent, provided
292 at least ten days' advance notice is given to such employer, which may
293 continue the coverage and avoid the effect of the termination by
294 remitting payment in full at any time prior to the effective date of
295 termination.

296 (3) The Comptroller may request the Attorney General to bring an
297 action in the superior court for the judicial district of Hartford to
298 recover any premium or premium equivalent, interest costs, paid claim

299 expenses or equitable relief from a terminated employer.

300 Sec. 6. (NEW) (*Effective July 1, 2011*) (a) There is established a
301 Nonstate Public Health Care Advisory Committee. The committee
302 shall make advisory recommendations to the Health Care Cost
303 Containment Committee concerning health care coverage for nonstate
304 public employees. The advisory committee shall consist of nonstate
305 public employers and employees participating in a partnership plan
306 and shall include the following members appointed by the
307 Comptroller: (1) Three municipal employer representatives, one of
308 whom represents towns with populations of one hundred thousand or
309 more, one of whom represents towns with populations of at least
310 twenty thousand but under one hundred thousand, and one of whom
311 represents towns with populations under twenty thousand; (2) three
312 municipal employee representatives, one of whom represents
313 employees in towns with populations of one hundred thousand or
314 more, one of whom represents employees in towns with populations
315 of at least twenty thousand but under one hundred thousand, and one
316 of whom represents employees in towns with populations under
317 twenty thousand; (3) three board of education employers, one of
318 whom represents towns with populations of one hundred thousand or
319 more, one of whom represents towns with populations of at least
320 twenty thousand but under one hundred thousand, and one of whom
321 represents towns with populations under twenty thousand; and (4)
322 three board of education employee representatives, one of whom
323 represents towns with populations of one hundred thousand or more,
324 one of whom represents towns with populations of at least twenty
325 thousand but under one hundred thousand, and one of whom
326 represents towns with populations under twenty thousand.

327 (b) There is established a Nonprofit Health Care Advisory
328 Committee. The committee shall make advisory recommendations to
329 the Health Care Cost Containment Committee concerning health care
330 coverage for nonprofit employees. The advisory committee shall
331 consist of nonprofit employers and their respective employees
332 participating in a partnership plan and shall include the following

333 members appointed by the Comptroller: (1) Three nonprofit employer
334 representatives; and (2) three nonprofit employee representatives.

335 Sec. 7. (NEW) (*Effective July 1, 2011*) The Comptroller may adopt
336 regulations, in accordance with chapter 54 of the general statutes, to
337 implement and administer partnership plans and the provisions of
338 sections 1 to 6, inclusive, of this act. The Comptroller may implement
339 policies and procedures necessary to administer the provisions of
340 sections 1 to 6, inclusive, of this act while in the process of adopting
341 such policies and procedures as regulation, provided the Comptroller
342 prints notice of intent to adopt regulations in the Connecticut Law
343 Journal not later than twenty days after the date of implementation.
344 Policies and procedures implemented pursuant to this section shall be
345 valid until the time final regulations are adopted.

346 Sec. 8. (NEW) (*Effective from passage*) (a) The Comptroller shall not
347 offer coverage under a partnership plan pursuant to sections 2 to 5,
348 inclusive, of this act until the Health Care Cost Containment
349 Committee has provided, in writing, its approval of sections 1 to 6,
350 inclusive, of this act to the Comptroller and until the State Employees
351 Bargaining Agent Coalition has provided its written consent to the
352 clerks of both houses of the General Assembly to incorporate the terms
353 of sections 1 to 6, inclusive, of this act into its collective bargaining
354 agreement.

355 (b) Nothing in this section or sections 1 to 7, inclusive, of this act
356 shall modify the state employee plan in any way without the written
357 consent of the State Employee Bargaining Agent Coalition and the
358 Secretary of the Office of Policy and Management.

359 Sec. 9. (NEW) (*Effective July 1, 2011*) (a) For the purposes of this
360 section, "employer" has the same meaning as provided in section 38a-
361 513f of the general statutes, as amended by this act.

362 (b) Not later than October first, annually, each employer that
363 sponsors a fully-insured group health insurance policy for its active
364 employees, early retirees and retirees that provides coverage of the

365 type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section
366 38a-469 of the general statutes shall submit electronically to the
367 Comptroller, in a form prescribed by the Comptroller, the following
368 information: For the two policy years immediately preceding, the
369 percentage increase or decrease in the policy or plan costs, calculated
370 as the total premium costs, inclusive of any premiums or contributions
371 paid by active employees, early retirees and retirees, divided by the
372 total number of active employees, early retirees and retirees covered
373 by such policy.

374 Sec. 10. Section 38a-513f of the general statutes is repealed and the
375 following is substituted in lieu thereof (*Effective July 1, 2011*):

376 (a) As used in this section:

377 (1) "Claims paid" means the amounts paid for the covered
378 employees of an employer by an insurer, health care center, hospital
379 service corporation, medical service corporation or other entity as
380 specified in subsection (b) of this section for medical services and
381 supplies and for prescriptions filled, but does not include expenses for
382 stop-loss coverage, reinsurance, enrollee educational programs or
383 other cost containment programs or features, administrative costs or
384 profit.

385 (2) "Employer" means any town, city, borough, school district,
386 taxing district or fire district employing more than fifty employees.

387 (3) "Utilization data" means (A) the aggregate number of procedures
388 or services performed for the covered employees of the employer, by
389 practice type and by service category, or (B) the aggregate number of
390 prescriptions filled for the covered employees of the employer, by
391 prescription drug name.

392 (b) Each insurer, health care center, hospital service corporation,
393 medical service corporation or other entity delivering, issuing for
394 delivery, renewing, amending or continuing in this state any group
395 health insurance policy providing coverage of the type specified in

396 subdivisions (1), (2), (4), (11), [and] (12) and (16) of section 38a-469
397 shall:

398 (1) [Disclose] Not later than October first, annually, provide to an
399 employer sponsoring such policy, [upon request by such employer]
400 free of charge, the following information for the most recent thirty-six-
401 month period or for the entire period of coverage, whichever is
402 shorter, ending not more than sixty days prior to the date of the
403 request, in a format as set forth in subdivision (3) of this subsection:

404 (A) Complete and accurate medical, dental and pharmaceutical
405 utilization data, as applicable;

406 (B) Claims paid by year, aggregated by practice type and by service
407 category, each reported separately for in-network and out-of-network
408 providers, and the total number of claims paid;

409 (C) Premiums paid by such employer by month; and

410 (D) The number of insureds by coverage tier, including, but not
411 limited to, single, two-person and family including dependents, by
412 month;

413 (2) Include in such requested information specified in subdivision
414 (1) of this subsection only health information that has had identifiers
415 removed, as set forth in 45 CFR 164.514, is not individually
416 identifiable, as defined in 45 CFR 160.103, and is permitted to be
417 disclosed under the Health Insurance Portability and Accountability
418 Act of 1996, P.L. 104-191, as amended from time to time, or regulations
419 adopted thereunder; and

420 (3) [Disclose] Provide such requested information (A) in a written
421 report, (B) through an electronic file transmitted by secure electronic
422 mail or a file transfer protocol site, or (C) through a secure web site or
423 web site portal that is accessible by such employer.

424 (c) Such insurer, health care center, hospital service corporation,
425 medical service corporation or other entity shall not be required to

426 provide such information to the employer more than once in any
427 twelve-month period.

428 (d) [Information disclosed] (1) Except as provided in subdivision (2)
429 of this subsection, information provided to an employer pursuant to
430 subsection (b) of this section shall be used by such employer only for
431 the purposes of obtaining competitive quotes for group health
432 insurance or to promote wellness initiatives for the employees of such
433 employer.

434 (2) Any employer may provide to the Comptroller upon request the
435 information disclosed to such employer pursuant to subsection (b) of
436 this section. The Comptroller shall maintain as confidential any such
437 information.

438 (e) Any information [disclosed] provided to an employer in
439 accordance with subsection (b) of this section or to the Comptroller in
440 accordance with subdivision (2) of subsection (d) of this section shall
441 not be subject to disclosure under section 1-210. An employee
442 organization, as defined in section 7-467, that is the exclusive
443 bargaining representative of the employees of such employer shall be
444 entitled to receive claim information from such employer in order to
445 fulfill its duties to bargain collectively pursuant to section 7-469.

446 (f) If a subpoena or other similar demand related to information
447 [disclosed] provided pursuant to subsection (b) of this section is issued
448 in connection with a judicial proceeding to an employer that receives
449 such information, such employer shall immediately notify the insurer,
450 health care center, hospital service corporation, medical service
451 corporation or other entity that [disclosed] provided such information
452 to such employer of such subpoena or demand. Such insurer, health
453 care center, hospital service corporation, medical service corporation
454 or other entity shall have standing to file an application or motion with
455 the court of competent jurisdiction to quash or modify such subpoena.
456 Upon the filing of such application or motion by such insurer, health
457 care center, hospital service corporation, medical service corporation

458 or other entity, the subpoena or similar demand shall be stayed
459 without penalty to the parties, pending a hearing on such application
460 or motion and until the court enters an order sustaining, quashing or
461 modifying such subpoena or demand.

462 Sec. 11. (NEW) (*Effective from passage*) (a) The Office of Health
463 Reform and Innovation established under subsection (b) of section 13
464 of this act shall convene a working group to develop a plan to
465 implement a state-wide multipayer data initiative to enhance the
466 state's use of health care data from multiple sources to increase
467 efficiency, enhance outcomes and improve the understanding of health
468 care expenditures in the public and private sectors. Such group shall
469 include, but not be limited to, the Secretary of the Office of Policy and
470 Management, the Comptroller, the Commissioners of Public Health
471 and Social Services, the Insurance Commissioner, representatives of
472 health insurance companies, health insurance purchasers, hospitals,
473 consumer advocates and health care providers.

474 (b) The Office of Health Reform and Innovation shall submit, in
475 accordance with section 11-4a of the general statutes, a report on such
476 plan to the joint standing committees of the General Assembly having
477 cognizance of matters relating to appropriations, insurance and public
478 health.

479 Sec. 12. Section 19a-654 of the general statutes is repealed and the
480 following is substituted in lieu thereof (*Effective July 1, 2011*):

481 (a) As used in this section:

482 (1) "Patient-identifiable data" means any information that identifies
483 or may reasonably be used as a basis to identify an individual patient;
484 and

485 (2) "De-identified patient data" means any information that meets
486 the requirements for de-identification of protected health information
487 as set forth in 45 CFR 164.514.

488 (b) [The Office of Health Care Access division of the Department of
489 Public Health shall require] Each short-term acute care general or
490 children's [hospitals to submit such data, including discharge data, as
491 it deems necessary] hospital shall submit patient identifiable inpatient
492 discharge data and emergency department data to the Office of Health
493 Care Access division of the Department of Public Health to fulfill the
494 responsibilities of the office. Such data shall include data taken from
495 patient medical record abstracts and [hospital] bills. The office shall
496 specify the timing and format of such [submission shall be specified by
497 the office. The data may be submitted through a contractual
498 arrangement with an intermediary. If the data is submitted]
499 submissions including submissions by outpatient surgical facilities as
500 provided for in subsection (c) of this section. If a hospital or outpatient
501 surgical facility submits data through an intermediary, the hospital or
502 the outpatient surgical facility shall ensure that such submission of
503 data is timely and [that the data is] accurate. The office may conduct an
504 audit of the data submitted [to] through such intermediary in order to
505 verify its accuracy. [Individual patient and physician data identified by
506 proper name or personal identification code submitted pursuant to this
507 section shall be kept confidential, but aggregate reports from which
508 individual patient and physician data cannot be identified shall be
509 available to the public.]

510 (c) With respect to the submission of outpatient data, an outpatient
511 surgical facility, as defined in section 19a-493b, a short-term acute care
512 general or children's hospital, or a facility that provides outpatient
513 surgical services as part of the outpatient surgery department of a
514 short-term acute care hospital shall submit to the office the data
515 identified in subsection (c) of section 19a-634. The office shall convene
516 a working group consisting of representatives of outpatient surgical
517 facilities, hospitals and other individuals necessary to develop
518 recommendations that address current obstacles to, and proposed
519 requirements for, patient-identifiable data reporting in the outpatient
520 setting. On or before February 1, 2012, the working group shall report,
521 in accordance with the provisions of section 11-4a, on its findings and

522 recommendations to the joint standing committees of the General
523 Assembly having cognizance of matters relating to public health and
524 insurance and real estate. Additional reporting of outpatient data as
525 the office deems necessary shall begin not later than July 1, 2015. On or
526 before July 1, 2012, and annually thereafter, the Connecticut
527 Association of Ambulatory Surgery Centers shall provide a progress
528 report to the Department of Public Health, until such time as all
529 ambulatory surgery centers are in full compliance with the
530 implementation of systems that allow for the reporting of outpatient
531 data as required by the commissioner. Until such additional reporting
532 requirements take effect, the department may work with the
533 Connecticut Association of Ambulatory Surgery Centers and the
534 Connecticut Hospital Association on specific data reporting initiatives
535 provided that no penalties shall be assessed under this chapter or any
536 other provision of law with respect to the failure to submit such data.

537 (d) Except as otherwise provided in this subsection, patient-
538 identifiable data received by the office shall be kept confidential and
539 shall not be considered public records or files subject to disclosure
540 under the Freedom of Information Act, as defined in section 1-200. The
541 office may release de-identified patient data or aggregate patient data
542 to the public in a manner consistent with the provisions of 45 CFR
543 164.514. Any de-identified patient data released by the office shall
544 exclude provider, physician and payer organization names or codes
545 and shall be kept confidential by the recipient. The office may not
546 release patient-identifiable data except as provided for in section 19a-
547 25 and regulations adopted pursuant to said section. No individual or
548 entity receiving patient-identifiable data may release such data in any
549 manner that may result in an individual patient, physician, provider or
550 payer being identified. The office shall impose a reasonable, cost-based
551 fee for any patient data provided to a nongovernmental entity.

552 (e) Not later than October 1, 2011, the Office of Health Care Access
553 shall enter into a memorandum of understanding with the
554 Comptroller that shall permit the Comptroller to access the data set
555 forth in subsections (b) and (c) of this section, provided the

556 Comptroller agrees, in writing, to keep individual patient and
557 physician data identified by proper name or personal identification
558 code and submitted pursuant to this section confidential.

559 (f) The Commissioner of Public Health shall adopt regulations, in
560 accordance with the provisions of chapter 54, to carry out the
561 provisions of this section.

562 (g) The duties assigned to the Department of Public Health under
563 the provisions of this section shall be implemented within available
564 appropriations.

565 Sec. 13. (NEW) (*Effective from passage*) (a) As used in this section and
566 section 14 of this act, "Affordable Care Act" means the Patient
567 Protection and Affordable Care Act, P.L. 111-148, as amended by the
568 Health Care and Education Reconciliation Act, P.L. 111-152, as both
569 may be amended from time to time, and federal regulations adopted
570 thereunder.

571 (b) There is established, in the office of the Lieutenant Governor, the
572 Office of Health Reform and Innovation. The Special Advisor to the
573 Governor on Healthcare Reform shall direct the activities of the Office
574 of Health Reform and Innovation.

575 (c) The Office of Health Reform and Innovation shall:

576 (1) Coordinate and implement the state's responsibilities under state
577 and federal health care reform;

578 (2) Identify (A) federal grants and other nonstate funding sources to
579 assist with implementing the Affordable Care Act, and (B) other
580 measures which further enhance access to health care, reduce costs and
581 improve the quality of health care in the state;

582 (3) Recommend and advance executive action and legislation to
583 effectively and efficiently implement the Affordable Care Act, and
584 state health care reform initiatives;

585 (4) Design processes to maximize stakeholder and public input and
586 ensure transparency in implementing health care reform;

587 (5) Ensure ongoing information sharing and coordination of efforts
588 with the General Assembly and state agencies concerning public health
589 and health care reform;

590 (6) Report on or after January 1, 2012, and annually thereafter, in
591 accordance with section 11-4a of the general statutes, to the joint
592 standing committees of the General Assembly having cognizance of
593 matters relating to appropriations and the budgets of state agencies,
594 human services, insurance and public health on the progress of state
595 agencies concerning implementation of the Affordable Care Act;

596 (7) Ensure coordination of efforts with state agencies concerning
597 prevention and management of chronic illnesses;

598 (8) Ensure that the structures of state government are working in
599 concert to effectively implement federal and state health care reform;

600 (9) Ensure, in consultation with the Connecticut Health Insurance
601 Exchange and the Department of Social Services, the necessary
602 coordination between said exchange and Medicaid enrollment
603 planning; and

604 (10) Maximize private philanthropic support to advance health care
605 reform initiatives.

606 (d) The Office of Health Reform and Innovation, in consultation
607 with the Sustinet Health Care Cabinet established pursuant to section
608 14 of this act, shall, on or before August 1, 2011, convene a consumer
609 advisory board that consists of not less than seven members.

610 (e) The Office of Health Reform and Innovation and the Office of the
611 Healthcare Advocate shall provide staff support to the Sustinet Health
612 Care Cabinet.

613 (f) The Office of Health Reform and Innovation shall maintain a

614 central comprehensive health reform web site.

615 (g) State agencies shall, within available appropriations, use their
616 best efforts to provide assistance to the Office of Health Reform and
617 Innovation.

618 (h) The Office of Health Reform and Innovation, in consultation
619 with the SustiNet Health Care Cabinet, may retain any consultants
620 necessary to carry out the statutory responsibilities of said office.
621 Consultants may be retained by said office for purposes that include,
622 but are not limited to, conducting feasibility and risk assessments
623 required to implement, as may be practicable, private and public
624 mechanisms to provide adequate health insurance products to
625 individuals, small employers, nonstate public employers, municipal-
626 related employers and nonprofit employers, commencing on January
627 1, 2014. Not later than October 1, 2012, the Office of Health Reform and
628 Innovation and the SustiNet Health Care Cabinet shall make
629 recommendations to the Governor based on the results of the analyses
630 undertaken pursuant to this subsection.

631 Sec. 14. (NEW) (*Effective from passage*) (a) There is established within
632 the office of the Lieutenant Governor, the SustiNet Health Care
633 Cabinet for the purpose of advising the Governor and the Office of
634 Health Reform and Innovation on the matters set forth in subsection
635 (c) of this section.

636 (b) (1) The SustiNet Health Care Cabinet shall consist of the
637 following members who shall be appointed on or before August 1,
638 2011: (A) Five appointed by the Governor, two of whom may represent
639 the health care industry and shall serve for terms of four years, one of
640 whom shall represent community health centers and shall serve for a
641 term of three years, one of whom shall represent insurance producers
642 and shall serve for a term of three years and one of whom shall be an
643 at-large appointment and shall serve for a term of three years; (B) one
644 appointed by the president pro tempore of the Senate, who shall be an
645 oral health specialist engaged in active practice and shall serve for a

646 term of four years; (C) one appointed by the majority leader of the
647 Senate, who shall represent labor and shall serve for a term of three
648 years; (D) one appointed by the minority leader of the Senate, who
649 shall be an advanced practice registered nurse engaged in active
650 practice and shall serve for a term of two years; (E) one appointed by
651 the speaker of the House of Representatives, who shall be a consumer
652 advocate and shall serve for a term of four years; (F) one appointed by
653 the majority leader of the House of Representatives, who shall be a
654 primary care physician engaged in active practice and shall serve for a
655 term of four years; (G) one appointed by the minority leader of the
656 House of Representatives, who shall represent the health information
657 technology industry and shall serve for a term of three years; (H) five
658 appointed jointly by the chairpersons of the SustiNet Health
659 Partnership board of directors, one of whom shall represent faith
660 communities, one of whom shall represent small businesses, one of
661 whom shall represent the home health care industry, one of whom
662 shall represent hospitals, and one of whom shall be an at-large
663 appointment, all of whom shall serve for terms of five years; (I) the
664 Lieutenant Governor; (J) the Secretary of the Office of Policy and
665 Management, or the secretary's designee; the Comptroller, or the
666 Comptroller's designee; the Special Advisor to the Governor on
667 Healthcare Reform, or the Special Advisor's designee; the
668 Commissioners of Social Services and Public Health, or their
669 designees; and the Healthcare Advocate, or the Healthcare Advocate's
670 designee, all of whom shall serve as ex-officio voting members; and (K)
671 the Commissioners of Children and Families, Developmental Services
672 and Mental Health and Addiction Services, and the Insurance
673 Commissioner or their designees, and the nonprofit liaison to the
674 Governor, or the nonprofit liaison's designee, all of whom shall serve
675 as ex-officio nonvoting members.

676 (2) Following the expiration of initial cabinet member terms,
677 subsequent cabinet terms shall be for four years, commencing on
678 August first of the year of the appointment. If an appointing authority
679 fails to make an initial appointment to the cabinet or an appointment

680 to fill a cabinet vacancy within ninety days of the date of such vacancy,
681 the appointed cabinet members shall, by majority vote, make such
682 appointment to the cabinet.

683 (3) Upon the expiration of the initial terms of the five cabinet
684 members appointed by Sustinet Health Partnership board of directors,
685 five successor cabinet members shall be appointed as follows: (A) One
686 appointed by the Governor; (B) one appointed by the president pro
687 tempore of the Senate; (C) one appointed by the speaker of the House
688 of Representatives; and (D) two appointed by majority vote of the
689 appointed board members. Successor board members appointed
690 pursuant to this subdivision shall be at-large appointments.

691 (4) The Lieutenant Governor shall serve as the chairperson of the
692 Sustinet Health Care Cabinet. The Lieutenant Governor shall schedule
693 the first meeting of the Sustinet Health Care Cabinet, which meeting
694 shall be held not later than September 1, 2011.

695 (c) The Sustinet Health Care Cabinet shall advise the Governor and
696 the Office of Health Reform and Innovation regarding the
697 development of an integrated health care system for Connecticut and
698 shall:

699 (1) Evaluate the means of ensuring an adequate health care
700 workforce in the state;

701 (2) Jointly evaluate, with the chief executive officer of the
702 Connecticut Health Insurance Exchange the feasibility of
703 implementing a basic health program option as set forth in Section
704 1331 of the Affordable Care Act;

705 (3) Identify short and long-range opportunities, issues and gaps
706 created by the enactment of federal health care reform;

707 (4) Coordinate with the Office of Health Reform and Innovation
708 concerning the effectiveness of delivery system reforms and other
709 efforts to control health care costs, including, but not limited to,

710 reforms and efforts implemented by state agencies;

711 (5) (A) Develop a business plan to be provided to the Governor and
712 the Office of Health Reform and Innovation that takes into account
713 feasibility and risk assessments conducted pursuant to subsection (h)
714 of section 13 of this act and evaluates private or public mechanisms
715 that will provide adequate health insurance products commencing on
716 January 1, 2014, including, but not limited to, for-profit and nonprofit
717 organizations, insurance cooperatives and self-insurance, and (B)
718 submit appropriate implementation recommendations for the
719 Governor's consideration; and

720 (6) Advise the Governor on matters relating to: (A) The design,
721 implementation, actionable objectives and evaluation of state and
722 federal health care policies, priorities and objectives relating to the
723 state's efforts to improve access to health care, and (B) the quality of
724 such care and the affordability and sustainability of the state's health
725 care system.

726 (d) The Sustinet Health Care Cabinet may convene working groups,
727 which include volunteer health care experts, to make
728 recommendations concerning the development and implementation of
729 service delivery and health care provider payment reforms, including
730 multi-payer initiatives, medical homes, electronic health records and
731 evidenced-based health care quality improvement.

732 Sec. 15. Subparagraph (B) of subdivision (15) of section 38a-816 of
733 the general statutes is repealed and the following is substituted in lieu
734 thereof (*Effective January 1, 2012*):

735 (B) Each insurer [] or other entity responsible for providing
736 payment to a health care provider pursuant to an insurance policy
737 subject to this section, shall pay claims not later than: [forty-five]

738 (i) For claims filed in paper format, sixty days after receipt by the
739 insurer of the claimant's proof of loss form or the health care provider's
740 request for payment filed in accordance with the insurer's practices or

741 procedures, except that when there is a deficiency in the information
742 needed for processing a claim, as determined in accordance with
743 section 38a-477, the insurer shall [(i)] (I) send written notice to the
744 claimant or health care provider, as the case may be, of all alleged
745 deficiencies in information needed for processing a claim not later than
746 thirty days after the insurer receives a claim for payment or
747 reimbursement under the contract, and [(ii)] (II) pay claims for
748 payment or reimbursement under the contract not later than thirty
749 days after the insurer receives the information requested; and

750 (ii) For claims filed in electronic format, twenty days after receipt by
751 the insurer of the claimant's proof of loss form or the health care
752 provider's request for payment filed in accordance with the insurer's
753 practices or procedures, except that when there is a deficiency in the
754 information needed for processing a claim, as determined in
755 accordance with section 38a-477, the insurer shall (I) notify the
756 claimant or health care provider, as the case may be, of all alleged
757 deficiencies in information needed for processing a claim not later than
758 ten days after the insurer receives a claim for payment or
759 reimbursement under the contract, and (II) pay claims for payment or
760 reimbursement under the contract not later than ten days after the
761 insurer receives the information requested.

762 Sec. 16. Section 38a-479b of the general statutes is repealed and the
763 following is substituted in lieu thereof (*Effective January 1, 2012*):

764 (a) No contracting health organization shall make material changes
765 to a provider's fee schedule except as follows:

766 (1) At one time annually, provided providers are given at least
767 ninety days' advance notice by mail, electronic mail or facsimile by
768 such organization of any such changes. Upon receipt of such notice, a
769 provider may terminate the participating provider contract with at
770 least sixty days' advance written notice to the contracting health
771 organization;

772 (2) At any time for the following, provided providers are given at

773 least thirty days' advance notice by mail, electronic mail or facsimile by
774 such organization of any such changes:

775 (A) To comply with requirements of federal or state law, regulation
776 or policy. If such federal or state law, regulation or policy takes effect
777 in less than thirty days, the organization shall give providers as much
778 notice as possible;

779 (B) To comply with changes to the medical data code sets set forth
780 in 45 CFR 162.1002, as amended from time to time;

781 (C) To comply with changes to national best practice protocols made
782 by the National Quality Forum or other national accrediting or
783 standard-setting organization based on peer-reviewed medical
784 literature generally recognized by the relevant medical community or
785 the results of clinical trials generally recognized and accepted by the
786 relevant medical community;

787 (D) To be consistent with changes made in Medicare pertaining to
788 billing or medical management practices, provided any such changes
789 are applied to relevant participating provider contracts where such
790 changes pertain to the same specialty or payment methodology;

791 (E) If a drug, treatment, procedure or device is identified as no
792 longer safe and effective by the federal Food and Drug Administration
793 or by peer-reviewed medical literature generally recognized by the
794 relevant medical community;

795 (F) To address payment or reimbursement for a new drug,
796 treatment, procedure or device that becomes available and is
797 determined to be safe and effective by the federal Food and Drug
798 Administration or by peer-reviewed medical literature generally
799 recognized by the relevant medical community; or

800 (G) As mutually agreed to by the contracting health organization
801 and the provider. If the contracting health organization and the
802 provider do not mutually agree, the provider's current fee schedule

803 shall remain in force until the annual change permitted pursuant to
804 subdivision (1) of this subsection.

805 (b) Notwithstanding subsection (a) of this section, a contracting
806 health organization may introduce a new insurance product to a
807 provider at any time, provided such provider is given at least sixty
808 days' advance notice by mail, electronic mail or facsimile by such
809 organization if the introduction of such insurance product will make
810 material changes to the provider's administrative requirements under
811 the participating provider contract or to the provider's fee schedule.
812 The provider may decline to participate in such new product by
813 providing notice to the contracting health organization as set forth in
814 the advance notice, which shall include a period of not less than thirty
815 days for a provider to decline, or in accordance with the time frames
816 under the applicable terms of such provider's participating provider
817 contract.

818 [(b)] (c) (1) No contracting health organization shall cancel, deny or
819 demand the return of full or partial payment for an authorized covered
820 service due to administrative or eligibility error, more than eighteen
821 months after the date of the receipt of a clean claim, except if:

822 (A) Such organization has a documented basis to believe that such
823 claim was submitted fraudulently by such provider;

824 (B) The provider did not bill appropriately for such claim based on
825 the documentation or evidence of what medical service was actually
826 provided;

827 (C) Such organization has paid the provider for such claim more
828 than once;

829 (D) Such organization paid a claim that should have been or was
830 paid by a federal or state program; or

831 (E) The provider received payment for such claim from a different
832 insurer, payor or administrator through coordination of benefits or

833 subrogation, or due to coverage under an automobile insurance or
834 workers' compensation policy. Such provider shall have one year after
835 the date of the cancellation, denial or return of full or partial payment
836 to resubmit an adjusted secondary payor claim with such organization
837 on a secondary payor basis, regardless of such organization's timely
838 filing requirements.

839 (2) (A) Such organization shall give at least thirty days' advance
840 notice to a provider by mail, electronic mail or facsimile of the
841 organization's cancellation, denial or demand for the return of full or
842 partial payment pursuant to subdivision (1) of this subsection.

843 (B) If such organization demands the return of full or partial
844 payment from a provider, the notice required under subparagraph (A)
845 of this subdivision shall disclose to the provider (i) the amount that is
846 demanded to be returned, (ii) the claim that is the subject of such
847 demand, and (iii) the basis on which such return is being demanded.

848 (C) Not later than thirty days after the receipt of the notice required
849 under subparagraph (A) of this subdivision, a provider may appeal
850 such cancellation, denial or demand in accordance with the procedures
851 provided by such organization. Any demand for the return of full or
852 partial payment shall be stayed during the pendency of such appeal.

853 (D) If there is no appeal or an appeal is denied, such provider may
854 resubmit an adjusted claim, if applicable, to such organization, not
855 later than thirty days after the receipt of the notice required under
856 subparagraph (A) of this subdivision or the denial of the appeal,
857 whichever is applicable, except that if a return of payment was
858 demanded pursuant to subparagraph (C) of subdivision (1) of this
859 subsection, such claim shall not be resubmitted.

860 (E) A provider shall have one year after the date of the written
861 notice set forth in subparagraph (A) of this subdivision to identify any
862 other appropriate insurance coverage applicable on the date of service
863 and to file a claim with such insurer, health care center or other issuing
864 entity, regardless of such insurer's, health care center's or other issuing

865 entity's timely filing requirements.

866 Sec. 17. (NEW) (*Effective January 1, 2012*) Each insurer, health care
867 center, managed care organization or other entity that delivers, issues
868 for delivery, renews, amends or continues an individual or group
869 health insurance policy or medical benefits plan, and each preferred
870 provider network, as defined in section 38a-479aa of the general
871 statutes, that contracts with a health care provider, as defined in
872 section 38a-478 of the general statutes, for the purposes of providing
873 covered health care services to its enrollees, shall maintain a network
874 of such providers that is consistent with the National Committee for
875 Quality Assurance's network adequacy requirements or URAC's
876 provider network access and availability standards.

877 Sec. 18. (NEW) (*Effective January 1, 2012*) (a) (1) No insurer, health
878 care center, fraternal benefit society, hospital service corporation or
879 medical service corporation or other entity, delivering, issuing for
880 delivery, renewing, amending or continuing an individual or group
881 health insurance policy in this state providing coverage of the type
882 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
883 the general statutes or utilization review company performing
884 utilization review for such insurer, center, society, corporation or
885 entity, that preauthorizes or precertifies, on or after January 1, 2012, an
886 admission, service, procedure or extension of stay shall reverse or
887 rescind such preauthorization or precertification or refuse to pay for
888 such admission, service, procedure or extension of stay if:

889 (A) Such insurer, center, society, corporation, entity or company
890 failed to notify the insured's or enrollee's health care provider at least
891 three business days prior to the scheduled date of such admission,
892 service, procedure or extension of stay that such preauthorization or
893 precertification has been reversed or rescinded on the basis of medical
894 necessity, fraud or lack of coverage; and

895 (B) Such admission, service, procedure or extension of stay has
896 taken place in reliance on such preauthorization or precertification.

897 (2) The provisions of this subsection shall apply regardless of
898 whether such preauthorization or precertification is required or is
899 requested by an insured's or enrollee's health care provider. Unless
900 reversed or rescinded as set forth in subparagraph (A) of subdivision
901 (1) of this subsection, such preauthorization or precertification shall be
902 effective for not less than sixty days from the date of issuance.

903 (b) Nothing in subsection (a) of this section shall be construed to
904 authorize benefits or services in excess of those that are provided for in
905 the insured's or enrollee's policy or contract.

906 (c) Nothing in subsection (a) of this section shall affect the
907 provisions of subsection (b) of section 38a-479b of the general statutes.

908 Sec. 19. (NEW) (*Effective January 1, 2012*) (a) No insurer, health care
909 center, fraternal benefit society, hospital service corporation, medical
910 service corporation or other entity delivering, issuing for delivery,
911 renewing, amending or continuing an individual or group dental plan
912 in this state shall include in any contract with a dentist licensed
913 pursuant to chapter 379 of the general statutes that is entered into,
914 renewed or amended on or after January 1, 2012, shall contain any
915 provision that requires such dentist to accept as payment an amount
916 set by such insurer, center, society, corporation or entity for services or
917 procedures provided to an insured or enrollee that are not covered
918 benefits under such insured's or enrollee's plan.

919 (b) A dentist shall not charge more for services or procedures that
920 are not covered benefits than such dentist's usual and customary rate
921 for such services or procedures.

922 (c) Each evidence of coverage for an individual or group dental plan
923 shall include the following statement:

924 "IMPORTANT: If you opt to receive dental services or procedures
925 that are not covered benefits under this plan, a participating dental
926 provider may charge you his or her usual and customary rate for such
927 services or procedures. Prior to providing you with dental services or

928 procedures that are not covered benefits, the dental provider should
929 provide you with a treatment plan that includes each anticipated
930 service or procedure to be provided and the estimated cost of each
931 such service or procedure. To fully understand your coverage, you
932 may wish to review your evidence of coverage document."

933 (d) Each dentist shall post, in a conspicuous place, a notice stating
934 that services or procedures that are not covered benefits under an
935 insurance policy or plan might not be offered at a discounted rate.

936 (e) The provisions of this section shall not apply to (1) a self-insured
937 plan that covers dental services, or (2) a contract that is incorporated in
938 or derived from a collective bargaining agreement or in which some or
939 all of the material terms are subject to a collective bargaining process.

940 Sec. 20. (NEW) (*Effective October 1, 2011*) As used in sections 20 to 34,
941 inclusive, of this act:

942 (1) "Adjuster" means an independent or contracted individual who
943 investigates or settles loss claims. "Adjuster" does not include an
944 employee of an insurer who investigates or settles claims incurred
945 under insurance contracts written by the insurer or an affiliated
946 insurer.

947 (2) "Affiliate" or "affiliated" has the same meaning as provided in
948 section 38a-1 of the general statutes.

949 (3) "Business entity" means a corporation, a limited liability
950 company or any other similar form of business organization, whether
951 for profit or nonprofit.

952 (4) "Commissioner" means the Insurance Commissioner.

953 (5) "Control" or "controlled by" has the same meaning as provided
954 in section 38a-1 of the general statutes.

955 (6) "Insurance producer" has the same meaning as provided in
956 section 38a-702a of the general statutes.

957 (7) "Insurer" or "insurance company" means any person or
958 combination of persons doing any kind or form of insurance business
959 other than a fraternal benefit society, and includes a captive insurance
960 company, as defined in section 38a-91aa of the general statutes, a
961 captive insurer as defined in section 38a-91k of the general statutes, a
962 licensed insurance company, a medical service corporation, a hospital
963 service corporation, a health care center, and a consumer dental plan
964 that provides employee welfare benefits on a self-funded basis or as
965 defined in section 38a-577 of the general statutes.

966 (8) "NAIC" means the National Association of Insurance
967 Commissioners.

968 (9) "Person" has the same meaning as provided in section 38a-1 of
969 the general statutes.

970 (10) "Sell" means the exchange of an insurance contract for money or
971 other consideration, by any means, on behalf of an insurance company.

972 (11) "Third-party administrator" means any person who directly or
973 indirectly underwrites, collects premiums or charges from, or adjusts
974 or settles claims on, residents of this state in connection with life,
975 annuity or health coverage offered or provided by an insurer. "Third-
976 party administrator" does not include:

977 (A) An employer administering its employee benefit plan or the
978 benefit plan of an affiliated employer under common management and
979 control;

980 (B) A union administering a benefit plan on behalf of its members;

981 (C) An insurer that is licensed in this state or is acting as an
982 authorized insurer with respect to insurance lawfully issued to cover a
983 Connecticut resident, and sales representatives thereof;

984 (D) An insurance producer who is licensed to sell life, annuity or
985 health coverage in this state, whose activities are limited exclusively to
986 the sale of insurance;

987 (E) A creditor acting on behalf of its debtors with respect to
988 insurance covering a debt between the creditor and its debtors;

989 (F) A trust and its trustees, agents and employees acting pursuant to
990 such trust established in conformity with 29 USC Section 186, as
991 amended from time to time;

992 (G) A trust exempt from taxation under Section 501(a) of the
993 Internal Revenue Code of 1986, or any subsequent corresponding
994 internal revenue code of the United States, as amended from time to
995 time, and its trustees and employees acting pursuant to such trust, or a
996 custodian and the custodian's agents and employees acting pursuant
997 to a custodian account that meets the requirements of Section 401(f) of
998 the Internal Revenue Code of 1986, or any subsequent corresponding
999 internal revenue code of the United States, as amended from time to
1000 time;

1001 (H) A credit union or a financial institution that is subject to
1002 supervision or examination by federal or state banking authorities, or a
1003 mortgage lender, to the extent such credit union, financial institution
1004 or mortgage lender collects or remits premiums to licensed insurance
1005 producers or limited lines producers or to authorized insurers, in
1006 connection with loan payments;

1007 (I) A credit card issuing company that advances or collects
1008 premiums or charges from its credit cardholders who have authorized
1009 collection;

1010 (J) An attorney-at-law who adjusts or settles claims in the normal
1011 course of such attorney's practice or employment and who does not
1012 collect premiums or charges in connection with life, annuity or health
1013 coverage;

1014 (K) An adjuster who is licensed in this state or is not subject to the
1015 licensure requirements of chapter 702 of the general statutes and
1016 whose activities are limited to adjusting claims;

1017 (L) An insurance producer who is licensed in this state and acting as
1018 a managing general agent, as defined in section 38a-90a of the general
1019 statutes, whose activities are limited exclusively to those specified in
1020 said section;

1021 (M) A business entity that is affiliated with an insurer licensed in
1022 this state and that undertakes activities as a third-party administrator
1023 only for the direct and assumed insurance business of the affiliated
1024 insurer;

1025 (N) A consortium of federally qualified health centers funded by the
1026 state, providing services only to the recipients of programs
1027 administered by the Department of Social Services;

1028 (O) A pharmacy benefits manager registered under section 38a-
1029 479bbb of the general statutes;

1030 (P) An entity providing administrative services to the Health
1031 Reinsurance Association established under section 38a-556 of the
1032 general statutes; or

1033 (Q) A nonprofit association or one of its direct subsidiaries that
1034 provides access to insurance as part of the benefits or services such
1035 association or subsidiary makes available to its members.

1036 (12) "Underwrites" or "underwriting" means the acceptance of
1037 employer or individual applications for coverage of individuals in
1038 accordance with the written rules of the insurer or self-funded plan,
1039 and the overall planning and coordination of a benefits program.

1040 (13) "Uniform application" means the current version of the
1041 National Association of Insurance Commissioners' Uniform
1042 Application for Third-Party Administrators.

1043 Sec. 21. (NEW) (*Effective October 1, 2011*) (a) No person shall offer to
1044 act as or hold himself out to be a third-party administrator in this state
1045 unless such person is licensed pursuant to section 30 of this act, or is
1046 exempt from licensure pursuant to subsection (b) of this section. This

1047 requirement shall not apply to a person employed by a third-party
1048 administrator to the extent that such person's activities are under the
1049 supervision and control of the third-party administrator. The authority
1050 granted to a third-party administrator pursuant to sections 20 to 29,
1051 inclusive, of this act shall not exempt such third-party administrator's
1052 employees from the licensing requirements of chapters 701b and 702 of
1053 the general statutes.

1054 (b) (1) Any insurer licensed in this state that directly or indirectly
1055 underwrites, collects premiums or charges from, or adjusts or settles
1056 claims for other than its policyholders, subscribers and certificate
1057 holders shall be exempt from sections 20 to 34, inclusive, of this act,
1058 provided such activities only involve the lines of insurance for which
1059 such insurer is licensed in this state. Any such insurer shall (A) be
1060 subject to the provisions of chapter 704 of the general statutes, (B)
1061 respond to all complaint inquiries received from the Insurance
1062 Department, not later than ten calendar days after the date a complaint
1063 is received by the insurer, and (C) with respect to any advertising that
1064 mentions any customer, obtain such customer's prior written consent.

1065 (2) Nothing in this section shall authorize the commissioner to
1066 regulate a self-insured health plan subject to the Employee Retirement
1067 Income Security Act of 1974. The commissioner is authorized to
1068 regulate those activities an insurer undertakes for the administration of
1069 a self-insured health plan that do not relate to the health benefit plan
1070 and that comport with the commissioner's statutory authority to
1071 regulate insurance and the business of insurance as provided for in 29
1072 USC 1144, as amended from time to time.

1073 (c) No third-party administrator shall act as such without a written
1074 agreement between such third-party administrator and an insurer or
1075 other person utilizing the services of the third-party administrator,
1076 which shall be retained as part of the official records of both the third-
1077 party administrator and such insurer or other person for the duration
1078 of such agreement and for five years thereafter. The agreement shall
1079 contain all provisions required by this section, except insofar as those

1080 provisions that do not apply to the activities performed by the third-
1081 party administrator.

1082 (d) The written agreement set forth in subsection (c) of this section
1083 shall include, but not be limited to:

1084 (1) A statement of activities that the third-party administrator shall
1085 undertake on behalf of the insurer or other person utilizing the services
1086 of the third-party administrator, and the lines, classes or types of
1087 insurance such third-party administrator is authorized to administer;

1088 (2) A statement of the activities and responsibilities of the third-
1089 party administrator regarding the administration of or any standards
1090 pertaining to business underwritten by the insurer, benefits, premium
1091 rates, underwriting criteria or claims payment;

1092 (3) A provision requiring the third-party administrator to render an
1093 accounting, on such frequency as the parties agree, that details all
1094 transactions performed by the third-party administrator pertaining to
1095 the business underwritten by the insurer or the business of the person
1096 utilizing the services of the third-party administrator;

1097 (4) The procedures for any withdrawals to be made by the third-
1098 party administrator from the fiduciary account established under
1099 section 26 of this act. Such procedures shall address, but not be limited
1100 to: (A) Remittance to an insurer or other person utilizing the services of
1101 the third-party administrator who is entitled to remittance, (B) deposit
1102 in an account maintained in the name of the insurer or other person
1103 utilizing the services of the third-party administrator, (C) transfer to
1104 and deposit in a claims-paying account, with claims to be paid as
1105 provided for in subsection (d) of section 26 of this act, (D) payment to a
1106 group policyholder for remittance to the insurer or other person
1107 utilizing the services of the third-party administrator entitled to such
1108 remittance, (E) payment to the third-party administrator for its
1109 commissions, fees or charges, and (F) remittance of return premiums to
1110 the person or persons entitled to such return premiums;

1111 (5) Procedures and requirements for the disclosures required to be
1112 made by the third-party administrator under section 28 of this act; and

1113 (6) A termination provision, by which either party to the written
1114 agreement may terminate such agreement for cause, that includes a
1115 procedure to resolve any disputes regarding the cause for termination
1116 of such agreement.

1117 (e) A third-party administrator or insurer or other person utilizing
1118 the services of the third-party administrator may, with written notice,
1119 terminate the written agreement for cause as provided in such written
1120 agreement. The insurer may suspend the underwriting authority of the
1121 third-party administrator during the pendency of any dispute
1122 regarding the cause for termination of the written agreement. The
1123 insurer or other person utilizing the services of the third-party
1124 administrator shall fulfill any legal obligations with respect to policies
1125 or plans affected by the written agreement, regardless of any dispute
1126 between the third-party administrator and the insurer or other person
1127 utilizing the services of the third-party administrator.

1128 Sec. 22. (NEW) (*Effective October 1, 2011*) (a) If an insurer or other
1129 person utilizes the services of a third-party administrator, the payment
1130 of any premiums or charges by or on behalf of an insured to the third-
1131 party administrator shall be deemed to have been received by the
1132 insurer or other person utilizing the services of the third-party
1133 administrator.

1134 (b) Return premium payments or claim payments forwarded by the
1135 insurer or other person utilizing the services of the third-party
1136 administrator to the third-party administrator shall not be deemed to
1137 have been paid to the insured or claimant until such payments are
1138 received by such insured or claimant.

1139 (c) Nothing in this section shall limit any right of an insurer or other
1140 person utilizing the services of a third-party administrator to bring a
1141 cause of action arising from the failure of such third-party
1142 administrator to make payments to the insurer, other person utilizing

1143 the services of the third-party administrator, insureds or claimants.

1144 Sec. 23. (NEW) (*Effective October 1, 2011*) (a) (1) Each third-party
1145 administrator shall maintain and make available to the insurer or other
1146 person utilizing the services of the third-party administrator complete
1147 books and records of all transactions performed on behalf of the
1148 insurer or other person utilizing the services of the third-party
1149 administrator. Each third-party administrator shall (A) maintain such
1150 books and records in accordance with prudent standards of insurance
1151 record keeping, and (B) retain such books and records for a period of
1152 not less than five years from the date of their creation.

1153 (2) The insurer or other person utilizing the services of a third-party
1154 administrator shall own any records generated by such third-party
1155 administrator pertaining to such insurer or other person utilizing the
1156 services of such third-party administrator. The third-party
1157 administrator shall retain the right to maintain continued access to
1158 books and records to permit the third-party administrator to fulfill all
1159 of its contractual obligations to the insurer, other person utilizing the
1160 services of the third-party administrator, insureds or claimants.

1161 (b) An insurer that is affiliated with a business entity as set forth in
1162 subparagraph (M) of subdivision (11) of section 20 of this act shall be
1163 responsible for the acts of such business entity to the extent of such
1164 business entity's activities as a third-party administrator for such
1165 insurer. Such insurer shall be responsible for furnishing the books and
1166 records of all transactions performed on behalf of the insurer to the
1167 commissioner upon the commissioner's request.

1168 (c) The commissioner shall have access for the purposes of
1169 examination, audit and inspection to books and records maintained by
1170 a third-party administrator. Any documents, materials or other
1171 information in the possession or control of the commissioner that are
1172 obtained by the commissioner from a third-party administrator,
1173 insurer, insurance producer or employee or agent thereof acting on
1174 behalf of such third-party administrator, insurer or insurance

1175 producer, in an investigation, examination or audit shall (1) be
1176 confidential by law and privileged; (2) not be subject to disclosure
1177 under section 1-210 of the general statutes; (3) not be subject to
1178 subpoena; and (4) not be subject to discovery or admissible in evidence
1179 in any private civil action. The commissioner may use such documents,
1180 materials or other information in the furtherance of any regulatory or
1181 legal action brought as a part of the commissioner's official duties.

1182 (d) Neither the commissioner nor any person who receives
1183 documents, materials or other information as set forth in subsection (c)
1184 of this section while acting under the authority of the commissioner
1185 shall testify or be required to testify in any private civil action
1186 concerning such documents, materials or information.

1187 (e) To assist the commissioner in the performance of the
1188 commissioner's duties, the commissioner may:

1189 (1) Share documents, materials or other information, including
1190 documents, materials or other information deemed confidential and
1191 privileged pursuant to subsection (c) of this section, with other state,
1192 federal and international regulatory agencies, the National Association
1193 of Insurance Commissioners or its affiliates or subsidiaries and state,
1194 federal and international law enforcement authorities, provided the
1195 recipient of such documents, materials or other information agrees to
1196 maintain the confidentiality and privileged status of such documents,
1197 materials or other information;

1198 (2) Receive documents, materials or other information, including
1199 confidential and privileged documents, materials or other information
1200 from the National Association of Insurance Commissioners or its
1201 affiliates or subsidiaries and from regulatory and law enforcement
1202 officials of foreign or domestic jurisdictions. The commissioner shall
1203 maintain as confidential or privileged any documents, materials or
1204 other information received with notice or the understanding that such
1205 documents, materials or other information are confidential or
1206 privileged under the laws of the jurisdiction that is the source of such

1207 documents, materials or other information; and

1208 (3) Enter into agreements governing the sharing and use of
1209 information consistent with this subsection.

1210 (f) No waiver of any applicable privilege or claim of confidentiality
1211 in any documents, materials or other information shall occur as a
1212 result of disclosure to the commissioner or of sharing in accordance
1213 with subsection (e) of this section.

1214 (g) Nothing in sections 20 to 34, inclusive, of this act shall prohibit
1215 the commissioner from releasing final, adjudicated actions, including
1216 for cause terminations of licenses issued to third-party administrators,
1217 to a database or other clearinghouse service maintained by the
1218 National Association of Insurance Commissioners or its affiliates or
1219 subsidiaries.

1220 (h) Notwithstanding the provisions of subparagraph (B) of
1221 subdivision (1) of subsection (a) of this section, if a written agreement
1222 set forth in subsection (c) of this section is terminated, the third-party
1223 administrator may, by a separate written agreement with the insurer
1224 or other person utilizing the services of the third-party administrator,
1225 transfer all books and records to a new third-party administrator. Such
1226 new third-party administrator shall acknowledge to the insurer or
1227 other person utilizing the services of the new third-party
1228 administrator, in writing, that the new third-party administrator shall
1229 be responsible for retaining the books and records of the prior third-
1230 party administrator as required under subparagraph (B) of subdivision
1231 (1) of subsection (a) of this section.

1232 Sec. 24. (NEW) (*Effective October 1, 2011*) A third-party administrator
1233 shall only use advertising pertaining to the business underwritten by
1234 an insurer that has been approved, in writing, by the insurer prior to
1235 its use. A third-party administrator that mentions any customer or
1236 person utilizing the services of the third-party administrator in its
1237 advertising shall obtain such customer's or person's prior written
1238 consent.

1239 Sec. 25. (NEW) (*Effective October 1, 2011*) (a) Each insurer or other
1240 person utilizing the services of a third-party administrator shall be
1241 responsible for determining the benefits, premium rates, underwriting
1242 criteria and claims payment procedures for the lines, classes or types of
1243 insurance such third-party administrator is authorized to administer,
1244 and for securing reinsurance, if any. The insurer or other person
1245 utilizing the services of a third-party administrator shall provide to
1246 such third-party administrator, in writing, procedures pertaining to
1247 such third-party administrator's administration of benefits, premium
1248 rates, underwriting criteria and claims payment. Each insurer or other
1249 person utilizing the services of a third-party administrator shall be
1250 responsible for the competent administration of such insurer's or other
1251 person's benefit and service programs.

1252 (b) If a third-party administrator administers benefits for more than
1253 one hundred certificate holders on behalf of an insurer or other person
1254 utilizing the services of a third-party administrator, such insurer or
1255 other person shall, at least semiannually, conduct a review of the
1256 operations of the third-party administrator. At least one such review
1257 shall be an on-site audit of the operations of the third-party
1258 administrator.

1259 Sec. 26. (NEW) (*Effective October 1, 2011*) (a) All premiums or charges
1260 collected by a third-party administrator on behalf of or for an insurer
1261 or other person utilizing the services of a third-party administrator,
1262 and the return of premiums received from such insurer or other
1263 person, shall be held by the third-party administrator in a fiduciary
1264 capacity. The funds shall be immediately remitted to the person
1265 entitled to them or deposited promptly in a fiduciary account
1266 established and maintained by the third-party administrator in a
1267 federal or state chartered, federally insured financial institution. The
1268 third-party administrator shall render an accounting to the insurer or
1269 other person utilizing the services of a third-party administrator that
1270 details all transactions performed by the third-party administrator
1271 pertaining to the business underwritten by the insurer or the business
1272 of the person utilizing the services of a third-party administrator.

1273 (b) Each third-party administrator that deposits in a fiduciary
1274 account charges or premiums collected on behalf of or for one or more
1275 insurers or other persons utilizing the services of the third-party
1276 administrator shall keep clear records of the deposits in and
1277 withdrawals from the account on behalf of each insurer or other
1278 person utilizing the services of the third-party administrator. The
1279 third-party administrator shall keep copies of all the records and, upon
1280 request by the insurer or other person utilizing the services of the
1281 third-party administrator, shall furnish such insurer or other person
1282 with a copy of the records of the deposits and withdrawals pertaining
1283 to such insurer or other person.

1284 (c) A third-party administrator shall not pay any claim by making
1285 withdrawals from a fiduciary account in which premiums or charges
1286 are deposited. Withdrawals from the account shall be made as
1287 provided in the written agreement set forth in subsection (c) of section
1288 21 of this act.

1289 (d) All claims paid by the third-party administrator from funds
1290 collected on behalf of or for an insurer or other person utilizing the
1291 services of the third-party administrator shall be paid only by drafts or
1292 checks of, and as authorized by, such insurer or other person.

1293 Sec. 27. (NEW) (*Effective October 1, 2011*) (a) A third-party
1294 administrator shall not enter into any written or oral agreement or
1295 understanding with an insurer or other person utilizing the services of
1296 the third-party administrator that makes or has the effect of making
1297 the amount of the third-party administrator's commissions, fees, or
1298 charges contingent upon savings effected in the adjustment, settlement
1299 or payment of losses covered by the insurer's or other person utilizing
1300 the services of the third-party administrator's obligations. This
1301 provision shall not prohibit a third-party administrator from receiving
1302 performance-based compensation for providing hospital auditing or
1303 other auditing services.

1304 (b) This section shall not prevent the compensation of a third-party

1305 administrator from being based on premiums or charges collected or
1306 the number of claims paid or processed.

1307 Sec. 28. (NEW) (*Effective October 1, 2011*) (a) When the services of a
1308 third-party administrator are utilized, such third-party administrator
1309 shall issue a benefits identification card to each insured that includes
1310 disclosure of, and relationship among, the third-party administrator,
1311 the policyholder and the insurer or other person utilizing the services
1312 of the third-party administrator.

1313 (b) When a third-party administrator collects premiums, charges or
1314 fees, the reason for collection of each item shall be identified to the
1315 insured and each item shall be shown separately. Additional charges
1316 shall not be made for services to the extent the services have been paid
1317 for by the insurer or other person utilizing the services of the third-
1318 party administrator.

1319 (c) The third-party administrator shall disclose to the insurer or
1320 other person utilizing the services of the third-party administrator all
1321 charges, fees and commissions that the third-party administrator
1322 receives arising from services it provides for the insurer or other
1323 person utilizing the services of the third-party administrator, including
1324 any fees or commissions paid by insurers providing reinsurance or
1325 stop loss coverage.

1326 Sec. 29. (NEW) (*Effective October 1, 2011*) Any policies, certificates,
1327 booklets, termination notices or other written communications
1328 delivered by an insurer or other person utilizing the services of a third-
1329 party administrator to such third-party administrator for delivery to
1330 such insurer's or other person's insureds shall be delivered by the
1331 third-party administrator promptly after receipt of instructions to
1332 deliver them from an insurer or other person utilizing the services of
1333 the third-party administrator.

1334 Sec. 30. (NEW) (*Effective October 1, 2011*) (a) (1) A third-party
1335 administrator applying for licensure shall execute a surety bond in an
1336 amount determined by the commissioner to be sufficient to protect

1337 insurers and other persons utilizing the services of the third-party
1338 administrator, but not less than the penal sum of five hundred
1339 thousand dollars. A third-party administrator licensed under this
1340 section shall maintain such surety bond as a condition for renewal of
1341 such license.

1342 (2) The commissioner may waive the requirement to execute such
1343 surety bond if the applicant submits audited annual financial
1344 statements or reports for the two most recent fiscal years that prove the
1345 applicant has a positive net worth. An audited annual financial
1346 statement or report prepared on a consolidated basis shall include a
1347 columnar consolidating or combining worksheet that shall be filed
1348 with the report and include the following: (A) Amounts shown on the
1349 consolidated audited financial report shall be shown on the worksheet,
1350 (B) amounts for each entity shall be stated separately, and (C)
1351 explanations of consolidating and eliminating entries shall be
1352 included. A third-party administrator who has submitted such
1353 statements or reports in lieu of executing a surety bond and who is
1354 renewing such administrator's license shall submit the most recent
1355 audited annual financial statement or report.

1356 (b) A third-party administrator applying for licensure shall submit
1357 an application to the commissioner by using the uniform application
1358 and paying a fee pursuant to section 38a-11 of the general statutes, as
1359 amended by this act. The uniform application shall include or be
1360 accompanied by the following information and documents: (1) All
1361 basic organizational documents of the applicant, including any articles
1362 of incorporation, articles of association, partnership agreement, trade
1363 name certificate, trust agreement, shareholder agreement and other
1364 applicable documents and all amendments to such documents; (2) the
1365 bylaws, rules, regulations or similar documents regulating the internal
1366 affairs of the applicant; (3) a NAIC biographical affidavit for the
1367 individuals responsible for the conduct of affairs of the applicant,
1368 including (A) all members of the board of directors, board of trustees,
1369 executive committee or other governing board or committee, (B) the
1370 principal officers in the case of a corporation or the partners or

1371 members in the case of a partnership, association or limited liability
1372 company, (C) any shareholders or member holding directly or
1373 indirectly ten per cent or more of the voting stock, voting securities or
1374 voting interest of the applicant, and (D) any other person who
1375 exercises control or influence over the affairs of the applicant; (4) a
1376 statement describing the business plan including information on
1377 staffing levels and activities proposed in this state and nationwide. The
1378 plan shall provide details setting forth the applicant's capability for
1379 providing a sufficient number of experienced and qualified personnel
1380 in the areas of claims processing, recordkeeping and underwriting;
1381 and (5) such other pertinent information as may be required by the
1382 commissioner.

1383 (c) A third-party administrator applying for licensure shall make
1384 available for inspection by the commissioner copies of all written
1385 agreements with insurers or other persons utilizing the services of the
1386 third-party administrator.

1387 (d) A third-party administrator applying for licensure shall produce
1388 its accounts, records and files for examination and shall make its
1389 officers available to give information with respect to its affairs, as often
1390 as is reasonably required by the commissioner.

1391 (e) The commissioner may refuse to issue a license if the
1392 commissioner determines that the third-party administrator or any
1393 individual responsible for the conduct of the affairs of the third-party
1394 administrator is not competent, trustworthy, financially responsible or
1395 of good personal and business reputation, or has had an insurance or a
1396 third-party administrator certificate of authority or license denied or
1397 revoked for cause by any jurisdiction, or if the commissioner
1398 determines that any of the grounds set forth in section 33 of this act
1399 exists with respect to the third-party administrator.

1400 (f) Any license issued to a third-party administrator shall be in force
1401 until September thirtieth of each year, unless sooner revoked or
1402 suspended as provided in this section. The license may be renewed, at

1403 the discretion of the commissioner, upon payment of the fee specified
1404 in section 38a-11 of the general statutes, as amended by this act,
1405 without the resubmission of the detailed information required in the
1406 original application.

1407 (g) A third-party administrator licensed or applying for licensure
1408 under this section shall notify the commissioner immediately of any
1409 material change in its ownership, control or other fact or circumstance
1410 affecting its qualification for a license in this state.

1411 (h) In addition to the surety bond required under subsection (a) of
1412 this section, a third-party administrator licensed or applying for a
1413 license under this section that administers or will administer
1414 governmental or church self-insured plans in this state or any other
1415 state shall execute and maintain a surety bond, for use by the
1416 commissioner and the insurance regulatory authority of any additional
1417 state in which the third-party administrator is authorized to conduct
1418 business, to cover individuals and persons who have remitted
1419 premiums, charges or fees to the third-party administrator in the
1420 course of the third-party administrator's business, in the greater of the
1421 following amounts: (1) One hundred thousand dollars; or (2) ten per
1422 cent of the aggregate total amount of self-funded coverage under
1423 governmental plans or church plans handled in this state and all
1424 additional states in which the third-party administrator is authorized
1425 to conduct business.

1426 Sec. 31. (NEW) (*Effective October 1, 2011*) A person who is not
1427 required to be licensed as a third-party administrator under
1428 subdivision (11) of section 20 or section 21 of this act and who directly
1429 or indirectly underwrites, collects charges or premiums from, or
1430 adjusts or settles claims on residents of this state, only in connection
1431 with life, annuity or health coverage provided by a self-funded plan
1432 other than governmental or church plans, shall register annually with
1433 the commissioner not later than October first on a form designated by
1434 the commissioner.

1435 Sec. 32. (NEW) (*Effective October 1, 2011*) (a) Each third-party
1436 administrator licensed under section 30 of this act shall file an annual
1437 report for the preceding calendar year with the commissioner on or
1438 before July first of each year or within such extension of time as the
1439 commissioner may grant for good cause. The annual report shall be in
1440 the form and contain such information as the commissioner prescribes,
1441 including evidence that the surety bond required under subdivision (1)
1442 of subsection (a) of this section and, if applicable, subsection (h) of
1443 section 30 of this act, remain in force. The information contained in
1444 such report shall be verified by at least two officers of the third-party
1445 administrator.

1446 (b) The annual report shall include the complete names and
1447 addresses of all insurers or other persons with which the third-party
1448 administrator had written agreements during the preceding fiscal year.

1449 (c) At the time of filing the annual report, the third-party
1450 administrator shall pay a filing fee as specified in section 38a-11 of the
1451 general statutes, as amended by this act.

1452 (d) The commissioner shall review the most recently filed annual
1453 report of each third-party administrator on or before September first of
1454 each year. Upon completion of its review, the commissioner shall: (1)
1455 Issue a certification to the third-party administrator that the annual
1456 report shows the third-party administrator is currently licensed and in
1457 good standing, or noting any deficiencies found in such annual report;
1458 or (2) update any electronic database maintained by the National
1459 Association of Insurance Commissioners, its affiliates or subsidiaries,
1460 indicating that the annual report shows the third-party administrator
1461 is compliant with existing law, or noting any deficiencies found in
1462 such annual report.

1463 Sec. 33. (NEW) (*Effective October 1, 2011*) (a) The commissioner shall
1464 suspend or revoke the license of a third-party administrator, or shall
1465 issue a cease and desist order if the third-party administrator does not
1466 have a license if, after notice and hearing, the commissioner finds that

1467 the third-party administrator: (1) Is in an unsound financial condition;
1468 (2) is using such methods or practices in the conduct of its business so
1469 as to render its further transaction of business in this state hazardous
1470 or injurious to insured persons or the public; or (3) has failed to pay
1471 any judgment rendered against it in this state within sixty days after
1472 the judgment has become final.

1473 (b) The commissioner may suspend or revoke the license of a third-
1474 party administrator, or may issue a cease and desist order if the third-
1475 party administrator does not have a license if, after notice and hearing,
1476 the commissioner finds that the third-party administrator: (1) Has
1477 violated any lawful rule or order of the commissioner or any provision
1478 of the insurance laws of this state; (2) (A) has refused to be examined
1479 or to produce its accounts, records and files for examination, or (B) if
1480 any individual responsible for the conduct of the affairs of the third-
1481 party administrator, including (i) members of the board of directors,
1482 board of trustees, executive committee or other governing board or
1483 committee, (ii) the principal officers in the case of a corporation or the
1484 partners or members in the case of a partnership, association or limited
1485 liability company, (iii) any shareholder or member holding directly or
1486 indirectly ten per cent or more of the voting stock, voting securities or
1487 voting interest of the third-party administrator, and (iv) any other
1488 person who exercises control or influence over the affairs of the third-
1489 party administrator, has refused to provide information with respect to
1490 its affairs or to perform other legal obligations as to an examination,
1491 when required by the commissioner; (3) has, without just cause,
1492 refused to pay proper claims or perform services arising under its
1493 contracts or has, without just cause, caused insureds to accept less than
1494 the amount due or caused insureds to employ attorneys or bring suit
1495 against the third-party administrator to secure full payment or
1496 settlement of such claims; (4) fails at any time to meet any qualification
1497 for which issuance of a license could have been refused had the failure
1498 then existed and been known to the commissioner; (5) has any
1499 individual who is responsible for the conduct of its affairs, including
1500 (A) members of the board of directors, board of trustees, executive

1501 committee or other governing board or committee, (B) the principal
1502 officers in the case of a corporation or the partners or members in the
1503 case of a partnership, association or limited liability company, (C) any
1504 shareholder or member holding directly or indirectly ten per cent or
1505 more of its voting stock, voting securities or voting interest, and (D)
1506 any other person who exercises control or influence over its affairs,
1507 who has been convicted of or has entered a plea of guilty or nolo
1508 contendere to a felony, without regard to whether adjudication was
1509 withheld; (6) is under suspension or revocation in another state; or (7)
1510 has failed to file a timely annual report pursuant to section 32 of this
1511 act.

1512 (c) (1) The commissioner may, without advance notice and before a
1513 hearing, issue an order immediately suspending the license of a third-
1514 party administrator, or may issue a cease and desist order if the third-
1515 party administrator does not have a license, if the commissioner finds
1516 that one or more of the following circumstances exist: (A) The third-
1517 party administrator is insolvent or impaired, (B) a proceeding for
1518 receivership, conservatorship, rehabilitation or other delinquency
1519 proceeding regarding the third-party administrator has been
1520 commenced in any state, or (C) the financial condition or business
1521 practices of the third-party administrator otherwise pose an imminent
1522 threat to the public health, safety or welfare of the residents of this
1523 state.

1524 (2) At the time the commissioner issues an order pursuant to
1525 subdivision (1) of this subsection, the commissioner shall serve notice
1526 to the third-party administrator that such third-party administrator
1527 may request a hearing not later than ten business days after the receipt
1528 of the order. If a hearing is requested, the commissioner shall schedule
1529 a hearing not later than ten business days after receipt of the request. If
1530 a hearing is not requested and the commissioner does not choose to
1531 hold one, the order shall remain in effect until modified or vacated by
1532 the commissioner.

1533 Sec. 34. (NEW) (*Effective October 1, 2011*) The Insurance

1534 Commissioner may adopt regulations, in accordance with chapter 54
1535 of the general statutes, to implement the provisions of sections 20 to 33,
1536 inclusive, of this act.

1537 Sec. 35. Subsection (a) of section 38a-15 of the general statutes is
1538 repealed and the following is substituted in lieu thereof (*Effective*
1539 *October 1, 2011*):

1540 (a) The commissioner shall, as often as [he] the commissioner deems
1541 it expedient, undertake a market conduct examination of the affairs of
1542 any insurance company, health care center, third-party administrator,
1543 as defined in section 20 of this act, or fraternal benefit society doing
1544 business in this state.

1545 Sec. 36. Subsection (a) of section 38a-11 of the general statutes is
1546 repealed and the following is substituted in lieu thereof (*Effective*
1547 *October 1, 2011*):

1548 (a) The commissioner shall demand and receive the following fees:
1549 (1) For the annual fee for each license issued to a domestic insurance
1550 company, two hundred dollars; (2) for receiving and filing annual
1551 reports of domestic insurance companies, fifty dollars; (3) for filing all
1552 documents prerequisite to the issuance of a license to an insurance
1553 company, two hundred twenty dollars, except that the fee for such
1554 filings by any health care center, as defined in section 38a-175, shall be
1555 one thousand three hundred fifty dollars; (4) for filing any additional
1556 paper required by law, thirty dollars; (5) for each certificate of
1557 valuation, organization, reciprocity or compliance, forty dollars; (6) for
1558 each certified copy of a license to a company, forty dollars; (7) for each
1559 certified copy of a report or certificate of condition of a company to be
1560 filed in any other state, forty dollars; (8) for amending a certificate of
1561 authority, two hundred dollars; (9) for each license issued to a rating
1562 organization, two hundred dollars. In addition, insurance companies
1563 shall pay any fees imposed under section 12-211; (10) a filing fee of
1564 fifty dollars for each initial application for a license made pursuant to
1565 section 38a-769; (11) with respect to insurance agents' appointments:

1566 (A) A filing fee of fifty dollars for each request for any agent
1567 appointment, except that no filing fee shall be payable for a request for
1568 agent appointment by an insurance company domiciled in a state or
1569 foreign country which does not require any filing fee for a request for
1570 agent appointment for a Connecticut insurance company; (B) a fee of
1571 one hundred dollars for each appointment issued to an agent of a
1572 domestic insurance company or for each appointment continued; and
1573 (C) a fee of eighty dollars for each appointment issued to an agent of
1574 any other insurance company or for each appointment continued,
1575 except that (i) no fee shall be payable for an appointment issued to an
1576 agent of an insurance company domiciled in a state or foreign country
1577 which does not require any fee for an appointment issued to an agent
1578 of a Connecticut insurance company, and (ii) the fee shall be twenty
1579 dollars for each appointment issued or continued to an agent of an
1580 insurance company domiciled in a state or foreign country with a
1581 premium tax rate below Connecticut's premium tax rate; (12) with
1582 respect to insurance producers: (A) An examination fee of fifteen
1583 dollars for each examination taken, except when a testing service is
1584 used, the testing service shall pay a fee of fifteen dollars to the
1585 commissioner for each examination taken by an applicant; (B) a fee of
1586 eighty dollars for each license issued; (C) a fee of eighty dollars per
1587 year, or any portion thereof, for each license renewed; and (D) a fee of
1588 eighty dollars for any license renewed under the transitional process
1589 established in section 38a-784; (13) with respect to public adjusters: (A)
1590 An examination fee of fifteen dollars for each examination taken,
1591 except when a testing service is used, the testing service shall pay a fee
1592 of fifteen dollars to the commissioner for each examination taken by an
1593 applicant; and (B) a fee of two hundred fifty dollars for each license
1594 issued or renewed; (14) with respect to casualty adjusters: (A) An
1595 examination fee of twenty dollars for each examination taken, except
1596 when a testing service is used, the testing service shall pay a fee of
1597 twenty dollars to the commissioner for each examination taken by an
1598 applicant; (B) a fee of eighty dollars for each license issued or renewed;
1599 and (C) the expense of any examination administered outside the state
1600 shall be the responsibility of the entity making the request and such

1601 entity shall pay to the commissioner two hundred dollars for such
1602 examination and the actual traveling expenses of the examination
1603 administrator to administer such examination; (15) with respect to
1604 motor vehicle physical damage appraisers: (A) An examination fee of
1605 eighty dollars for each examination taken, except when a testing
1606 service is used, the testing service shall pay a fee of eighty dollars to
1607 the commissioner for each examination taken by an applicant; (B) a fee
1608 of eighty dollars for each license issued or renewed; and (C) the
1609 expense of any examination administered outside the state shall be the
1610 responsibility of the entity making the request and such entity shall
1611 pay to the commissioner two hundred dollars for such examination
1612 and the actual traveling expenses of the examination administrator to
1613 administer such examination; (16) with respect to certified insurance
1614 consultants: (A) An examination fee of twenty-six dollars for each
1615 examination taken, except when a testing service is used, the testing
1616 service shall pay a fee of twenty-six dollars to the commissioner for
1617 each examination taken by an applicant; (B) a fee of two hundred fifty
1618 dollars for each license issued; and (C) a fee of two hundred fifty
1619 dollars for each license renewed; (17) with respect to surplus lines
1620 brokers: (A) An examination fee of twenty dollars for each
1621 examination taken, except when a testing service is used, the testing
1622 service shall pay a fee of twenty dollars to the commissioner for each
1623 examination taken by an applicant; and (B) a fee of six hundred
1624 twenty-five dollars for each license issued or renewed; (18) with
1625 respect to fraternal agents, a fee of eighty dollars for each license
1626 issued or renewed; (19) a fee of twenty-six dollars for each license
1627 certificate requested, whether or not a license has been issued; (20)
1628 with respect to domestic and foreign benefit societies shall pay: (A) For
1629 service of process, fifty dollars for each person or insurer to be served;
1630 (B) for filing a certified copy of its charter or articles of association,
1631 fifteen dollars; (C) for filing the annual report, twenty dollars; and (D)
1632 for filing any additional paper required by law, fifteen dollars; (21)
1633 with respect to foreign benefit societies: (A) For each certificate of
1634 organization or compliance, fifteen dollars; (B) for each certified copy
1635 of permit, fifteen dollars; and (C) for each copy of a report or certificate

1636 of condition of a society to be filed in any other state, fifteen dollars;
1637 (22) with respect to reinsurance intermediaries: A fee of six hundred
1638 twenty-five dollars for each license issued or renewed; (23) with
1639 respect to life settlement providers: (A) A filing fee of twenty-six
1640 dollars for each initial application for a license made pursuant to
1641 section 38a-465a; and (B) a fee of forty dollars for each license issued or
1642 renewed; (24) with respect to life settlement brokers: (A) A filing fee of
1643 twenty-six dollars for each initial application for a license made
1644 pursuant to section 38a-465a; and (B) a fee of forty dollars for each
1645 license issued or renewed; (25) with respect to preferred provider
1646 networks, a fee of two thousand seven hundred fifty dollars for each
1647 license issued or renewed; (26) with respect to rental companies, as
1648 defined in section 38a-799, a fee of eighty dollars for each permit
1649 issued or renewed; (27) with respect to medical discount plan
1650 organizations licensed under section 38a-479rr, a fee of six hundred
1651 twenty-five dollars for each license issued or renewed; (28) with
1652 respect to pharmacy benefits managers, an application fee of one
1653 hundred dollars for each registration issued or renewed; (29) with
1654 respect to captive insurance companies, as defined in section 38a-91aa,
1655 a fee of three hundred seventy-five dollars for each license issued or
1656 renewed; [and] (30) with respect to each duplicate license issued a fee
1657 of fifty dollars for each license issued; and (31) with respect to third-
1658 party administrators, as defined in section 20 of this act, (A) a fee of
1659 five hundred dollars for each license issued, (B) a fee of three hundred
1660 fifty dollars for each license renewed, and (C) a fee of one hundred
1661 dollars for each annual report filed pursuant to section 32 of this act.

1662 Sec. 37. Section 38a-497 of the general statutes is repealed and the
1663 following is substituted in lieu thereof (*Effective from passage*):

1664 [Every] Each individual health insurance policy providing coverage
1665 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12)
1666 of section 38a-469 delivered, issued for delivery, amended, renewed or
1667 continued in this state shall provide that coverage of a child shall
1668 terminate no earlier than the policy anniversary date on or after
1669 whichever of the following occurs first, the date on which the child:

1670 [Marries; ceases to be a resident of the state; becomes] Becomes
1671 covered under a group health plan through the dependent's own
1672 employment; or attains the age of twenty-six. [The residency
1673 requirement shall not apply to dependent children under nineteen
1674 years of age or full-time students attending an accredited institution of
1675 higher education.] Each such policy shall cover a stepchild on the same
1676 basis as a biological child.

1677 Sec. 38. (NEW) (*Effective from passage*) Each group health insurance
1678 policy providing coverage of the type specified in subdivisions (1), (2),
1679 (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes
1680 delivered, issued for delivery, amended, renewed or continued in this
1681 state shall provide that coverage of a child shall terminate no earlier
1682 than the policy anniversary date on or after whichever of the following
1683 occurs first, the date on which the child: Becomes covered under a
1684 group health plan through the dependent's own employment; or
1685 attains the age of twenty-six. Each such policy shall cover a stepchild
1686 on the same basis as a biological child.

1687 Sec. 39. Subsection (a) of section 5-259 of the general statutes is
1688 repealed and the following is substituted in lieu thereof (*Effective from*
1689 *passage*):

1690 (a) The Comptroller, with the approval of the Attorney General and
1691 of the Insurance Commissioner, shall arrange and procure a group
1692 hospitalization and medical and surgical insurance plan or plans for
1693 (1) state employees, (2) members of the General Assembly who elect
1694 coverage under such plan or plans, (3) participants in an alternate
1695 retirement program who meet the service requirements of section
1696 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits
1697 under section 5-144 or from any state-sponsored retirement system,
1698 except the teachers' retirement system and the municipal employees
1699 retirement system, (5) judges of probate and Probate Court employees,
1700 (6) the surviving spouse, and any dependent children [until they reach
1701 the age of eighteen,] of a state police officer, a member of an organized
1702 local police department, a firefighter or a constable who performs

1703 criminal law enforcement duties who dies before, on or after June 26,
1704 2003, as the result of injuries received while acting within the scope of
1705 such officer's or firefighter's or constable's employment and not as the
1706 result of illness or natural causes, and whose surviving spouse and
1707 dependent children are not otherwise eligible for a group
1708 hospitalization and medical and surgical insurance plan. Coverage for
1709 a dependent child pursuant to this subdivision shall terminate no
1710 earlier than the policy anniversary date on or after whichever of the
1711 following occurs first, the date on which the child: Becomes covered
1712 under a group health plan through the dependent's own employment;
1713 or attains the age of twenty-six, (7) employees of the Capital City
1714 Economic Development Authority established by section 32-601, and
1715 (8) the surviving spouse and dependent children of any employee of a
1716 municipality who dies on or after October 1, 2000, as the result of
1717 injuries received while acting within the scope of such employee's
1718 employment and not as the result of illness or natural causes, and
1719 whose surviving spouse and dependent children are not otherwise
1720 eligible for a group hospitalization and medical and surgical insurance
1721 plan. For purposes of this subdivision, "employee" means any regular
1722 employee or elective officer receiving pay from a municipality,
1723 "municipality" means any town, city, borough, school district, taxing
1724 district, fire district, district department of health, probate district,
1725 housing authority, regional work force development board established
1726 under section 31-3k, flood commission or authority established by
1727 special act or regional planning agency. For purposes of subdivision
1728 (6) of this subsection, "firefighter" means any person who is regularly
1729 employed and paid by any municipality for the purpose of performing
1730 firefighting duties for a municipality on average of not less than thirty-
1731 five hours per week. The minimum benefits to be provided by such
1732 plan or plans shall be substantially equal in value to the benefits that
1733 each such employee or member of the General Assembly could secure
1734 in such plan or plans on an individual basis on the preceding first day
1735 of July. The state shall pay for each such employee and each member
1736 of the General Assembly covered by such plan or plans the portion of
1737 the premium charged for such member's or employee's individual

1738 coverage and seventy per cent of the additional cost of the form of
1739 coverage and such amount shall be credited to the total premiums
1740 owed by such employee or member of the General Assembly for the
1741 form of such member's or employee's coverage under such plan or
1742 plans. On and after January 1, 1989, the state shall pay for anyone
1743 receiving benefits from any such state-sponsored retirement system
1744 one hundred per cent of the portion of the premium charged for such
1745 member's or employee's individual coverage and one hundred per
1746 cent of any additional cost for the form of coverage. The balance of any
1747 premiums payable by an individual employee or by a member of the
1748 General Assembly for the form of coverage shall be deducted from the
1749 payroll by the State Comptroller. The total premiums payable shall be
1750 remitted by the Comptroller to the insurance company or companies
1751 or nonprofit organization or organizations providing the coverage. The
1752 amount of the state's contribution per employee for a health
1753 maintenance organization option shall be equal, in terms of dollars and
1754 cents, to the largest amount of the contribution per employee paid for
1755 any other option that is available to all eligible state employees
1756 included in the health benefits plan, but shall not be required to exceed
1757 the amount of the health maintenance organization premium.

1758 Sec. 40. Subsection (f) of section 5-259 of the general statutes is
1759 repealed and the following is substituted in lieu thereof (*Effective from*
1760 *passage*):

1761 (f) The Comptroller, with the approval of the Attorney General and
1762 of the Insurance Commissioner, shall arrange and procure a group
1763 hospitalization and medical and surgical insurance plan or plans for
1764 any person who adopts a child from the state foster care system, any
1765 person who has been a foster parent for the Department of Children
1766 and Families for six months or more, a parent in a permanent family
1767 residence for six months or more, and any dependent of such adoptive
1768 parent, foster parent or parent in a permanent family residence who
1769 elects coverage under such plan or plans. The Comptroller may also
1770 arrange for inclusion of such person and any such dependent in an
1771 existing group hospitalization and medical and surgical insurance plan

1772 offered by the state. Any adoptive parent, foster parent or a parent in a
1773 permanent family residence and any dependent who elects coverage
1774 shall pay one hundred per cent of the premium charged for such
1775 coverage directly to the insurer, provided such adoptive parent, foster
1776 parent or parent and all such dependents shall be included in such
1777 group hospitalization and medical and surgical insurance plan. A
1778 person and his dependents electing coverage pursuant to this
1779 subsection shall be eligible for such coverage until no longer an
1780 adoptive parent, a foster parent or a parent in a permanent family
1781 residence. An adoptive parent shall be eligible for such coverage until
1782 the [adopted child reaches the age of eighteen or, if the child has not
1783 completed a secondary education program, until such child reaches
1784 the age of twenty-one] coverage anniversary date on or after
1785 whichever of the following occurs first, the date on which the child:
1786 Becomes covered under a group health plan through the dependent's
1787 own employment; or attains the age of twenty-six. As used in this
1788 section "dependent" means a spouse or natural or adopted child if such
1789 child is wholly or partially dependent for support upon the adoptive
1790 parent, foster parent or parent in a permanent family residence.

1791 Sec. 41. Subsection (b) of section 38a-476 of the general statutes is
1792 repealed and the following is substituted in lieu thereof (*Effective from*
1793 *passage*):

1794 (b) (1) No group health insurance plan or insurance arrangement
1795 shall impose a preexisting conditions provision that excludes coverage
1796 for (A) individuals eighteen years of age and younger, or (B) a period
1797 beyond twelve months following the insured's effective date of
1798 coverage. Any preexisting conditions provision shall only relate to
1799 conditions, whether physical or mental, for which medical advice,
1800 diagnosis or care or treatment was recommended or received during
1801 the six months immediately preceding the effective date of coverage.

1802 (2) No individual health insurance plan or insurance arrangement
1803 shall impose a preexisting conditions provision that excludes coverage
1804 for (A) individuals eighteen years of age and younger, or (B) a period

1805 beyond twelve months following the insured's effective date of
1806 coverage. Any preexisting conditions provision shall only relate to
1807 conditions, whether physical or mental, for which medical advice,
1808 diagnosis or care or treatment was recommended or received during
1809 the twelve months immediately preceding the effective date of
1810 coverage.

1811 (3) No insurance company, fraternal benefit society, hospital service
1812 corporation, medical service corporation or health care center shall
1813 refuse to issue an individual health insurance plan or insurance
1814 arrangement to individuals eighteen years of age and younger solely
1815 on the basis that an individual has a preexisting condition.

1816 Sec. 42. (NEW) (*Effective from passage*) (a) No individual health
1817 insurance policy providing coverage of the type specified in
1818 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
1819 statutes delivered, issued for delivery, amended, renewed or
1820 continued in this state shall include a lifetime limit on the dollar value
1821 of benefits for a covered individual, for covered benefits that are
1822 essential health benefits, as defined in the Patient Protection and
1823 Affordable Care Act, P.L. 111-1448, as amended from time to time, or
1824 regulations adopted thereunder.

1825 (b) This section shall not prohibit the inclusion of a lifetime limit on
1826 specific covered benefits that are not essential health benefits, provided
1827 the lifetime limit for reasonable charges or, when applicable, the
1828 allowance agreed upon by a health care provider and an insurer,
1829 health care center, hospital service corporation, medical service
1830 corporation or fraternal benefit society for charges actually incurred
1831 for any specific covered benefit, shall be not less than one million
1832 dollars per covered individual.

1833 Sec. 43. (NEW) (*Effective from passage*) (a) No group health insurance
1834 policy providing coverage of the type specified in subdivisions (1), (2),
1835 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
1836 issued for delivery, amended, renewed or continued in this state shall

1837 include a lifetime limit on the dollar value of benefits for a covered
1838 individual, for covered benefits that are essential health benefits, as
1839 defined in the Patient Protection and Affordable Care Act, P.L. 111-
1840 1448, as amended from time to time, or regulations adopted
1841 thereunder.

1842 (b) This section shall not prohibit the inclusion of a lifetime limit on
1843 specific covered benefits that are not essential health benefits, provided
1844 the lifetime limit for reasonable charges or, when applicable, the
1845 allowance agreed upon by a health care provider and an insurer,
1846 health care center, hospital service corporation, medical service
1847 corporation or fraternal benefit society for charges actually incurred
1848 for any specific covered benefit, shall be not less than one million
1849 dollars per covered individual.

1850 Sec. 44. (NEW) (*Effective from passage*) (a) (1) Each insurer, health
1851 care center, hospital service corporation, medical service corporation,
1852 fraternal benefit society or other entity delivering, issuing for delivery,
1853 renewing, amending or continuing a group health insurance policy in
1854 this state that provides coverage of the type specified in subdivisions
1855 (1), (2), (3), (4), (11) and (12) of section 38a-469 of the general statutes
1856 shall provide the option to continue coverage under each of the
1857 following circumstances until the individual is eligible for other group
1858 insurance, except as provided in subparagraphs (C) and (D) of this
1859 subdivision:

1860 (A) Upon layoff, reduction of hours, leave of absence or termination
1861 of employment, other than as a result of death of the employee or as a
1862 result of such employee's "gross misconduct" as that term is used in 29
1863 USC 1163(2), continuation of coverage for such employee and such
1864 employee's covered dependents for a period of thirty months after the
1865 date of such layoff, reduction of hours, leave of absence or termination
1866 of employment, except that if such reduction of hours, leave of absence
1867 or termination of employment results from an employee's eligibility to
1868 receive Social Security income, continuation of coverage for such
1869 employee and such employee's covered dependents until midnight of

1870 the day preceding such person's eligibility for benefits under Title
1871 XVIII of the Social Security Act;

1872 (B) Upon the death of the employee, continuation of coverage for
1873 the covered dependents of such employee for the periods set forth for
1874 such event under federal extension requirements established by the
1875 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1876 as amended from time to time;

1877 (C) Regardless of the employee's or dependent's eligibility for other
1878 group insurance, during an employee's absence due to illness or injury,
1879 continuation of coverage for such employee and such employee's
1880 covered dependents during continuance of such illness or injury or for
1881 up to twelve months from the beginning of such absence;

1882 (D) Regardless of an individual's eligibility for other group
1883 insurance, upon termination of the group policy, coverage for covered
1884 individuals who were totally disabled on the date of termination shall
1885 be continued without premium payment during the continuance of
1886 such disability for a period of twelve calendar months following the
1887 calendar month in which such policy was terminated, provided claim
1888 is submitted for coverage within one year of the termination of such
1889 policy;

1890 (E) The coverage of any covered individual shall terminate: (i) As to
1891 a child, (I) as set forth in section 38 of this act. If on the date specified
1892 for termination of coverage on a child, the child is incapable of self-
1893 sustaining employment by reason of mental or physical handicap and
1894 chiefly dependent upon the employee for support and maintenance,
1895 the coverage on such child shall continue while the plan remains in
1896 force and the child remains in such condition, provided proof of such
1897 handicap is received by such insurer, center, corporation, society or
1898 other entity within thirty-one days of the date on which the child's
1899 coverage would have terminated in the absence of such incapacity.
1900 Such insurer, center, corporation, society or other entity may require
1901 subsequent proof of the child's continued incapacity and dependency

1902 but not more often than once a year thereafter, or (II) for the periods
1903 set forth for such child under federal extension requirements
1904 established by the Consolidated Omnibus Budget Reconciliation Act of
1905 1985, P.L. 99-272, as amended from time to time; (ii) as to the
1906 employee's spouse, at the end of the month following the month in
1907 which a divorce, court-ordered annulment or legal separation is
1908 obtained, whichever is earlier, except that the plan shall provide the
1909 option for said spouse to continue coverage for the periods set forth for
1910 such events under federal extension requirements established by the
1911 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1912 as amended from time to time; and (iii) as to the employee or
1913 dependent who is sixty-five years of age or older, as of midnight of the
1914 day preceding such person's eligibility for benefits under Title XVIII of
1915 the federal Social Security Act;

1916 (F) As to any other event listed as a "qualifying event" in 29 USC
1917 1163, as amended from time to time, continuation of coverage for such
1918 periods set forth for such event in 29 USC 1162, as amended from time
1919 to time, provided such plan may require the individual whose
1920 coverage is to be continued to pay up to the percentage of the
1921 applicable premium as specified for such event in 29 USC 1162, as
1922 amended from time to time.

1923 (2) Any continuation of coverage required by this subsection except
1924 subparagraph (D) or (F) of subdivision (1) of this subsection may be
1925 subject to the requirement, on the part of the individual whose
1926 coverage is to be continued, that such individual contribute that
1927 portion of the premium the individual would have been required to
1928 contribute had the employee remained an active covered employee,
1929 except that the individual may be required to pay up to one hundred
1930 two per cent of the entire premium at the group rate if coverage is
1931 continued in accordance with subparagraph (A), (B) or (E) of
1932 subdivision (1) of this subsection. The employer shall not be legally
1933 obligated by sections 38a-505 or 38a-546, as amended by this act, of the
1934 general statutes to pay such premium if not paid timely by the
1935 employee.

1936 (b) The plan shall make available to Connecticut residents, in
1937 addition to any other conversion privilege available, a conversion
1938 privilege under which coverage shall be available immediately upon
1939 termination of coverage under the group policy. The terms and
1940 benefits offered under the conversion benefits shall be at least equal to
1941 the terms and benefits of an individual health insurance policy.

1942 (c) Nothing in this section shall alter or impair existing group
1943 policies which have been established pursuant to an agreement which
1944 resulted from collective bargaining, and the provisions required by
1945 this section shall become effective upon the next regular renewal and
1946 completion of such collective bargaining agreement.

1947 Sec. 45. Section 38a-546 of the general statutes is repealed and the
1948 following is substituted in lieu thereof (*Effective from passage*):

1949 [(a) In order to assure reasonable continuation of coverage and
1950 extension of benefits to the citizens of this state, each group health
1951 insurance policy, regardless of the number of insureds, providing
1952 coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and
1953 (12) of section 38a-469, delivered, issued for delivery, renewed,
1954 amended or continued in this state shall, subject to the provisions of
1955 subsection (d), contain those provisions described in subsections (b)
1956 and (d) of section 38a-554.]

1957 [(b)] (a) In any case of the discontinuance of a group health
1958 insurance policy providing coverage of the type specified in
1959 subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 and
1960 delivered, issued for delivery, renewed, amended or continued in this
1961 state and the subsequent replacement of such coverage with another
1962 such policy, the succeeding carrier, in applying any deductible,
1963 coinsurance or waiting period provisions in its plan, shall give credit
1964 for the satisfaction or partial satisfaction of the same or similar
1965 provisions under a prior plan providing similar benefits. In the case of
1966 deductible or coinsurance provisions, the credit shall apply for the
1967 same or overlapping benefit periods and shall be given for expenses

1968 actually incurred and applied against the deductible or coinsurance
1969 provisions of the prior carrier's plan during the ninety days preceding
1970 the effective date of the succeeding carrier's plan but only to the extent
1971 these expenses are recognized under the terms of the succeeding
1972 carrier's plan and are subject to a similar deductible or coinsurance
1973 provision.

1974 [(c)] (b) The commissioner shall adopt regulations in accordance
1975 with the provisions of chapter 54, covering group coverage
1976 discontinuance and replacement.

1977 [(d)] (c) Nothing in this section shall alter or impair existing group
1978 policies which have been established pursuant to an agreement which
1979 resulted from collective bargaining, and the provisions required by
1980 this section shall become effective upon the next regular renewal and
1981 completion of such collective bargaining agreement.

1982 Sec. 46. Subdivision (17) of section 38a-564 of the general statutes is
1983 repealed and the following is substituted in lieu thereof (*Effective from*
1984 *passage*):

1985 (17) "Preexisting conditions provision" means a policy provision
1986 [which] that excludes coverage for charges or expenses incurred
1987 during a specified period following the insured's effective date of
1988 coverage as to a condition [which] that, during a specified period
1989 immediately preceding the effective date of coverage, had manifested
1990 itself in such a manner as would cause an ordinary prudent person to
1991 seek diagnosis, care or treatment or for which medical advice,
1992 diagnosis, care or treatment was recommended or received as to that
1993 condition, [or as to a condition which is pregnancy existing on the
1994 effective date of coverage.]

1995 Sec. 47. Subsection (b) of section 38a-477b of the general statutes is
1996 repealed and the following is substituted in lieu thereof (*Effective from*
1997 *passage*):

1998 (b) An insurer or health care center shall apply for approval of such

1999 rescission, cancellation or limitation by submitting such written
2000 information to the Insurance Commissioner on an application in such
2001 form as the commissioner prescribes. Such insurer or health care center
2002 shall provide a copy of the application for such approval to the insured
2003 or the insured's representative. Not later than seven business days
2004 after receipt of the application for such approval, the insured or the
2005 insured's representative shall have an opportunity to review such
2006 application and respond and submit relevant information to the
2007 commissioner with respect to such application. Not later than fifteen
2008 business days after the submission of information by the insured or the
2009 insured's representative, the commissioner shall issue a written
2010 decision on such application. The commissioner [may] shall only
2011 approve; [such rescission, cancellation]

2012 (1) Such rescission or limitation if the commissioner finds that [(1)
2013 (A) the insured or such insured's representative submitted the written
2014 information [submitted] on or with the insurance application that was
2015 [false] fraudulent at the time such application was made, [and] (B) the
2016 insured or such insured's representative [knew or should have known
2017 of the falsity] intentionally misrepresented information therein [,] and
2018 such [submission] misrepresentation materially affects the risk or the
2019 hazard assumed by the insurer or health care center, or [(2)] (C) the
2020 information omitted from the insurance application was [knowingly]
2021 intentionally omitted by the insured or such insured's representative [,
2022 or the insured or such insured's representative should have known of
2023 such omission,] and such omission materially affects the risk or the
2024 hazard assumed by the insurer or health care center. Such decision
2025 shall be mailed to the insured, the insured's representative, if any, and
2026 the insurer or health care center; and

2027 (2) Such cancellation in accordance with the provisions set forth in
2028 the Public Health Service Act, 42 USC 300gg et seq., as amended from
2029 time to time.

2030 Sec. 48. Subparagraph (D) of subdivision (1) of section 38a-567 of the
2031 general statutes is repealed and the following is substituted in lieu

2032 thereof (*Effective from passage*):

2033 (D) Notwithstanding the provisions of this subdivision, any such
2034 plan or arrangement, or any coverage provided under such plan or
2035 arrangement may be rescinded for fraud, intentional material
2036 misrepresentation or concealment by an applicant, employee,
2037 dependent or small employer.

2038 Sec. 49. Subsection (b) of section 38a-478l of the general statutes is
2039 repealed and the following is substituted in lieu thereof (*Effective*
2040 *January 1, 2012*):

2041 (b) (1) The consumer report card shall be known as the "Consumer
2042 Report Card on Health Insurance Carriers in Connecticut" and shall
2043 include [(1)] (A) all health care centers licensed pursuant to chapter
2044 698a, [(2)] (B) the fifteen largest licensed health insurers that use
2045 provider networks and that are not included in [subdivision (1)]
2046 subparagraph (A) of this [subsection] subdivision, [(3)] (C) the state
2047 medical loss ratio of each such health care center or licensed health
2048 insurer, [(4)] (D) the federal medical loss ratio of each such health care
2049 center or licensed health insurer, (E) the information required under
2050 subdivision (6) of subsection (a) of section 38a-478c, as amended by
2051 this act, and [(5)] (F) information concerning mental health services, as
2052 specified in subsection (c) of this section. The insurers selected
2053 pursuant to [subdivision (2)] subparagraph (B) of this [subsection]
2054 subdivision shall be selected on the basis of Connecticut direct written
2055 health premiums from such network plans.

2056 (2) For the purposes of this section and sections 38a-477c, 38a-478c
2057 and 38a-478g, as amended by this act: ["medical"]

2058 (A) "State medical loss ratio" means the ratio of incurred claims to
2059 earned premiums for the prior calendar year for managed care plans
2060 issued in the state. Claims shall be limited to medical expenses for
2061 services and supplies provided to enrollees and shall not include
2062 expenses for stop loss coverage, reinsurance, enrollee educational
2063 programs or other cost containment programs or features;

2064 (B) "Federal medical loss ratio" has the same meaning as provided
2065 in, and shall be calculated in accordance with, the Patient Protection
2066 and Affordable Care Act, P.L. 111-148, as amended from time to time,
2067 and regulations adopted thereunder.

2068 Sec. 50. Section 38a-477c of the general statutes is repealed and the
2069 following is substituted in lieu thereof (*Effective January 1, 2012*):

2070 An insurer or health care center shall include a written notice with
2071 each application for individual or group health insurance coverage
2072 that discloses such insurer's or health care center's state medical loss
2073 ratio and federal medical loss ratio, as both terms are defined in
2074 [subsection (b) of] section 38a-478l, as amended by this act, as reported
2075 in the last Consumer Report Card on Health Insurance Carriers in
2076 Connecticut, to an applicant at the time of application for coverage.

2077 Sec. 51. Section 38a-478c of the general statutes is repealed and the
2078 following is substituted in lieu thereof (*Effective January 1, 2012*):

2079 (a) On or before May first of each year, each managed care
2080 organization shall submit to the commissioner:

2081 (1) A report on its quality assurance plan that includes, but is not
2082 limited to, information on complaints related to providers and quality
2083 of care, on decisions related to patient requests for coverage and on
2084 prior authorization statistics. Statistical information shall be submitted
2085 in a manner permitting comparison across plans and shall include, but
2086 not be limited to: (A) The ratio of the number of complaints received to
2087 the number of enrollees; (B) a summary of the complaints received
2088 related to providers and delivery of care or services and the action
2089 taken on the complaint; (C) the ratio of the number of prior
2090 authorizations denied to the number of prior authorizations requested;
2091 (D) the number of utilization review determinations made by or on
2092 behalf of a managed care organization not to certify an admission,
2093 service, procedure or extension of stay, and the denials upheld and
2094 reversed on appeal within the managed care organization's utilization
2095 review procedure; (E) the percentage of those employers or groups

2096 that renew their contracts within the previous twelve months; and (F)
2097 notwithstanding the provisions of this subsection, on or before July
2098 first of each year, all data required by the National Committee for
2099 Quality Assurance (NCQA) for its Health Plan Employer Data and
2100 Information Set (HEDIS). If an organization does not provide
2101 information for the National Committee for Quality Assurance for its
2102 Health Plan Employer Data and Information Set, then it shall provide
2103 such other equivalent data as the commissioner may require by
2104 regulations adopted in accordance with the provisions of chapter 54.
2105 The commissioner shall find that the requirements of this subdivision
2106 have been met if the managed care plan has received a one-year or
2107 higher level of accreditation by the National Committee for Quality
2108 Assurance and has submitted the Health Plan Employee Data
2109 Information Set data required by subparagraph (F) of this subdivision.

2110 (2) A model contract that contains the provisions currently in force
2111 in contracts between the managed care organization and preferred
2112 provider networks in this state, and the managed care organization
2113 and participating providers in this state and, upon the commissioner's
2114 request, a copy of any individual contracts between such parties,
2115 provided the contract may withhold or redact proprietary fee schedule
2116 information; [.]

2117 (3) A written statement of the types of financial arrangements or
2118 contractual provisions that the managed care organization has with
2119 hospitals, utilization review companies, physicians, preferred provider
2120 networks and any other health care providers including, but not
2121 limited to, compensation based on a fee-for-service arrangement, a
2122 risk-sharing arrangement or a capitated risk arrangement; [.]

2123 (4) Such information as the commissioner deems necessary to
2124 complete the consumer report card required pursuant to section 38a-
2125 478l, as amended by this act. Such information may include, but need
2126 not be limited to: (A) The organization's characteristics, including its
2127 model, its profit or nonprofit status, its address and telephone number,
2128 the length of time it has been licensed in this and any other state, its

2129 number of enrollees and whether it has received any national or
2130 regional accreditation; (B) a summary of the information required by
2131 subdivision (3) of this section, including any change in a plan's rates
2132 over the prior three years, its state medical loss ratio and its federal
2133 medical loss ratio, as both terms are defined in [subsection (b) of]
2134 section 38a-478l, as amended by this act, how it compensates health
2135 care providers and its premium level; (C) a description of services, the
2136 number of primary care physicians and specialists, the number and
2137 nature of participating preferred provider networks and the
2138 distribution and number of hospitals, by county; (D) utilization review
2139 information, including the name or source of any established medical
2140 protocols and the utilization review standards; (E) medical
2141 management information, including the provider-to-patient ratio by
2142 primary care provider and specialty care provider, the percentage of
2143 primary and specialty care providers who are board certified, and how
2144 the medical protocols incorporate input as required in section 38a-
2145 478e; (F) the quality assurance information required to be submitted
2146 under the provisions of subdivision (1) of subsection (a) of this section;
2147 (G) the status of the organization's compliance with the reporting
2148 requirements of this section; (H) whether the organization markets to
2149 individuals and Medicare recipients; (I) the number of hospital days
2150 per thousand enrollees; and (J) the average length of hospital stays for
2151 specific procedures, as may be requested by the commissioner; [.]

2152 (5) A summary of the procedures used by managed care
2153 organizations to credential providers; and [.]

2154 (6) A report on claims denial data for lives covered in the state for
2155 the prior calendar year, in a format prescribed by the commissioner,
2156 that includes: (A) The total number of claims received; (B) the total
2157 number of claims denied; (C) the total number of denials that were
2158 appealed; (D) the total number of denials that were reversed upon
2159 appeal; (E) (i) the reasons for the denials, including, but not limited to,
2160 "not a covered benefit", "not medically necessary" and "not an eligible
2161 enrollee", (ii) the total number of times each reason was used, and (iii)
2162 the percentage of the total number of denials each reason was used;

2163 and (F) other information the commissioner deems necessary.

2164 (b) The information required pursuant to subsection (a) of this
2165 section shall be consistent with the data required by the National
2166 Committee for Quality Assurance (NCQA) for its Health Plan
2167 Employer Data and Information Set (HEDIS).

2168 (c) The commissioner may accept electronic filing for any of the
2169 requirements under this section.

2170 (d) No managed care organization shall be liable for a claim arising
2171 out of the submission of any information concerning complaints
2172 concerning providers, provided the managed care organization
2173 submitted the information in good faith.

2174 (e) The information required under subdivision (6) of subsection (a)
2175 of this section shall be posted on the Insurance Department's Internet
2176 web site.

2177 Sec. 52. Subsection (b) of section 38a-478g of the general statutes is
2178 repealed and the following is substituted in lieu thereof (*Effective*
2179 *January 1, 2012*):

2180 (b) Each managed care organization shall provide every enrollee
2181 with a plan description. The plan description shall be in plain language
2182 as commonly used by the enrollees and consistent with chapter 699a.
2183 The plan description shall be made available to each enrollee and
2184 potential enrollee prior to the enrollee's entering into the contract and
2185 during any open enrollment period. The plan description shall not
2186 contain provisions or statements that are inconsistent with the plan's
2187 medical protocols. The plan description shall contain:

2188 (1) A clear summary of the provisions set forth in subdivisions (1) to
2189 (12), inclusive, of subsection (a) of this section, subdivision (3) of
2190 subsection (a) of section 38a-478c and sections 38a-478j to 38a-478l,
2191 inclusive, as amended by this act;

2192 (2) A statement of the number of managed care organization's

2193 utilization review determinations not to certify an admission, service,
2194 procedure or extension of stay, and the denials upheld and reversed on
2195 appeal within the managed care organization's utilization review
2196 procedure;

2197 (3) A description of emergency services, the appropriate use of
2198 emergency services, including to the use of E 9-1-1 telephone systems,
2199 any cost sharing applicable to emergency services and the location of
2200 emergency departments and other settings in which participating
2201 physicians and hospitals provide emergency services and post
2202 stabilization care;

2203 (4) Coverage of the plans, including exclusions of specific
2204 conditions, ailments or disorders;

2205 (5) The use of drug formularies or any limits on the availability of
2206 prescription drugs and the procedure for obtaining information on the
2207 availability of specific drugs covered;

2208 (6) The number, types and specialties and geographic distribution of
2209 direct health care providers;

2210 (7) Participating and nonparticipating provider reimbursement
2211 procedure;

2212 (8) Preauthorization and utilization review requirements and
2213 procedures, internal grievance procedures and internal and external
2214 complaint procedures;

2215 (9) The state medical loss ratio and the federal medical loss ratio, as
2216 both terms are defined in [subsection (b) of] section 38a-478l, as
2217 amended by this act, as reported in the last Consumer Report Card on
2218 Health Insurance Carriers in Connecticut;

2219 (10) The plan's for-profit, nonprofit incorporation and ownership
2220 status;

2221 (11) Telephone numbers for obtaining further information,

2222 including the procedure for enrollees to contact the organization
2223 concerning coverage and benefits, claims grievance and complaint
2224 procedures after normal business hours;

2225 (12) How notification is provided to an enrollee when the plan is no
2226 longer contracting with an enrollee's primary care provider;

2227 (13) The procedures for obtaining referrals to specialists or for
2228 consulting a physician other than the primary care physician;

2229 (14) The status of the National Committee for Quality Assurance
2230 (NCQA) accreditation;

2231 (15) Enrollee satisfaction information; and

2232 (16) Procedures for protecting the confidentiality of medical records
2233 and other patient information.

2234 Sec. 53. (NEW) (*Effective from passage*) (a) For purposes of this
2235 section, "Affordable Care Act" means the Patient Protection and
2236 Affordable Care Act, P.L. 111-148, as amended from time to time, and
2237 regulations adopted thereunder.

2238 (b) Each insurance company, fraternal benefit society, hospital
2239 service corporation, medical service corporation and health care center
2240 licensed to do business in the state shall comply with Sections 1251,
2241 1252 and 1304 of the Affordable Care Act and the following Sections of
2242 the Public Health Service Act, as amended by the Affordable Care Act:
2243 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
2244 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

2245 (c) This section shall apply, on and after the effective dates specified
2246 in the Affordable Care Act, to insurance companies, fraternal benefit
2247 societies, hospital service corporations, medical service corporations
2248 and health care centers licensed to do business in the state.

2249 (d) No provision of the general statutes concerning a requirement of
2250 the Affordable Care Act shall be construed to supersede a provision of

2251 the general statutes that provides greater protection to an insured,
2252 except to the extent the latter prevents the application of a requirement
2253 of the Affordable Care Act.

2254 (e) The Insurance Commissioner may adopt regulations, in
2255 accordance with the provisions of chapter 54 of the general statutes, to
2256 implement the provisions of this section.

2257 Sec. 54. (NEW) (*Effective July 1, 2011*) As used in this section and
2258 sections 55 to 66, inclusive, of this act:

2259 (1) "Adverse determination" means:

2260 (A) The denial, reduction, termination or failure to provide or make
2261 payment, in whole or in part, for a benefit under the health carrier's
2262 health benefit plan requested by a covered person or a covered
2263 person's treating health care professional, based on a determination by
2264 a health carrier or its designee utilization review company:

2265 (i) That, based upon the information provided, (I) upon application
2266 of any utilization review technique, such benefit does not meet the
2267 health carrier's requirements for medical necessity, appropriateness,
2268 health care setting, level of care or effectiveness, or (II) is determined to
2269 be experimental or investigational;

2270 (ii) Of a covered person's eligibility to participate in the health
2271 carrier's health benefit plan; or

2272 (B) Any prospective review, concurrent review or retrospective
2273 review determination that denies, reduces or terminates or fails to
2274 provide or make payment, in whole or in part, for a benefit under the
2275 health carrier's health benefit plan requested by a covered person or a
2276 covered person's treating health care professional.

2277 "Adverse determination" includes a rescission of coverage
2278 determination for grievance purposes.

2279 (2) "Authorized representative" means:

2280 (A) A person to whom a covered person has given express written
2281 consent to represent the covered person for the purposes of this section
2282 and sections 55 to 66, inclusive, of this act;

2283 (B) A person authorized by law to provide substituted consent for a
2284 covered person;

2285 (C) A family member of the covered person or the covered person's
2286 treating health care professional when the covered person is unable to
2287 provide consent;

2288 (D) A health care professional when the covered person's health
2289 benefit plan requires that a request for a benefit under the plan be
2290 initiated by the health care professional; or

2291 (E) In the case of an urgent care request, a health care professional
2292 with knowledge of the covered person's medical condition.

2293 (3) "Best evidence" means evidence based on (A) randomized
2294 clinical trials, (B) if randomized clinical trials are not available, cohort
2295 studies or case-control studies, (C) if such trials and studies are not
2296 available, case-series, or (D) if such trials, studies and case-series are
2297 not available, expert opinion.

2298 (4) "Case-control study" means a retrospective evaluation of two
2299 groups of patients with different outcomes to determine which specific
2300 interventions the patients received.

2301 (5) "Case-series" means an evaluation of a series of patients with a
2302 particular outcome, without the use of a control group.

2303 (6) "Certification" means a determination by a health carrier or its
2304 designee utilization review company that a request for a benefit under
2305 the health carrier's health benefit plan has been reviewed and, based
2306 on the information provided, satisfies the health carrier's requirements
2307 for medical necessity, appropriateness, health care setting, level of care
2308 and effectiveness.

2309 (7) "Clinical peer" means a physician or other health care
2310 professional who holds a nonrestricted license in a state of the United
2311 States and in the same or similar specialty as typically manages the
2312 medical condition, procedure or treatment under review.

2313 (8) "Clinical review criteria" means the written screening
2314 procedures, decision abstracts, clinical protocols and practice
2315 guidelines used by the health carrier to determine the medical
2316 necessity and appropriateness of health care services.

2317 (9) "Cohort study" means a prospective evaluation of two groups of
2318 patients with only one group of patients receiving a specific
2319 intervention or specific interventions.

2320 (10) "Commissioner" means the Insurance Commissioner.

2321 (11) "Concurrent review" means utilization review conducted
2322 during a patient's stay or course of treatment in a facility, the office of a
2323 health care professional or other inpatient or outpatient health care
2324 setting, including home care.

2325 (12) "Covered benefits" or "benefits" means health care services to
2326 which a covered person is entitled under the terms of a health benefit
2327 plan.

2328 (13) "Covered person" means a policyholder, subscriber, enrollee or
2329 other individual participating in a health benefit plan.

2330 (14) "Emergency medical condition" means a medical condition
2331 manifesting itself by acute symptoms of sufficient severity, including
2332 severe pain, such that a prudent lay-person with an average
2333 knowledge of health and medicine, acting reasonably, would have
2334 believed that the absence of immediate medical attention would result
2335 in serious impairment to bodily functions or serious dysfunction of a
2336 bodily organ or part, or would place the person's health or, with
2337 respect to a pregnant woman, the health of the woman or her unborn
2338 child, in serious jeopardy.

2339 (15) "Emergency services" means, with respect to an emergency
2340 medical condition:

2341 (A) A medical screening examination that is within the capability of
2342 the emergency department of a hospital, including ancillary services
2343 routinely available to the emergency department to evaluate such
2344 emergency medical condition; and

2345 (B) Such further medical examination and treatment, to the extent
2346 they are within the capability of the staff and facilities available at a
2347 hospital, to stabilize a patient.

2348 (16) "Evidence-based standard" means the conscientious, explicit
2349 and judicious use of the current best evidence based on an overall
2350 systematic review of medical research when making determinations
2351 about the care of individual patients.

2352 (17) "Expert opinion" means a belief or an interpretation by
2353 specialists with experience in a specific area about the scientific
2354 evidence pertaining to a particular service, intervention or therapy.

2355 (18) "Facility" means an institution providing health care services or
2356 a health care setting. "Facility" includes a hospital and other licensed
2357 inpatient center, ambulatory surgical or treatment center, skilled
2358 nursing center, residential treatment center, diagnostic, laboratory and
2359 imaging center, and rehabilitation and other therapeutic health care
2360 setting.

2361 (19) "Final adverse determination" means an adverse determination
2362 (A) that has been upheld by the health carrier at the completion of its
2363 internal grievance process, or (B) for which the internal grievance
2364 process has been deemed exhausted.

2365 (20) "Grievance" means a written complaint or, if the complaint
2366 involves an urgent care request, an oral complaint, submitted by or on
2367 behalf of a covered person regarding:

2368 (A) The availability, delivery or quality of health care services,

2369 including a complaint regarding an adverse determination made
2370 pursuant to utilization review;

2371 (B) Claims payment, handling or reimbursement for health care
2372 services; or

2373 (C) Any matter pertaining to the contractual relationship between a
2374 covered person and a health carrier.

2375 (21) (A) "Health benefit plan" means an insurance policy or contract,
2376 certificate or agreement offered, delivered, issued for delivery,
2377 renewed, amended or continued in this state to provide, deliver,
2378 arrange for, pay for or reimburse any of the costs of health care
2379 services;

2380 (B) "Health benefit plan" does not include:

2381 (i) Coverage of the type specified in subdivisions (5) to (9), inclusive,
2382 (14) and (15) of section 38a-469 of the general statutes or any
2383 combination thereof;

2384 (ii) Coverage issued as a supplement to liability insurance;

2385 (iii) Liability insurance, including general liability insurance and
2386 automobile liability insurance;

2387 (iv) Workers' compensation insurance;

2388 (v) Automobile medical payment insurance;

2389 (vi) Credit insurance;

2390 (vii) Coverage for on-site medical clinics;

2391 (viii) Other insurance coverage similar to the coverages specified in
2392 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are
2393 specified in regulations issued pursuant to the Health Insurance
2394 Portability and Accountability Act of 1996, P.L. 104-191, as amended
2395 from time to time, under which benefits for health care services are

2396 secondary or incidental to other insurance benefits;

2397 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
2398 term care, nursing home care, home health care, community-based
2399 care or any combination thereof, or (III) other similar, limited benefits
2400 specified in regulations issued pursuant to the Health Insurance
2401 Portability and Accountability Act of 1996, P.L. 104-191, as amended
2402 from time to time, provided any benefits specified in subparagraphs
2403 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided
2404 under a separate insurance policy, certificate or contract and are not
2405 otherwise an integral part of a health benefit plan; or

2406 (x) Coverage of the type specified in subdivisions (3) and (13) of
2407 section 38a-469 of the general statutes or other fixed indemnity
2408 insurance if (I) they are provided under a separate insurance policy,
2409 certificate or contract, (II) there is no coordination between the
2410 provision of the benefits and any exclusion of benefits under any
2411 group health plan maintained by the same plan sponsor, and (III) the
2412 benefits are paid with respect to an event without regard to whether
2413 benefits were also provided under any group health plan maintained
2414 by the same plan sponsor.

2415 (22) "Health care center" has the same meaning as provided in
2416 section 38a-175 of the general statutes.

2417 (23) "Health care professional" means a physician or other health
2418 care practitioner licensed, accredited or certified to perform specified
2419 health care services consistent with state law.

2420 (24) "Health care services" has the same meaning as provided in
2421 section 38a-478 of the general statutes, as amended by this act.

2422 (25) "Health carrier" means an entity subject to the insurance laws
2423 and regulations of this state or subject to the jurisdiction of the
2424 commissioner, that contracts or offers to contract to provide, deliver,
2425 arrange for, pay for or reimburse any of the costs of health care
2426 services, including a sickness and accident insurance company, a

2427 health care center, a managed care organization, a hospital service
2428 corporation, a medical service corporation or any other entity
2429 providing a plan of health insurance, health benefits or health care
2430 services.

2431 (26) "Health information" means information or data, whether oral
2432 or recorded in any form or medium, and personal facts or information
2433 about events or relationships that relate to (A) the past, present or
2434 future physical, mental, or behavioral health or condition of a covered
2435 person or a member of the covered person's family, (B) the provision of
2436 health care services to a covered person, or (C) payment for the
2437 provision of health care services to a covered person.

2438 (27) "Independent review organization" means an entity that
2439 conducts independent external reviews of adverse determinations and
2440 final adverse determinations. Such review entities include, but are not
2441 limited to, medical peer review organizations, independent utilization
2442 review companies, provided such organizations or companies are not
2443 related to or associated with any health carrier, and nationally
2444 recognized health experts or institutions approved by the Insurance
2445 Commissioner.

2446 (28) "Medical or scientific evidence" means evidence found in the
2447 following sources:

2448 (A) Peer-reviewed scientific studies published in or accepted for
2449 publication by medical journals that meet nationally recognized
2450 requirements for scientific manuscripts and that submit most of their
2451 published articles for review by experts who are not part of the
2452 editorial staff;

2453 (B) Peer-reviewed medical literature, including literature relating to
2454 therapies reviewed and approved by a qualified institutional review
2455 board, biomedical compendia and other medical literature that meet
2456 the criteria of the National Institutes of Health's Library of Medicine
2457 for indexing in Index Medicus (Medline) or Elsevier Science for
2458 indexing in Excerpta Medicus (EMBASE);

2459 (C) Medical journals recognized by the Secretary of the United
2460 States Department of Health and Human Services under Section
2461 1861(t)(2) of the Social Security Act;

2462 (D) The following standard reference compendia: (i) The American
2463 Hospital Formulary Service - Drug Information; (ii) Drug Facts and
2464 Comparisons; (iii) The American Dental Association's Accepted Dental
2465 Therapeutics; and (iv) The United States Pharmacopoeia - Drug
2466 Information;

2467 (E) Findings, studies or research conducted by or under the auspices
2468 of federal government agencies and nationally recognized federal
2469 research institutes, including: (i) The Agency for Healthcare Research
2470 and Quality; (ii) the National Institutes of Health; (iii) the National
2471 Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers
2472 for Medicare and Medicaid Services; (vi) the Food and Drug
2473 Administration; and (vii) any national board recognized by the
2474 National Institutes of Health for the purpose of evaluating the medical
2475 value of health care services; or

2476 (F) Any other findings, studies or research conducted by or under
2477 the auspices of a source comparable to those listed in subparagraphs
2478 (E)(i) to (E)(v), inclusive, of this subdivision.

2479 (29) "Medical necessity" has the same meaning as provided in
2480 sections 38a-482a and 38a-513c of the general statutes.

2481 (30) "Participating provider" means a health care professional who,
2482 under a contract with the health carrier, its contractor or subcontractor,
2483 has agreed to provide health care services to covered persons, with an
2484 expectation of receiving payment or reimbursement directly or
2485 indirectly from the health carrier, other than coinsurance, copayments
2486 or deductibles.

2487 (31) "Person" has the same meaning as provided in section 38a-1 of
2488 the general statutes.

2489 (32) "Prospective review" means utilization review conducted prior
2490 to an admission or the provision of a health care service or a course of
2491 treatment, in accordance with a health carrier's requirement that such
2492 service or treatment be approved, in whole or in part, prior to such
2493 service's or treatment's provision.

2494 (33) "Protected health information" means health information (A)
2495 that identifies an individual who is the subject of the information, or
2496 (B) for which there is a reasonable basis to believe that such
2497 information could be used to identify such individual.

2498 (34) "Randomized clinical trial" means a controlled, prospective
2499 study of patients that have been randomized into an experimental
2500 group and a control group at the beginning of the study, with only the
2501 experimental group of patients receiving a specific intervention, and
2502 that includes study of the groups for variables and anticipated
2503 outcomes over time.

2504 (35) "Rescission" means a cancellation or discontinuance of coverage
2505 under a health benefit plan that has a retroactive effect. "Rescission"
2506 does not include a cancellation or discontinuance of coverage under a
2507 health benefit plan if (A) such cancellation or discontinuance has a
2508 prospective effect only, or (B) such cancellation or discontinuance is
2509 effective retroactively to the extent it is attributable to the covered
2510 person's failure to timely pay required premiums or contributions
2511 towards the cost of such coverage.

2512 (36) "Retrospective review" means any review of a request for a
2513 benefit that is not a prospective review or concurrent review.
2514 "Retrospective review" does not include a review of a request that is
2515 limited to the veracity of documentation or the accuracy of coding.

2516 (37) "Stabilize" means, with respect to an emergency medical
2517 condition, that (A) no material deterioration of such condition is likely,
2518 within reasonable medical probability, to result from or occur during
2519 the transfer of the individual from a facility, or (B) with respect to a
2520 pregnant woman, the woman has delivered, including the placenta.

2521 (38) "Urgent care request" means a request for a health care service
2522 or course of treatment for which the time period for making a non-
2523 urgent care request determination (A) could seriously jeopardize the
2524 life or health of the covered person or the ability of the covered person
2525 to regain maximum function, or (B) in the opinion of a health care
2526 professional with knowledge of the covered person's medical
2527 condition, would subject the covered person to severe pain that cannot
2528 be adequately managed without the health care service or treatment
2529 being requested.

2530 (39) "Utilization review" means the use of a set of formal techniques
2531 designed to monitor the use of, or evaluate the medical necessity,
2532 appropriateness, efficacy or efficiency of, health care services, health
2533 care procedures or health care settings. Such techniques may include
2534 the monitoring of or evaluation of (A) health care services performed
2535 or provided in an outpatient setting, (B) the formal process for
2536 determining, prior to discharge from a facility, the coordination and
2537 management of the care that a patient receives following discharge
2538 from a facility, (C) opportunities or requirements to obtain a clinical
2539 evaluation by a health care professional other than the one originally
2540 making a recommendation for a proposed health care service, (D)
2541 coordinated sets of activities conducted for individual patient
2542 management of serious, complicated, protracted or other health
2543 conditions, or (E) prospective review, concurrent review, retrospective
2544 review or certification.

2545 (40) "Utilization review company" means an entity that conducts
2546 utilization review.

2547 Sec. 55. (NEW) (*Effective July 1, 2011*) (a) Sections 54 to 66, inclusive,
2548 of this act shall apply to (1) any health carrier offering a health benefit
2549 plan and that provides or performs utilization review including
2550 prospective, concurrent or retrospective review benefit determinations,
2551 and (2) any utilization review company or designee of a health carrier
2552 that performs utilization review on the health carrier's behalf,
2553 including prospective, concurrent or retrospective review benefit

2554 determinations.

2555 (b) Each health carrier shall be responsible for monitoring all
2556 utilization review program activities carried out by or on behalf of
2557 such health carrier. Such health carrier shall comply with the
2558 provisions of sections 54 to 66, inclusive, of this act and any regulations
2559 adopted thereunder, and shall be responsible for ensuring that any
2560 utilization review company or other entity such health carrier contracts
2561 with to perform utilization review complies with said sections and
2562 regulations. Each health carrier shall ensure that appropriate personnel
2563 have operational responsibility for the activities of the health carrier's
2564 utilization review program.

2565 (c) (1) A health carrier that requires utilization review of a benefit
2566 request under a health benefit plan shall implement a utilization
2567 review program and develop a written document that describes all
2568 utilization review activities and procedures, whether or not delegated,
2569 for (A) the filing of benefit requests, (B) the notification to covered
2570 persons of utilization review and benefit determinations, and (C) the
2571 review of adverse determinations and grievances in accordance with
2572 sections 58 and 59 of this act.

2573 (2) Such document shall describe the following:

2574 (A) Procedures to evaluate the medical necessity, appropriateness,
2575 health care setting, level of care or effectiveness of health care services;

2576 (B) Data sources and clinical review criteria used in making
2577 determinations;

2578 (C) Procedures to ensure consistent application of clinical review
2579 criteria and compatible determinations;

2580 (D) Data collection processes and analytical methods used to assess
2581 utilization of health care services;

2582 (E) Provisions to ensure the confidentiality of clinical, proprietary
2583 and protected health information;

2584 (F) The health carrier's organizational mechanism, such as a
2585 utilization review committee or quality assurance or other committee,
2586 that periodically assesses the health carrier's utilization review
2587 program and reports to the health carrier's governing body; and

2588 (G) The health carrier's staff position that is responsible for the day-
2589 to-day management of the utilization review program.

2590 (d) Each health carrier shall:

2591 (1) Include in the insurance policy, certificate of coverage or
2592 handbook provided to covered persons a clear and comprehensive
2593 description of:

2594 (A) Its utilization review and benefit determination procedures;

2595 (B) Its grievance procedures, including the grievance procedures for
2596 requesting a review of an adverse determination;

2597 (C) A description of the external review procedures set forth in
2598 section 60 of this act, in a format prescribed by the commissioner and
2599 including a statement that discloses that:

2600 (i) A covered person may file a request for an external review of an
2601 adverse determination or a final adverse determination with the
2602 commissioner and that such review is available when the adverse
2603 determination or the final adverse determination involves an issue of
2604 medical necessity, appropriateness, health care setting, level of care or
2605 effectiveness. Such disclosure shall include the contact information of
2606 the commissioner; and

2607 (ii) When filing a request for an external review of an adverse
2608 determination or a final adverse determination, the covered person
2609 shall be required to authorize the release of any medical records that
2610 may be required to be reviewed for the purpose of making a decision
2611 on such request;

2612 (D) A statement of the rights and responsibilities of covered persons

2613 with respect to each of the procedures under subparagraphs (A) to (C),
2614 inclusive, of this subdivision. Such statement shall include a disclosure
2615 that a covered person has the right to contact the commissioner's office
2616 or the Office of Healthcare Advocate at any time for assistance and
2617 shall include the contact information for said offices;

2618 (2) Inform its covered persons, at the time of initial enrollment and
2619 at least annually thereafter, of its grievance procedures. This
2620 requirement may be fulfilled by including such procedures in an
2621 enrollment agreement or update to such agreement;

2622 (3) Inform a covered person and the covered person's health care
2623 professional of the health carrier's grievance procedures whenever the
2624 health carrier denies certification of a benefit requested by a covered
2625 person's health care professional;

2626 (4) Include in materials intended for prospective covered persons a
2627 summary of its utilization review and benefit determination
2628 procedures;

2629 (5) Print on its membership or identification cards a toll-free
2630 telephone number for utilization review and benefit determinations;

2631 (6) Maintain records of all benefit requests, claims and notices
2632 associated with utilization review and benefit determinations made in
2633 accordance with section 57 of this act for not less than six years after
2634 such requests, claims and notices were made. Each health carrier shall
2635 make such records available for examination by the commissioner and
2636 appropriate federal oversight agencies upon request; and

2637 (7) Maintain records in accordance with section 61 of this act of all
2638 grievances received. Each health carrier shall make such records
2639 available for examination by covered persons, to the extent such
2640 records are permitted to be disclosed by law, the commissioner and
2641 appropriate federal oversight agencies upon request.

2642 (e) (1) On or before March first annually, each health carrier shall

2643 file with the commissioner:

2644 (A) A summary report of its utilization review program activities in
2645 the calendar year immediately preceding; and

2646 (B) A report that includes for each type of health benefit plan
2647 offered by the health carrier:

2648 (i) A certificate of compliance certifying that the utilization review
2649 program of the health carrier or its designee complies with all
2650 applicable state and federal laws concerning confidentiality and
2651 reporting requirements;

2652 (ii) The number of covered lives;

2653 (iii) The total number of grievances received;

2654 (iv) The number of grievances resolved at each level, if applicable,
2655 and their resolution;

2656 (v) The number of grievances appealed to the commissioner of
2657 which the health carrier has been informed;

2658 (vi) The number of grievances referred to alternative dispute
2659 resolution procedures or resulting in litigation; and

2660 (vii) A synopsis of actions being taken to correct any problems
2661 identified.

2662 (2) The commissioner shall adopt regulations, in accordance with
2663 chapter 54, to establish the form and content of the reports specified in
2664 subdivision (1) of this subsection.

2665 Sec. 56. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
2666 contract with (A) health care professionals to administer such health
2667 carrier's utilization review program and oversee utilization review
2668 determinations, and (B) with clinical peers to evaluate the clinical
2669 appropriateness of an adverse determination.

2670 (2) Each utilization review program shall use documented clinical
2671 review criteria that are based on sound clinical evidence and are
2672 evaluated periodically by the health carrier's organizational
2673 mechanism specified in subparagraph (F) of subdivision (2) of
2674 subsection (c) of section 55 of this act to assure such program's ongoing
2675 effectiveness. A health carrier may develop its own clinical review
2676 criteria or it may purchase or license clinical review criteria from
2677 qualified vendors approved by the commissioner. Each health carrier
2678 shall make its clinical review criteria available upon request to
2679 authorized government agencies.

2680 (b) Each health carrier shall:

2681 (1) Have procedures in place to ensure that the health care
2682 professionals administering such health carrier's utilization review
2683 program are applying the clinical review criteria consistently in
2684 utilization review determinations;

2685 (2) Have data systems sufficient to support utilization review
2686 program activities and to generate management reports to enable the
2687 health carrier to monitor and manage health care services effectively;

2688 (3) Provide covered persons and participating providers with access
2689 to its utilization review staff through a toll-free telephone number or
2690 any other free calling option or by electronic means;

2691 (4) Coordinate the utilization review program with other medical
2692 management activity conducted by the health carrier, such as quality
2693 assurance, credentialing, contracting with health care professionals,
2694 data reporting, grievance procedures, processes for assessing member
2695 satisfaction and risk management; and

2696 (5) Routinely assess the effectiveness and efficiency of its utilization
2697 review program.

2698 (c) If a health carrier delegates any utilization review activities to a
2699 utilization review company, the health carrier shall maintain adequate

2700 oversight, which shall include (1) a written description of the
2701 utilization review company's activities and responsibilities, including
2702 such company's reporting requirements, (2) evidence of the health
2703 carrier's formal approval of the utilization review company program,
2704 and (3) a process by which the health carrier shall evaluate the
2705 utilization review company's performance.

2706 (d) When conducting utilization review, the health carrier shall (1)
2707 collect only the information necessary, including pertinent clinical
2708 information, to make the utilization review or benefit determination,
2709 and (2) ensure that such review is conducted in a manner to ensure the
2710 independence and impartiality of the individual or individuals
2711 involved in making the utilization review or benefit determination. No
2712 health carrier shall make decisions regarding the hiring, compensation,
2713 termination, promotion or other similar matters of such individual or
2714 individuals based on the likelihood that the individual or individuals
2715 will support the denial of benefits.

2716 Sec. 57. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
2717 maintain written procedures for (A) utilization review and benefit
2718 determinations, (B) expedited utilization review and benefit
2719 determinations with respect to prospective urgent care requests and
2720 concurrent review urgent care requests, and (C) notifying covered
2721 persons or covered persons' authorized representatives of such review
2722 and benefit determinations. Each health carrier shall make such review
2723 and benefit determinations within the specified time periods under
2724 this section.

2725 (2) In determining whether a benefit request shall be considered an
2726 urgent care request, an individual acting on behalf of a health carrier
2727 shall apply the judgment of a prudent layperson who possesses an
2728 average knowledge of health and medicine, except that any benefit
2729 request determined to be an urgent care request by a health care
2730 professional with knowledge of the covered person's medical
2731 condition shall be deemed an urgent care request.

2732 (b) With respect to a nonurgent care request:

2733 (1) For a prospective or concurrent review request, a health carrier
2734 shall make a determination within a reasonable period of time
2735 appropriate to the covered person's medical condition, but not later
2736 than fifteen calendar days after the date the health carrier receives such
2737 request, and shall notify the covered person and, if applicable, the
2738 covered person's authorized representative of such determination,
2739 whether or not the carrier certifies the provision of the benefit.

2740 (2) For a retrospective review request, a health carrier shall make a
2741 determination within a reasonable period of time, but not later than
2742 thirty calendar days after the date the health carrier receives such
2743 request.

2744 (3) The time periods specified in subdivisions (1) and (2) of this
2745 subsection may be extended once by the health carrier for up to fifteen
2746 calendar days, provided the health carrier:

2747 (A) Determines that an extension is necessary due to circumstances
2748 beyond the health carrier's control; and

2749 (B) Notifies the covered person and, if applicable, the covered
2750 person's authorized representative prior to the expiration of the initial
2751 time period, of the circumstances requiring the extension of time and
2752 the date by which the health carrier expects to make a determination.

2753 (4) (A) If the extension pursuant to subdivision (3) of this subsection
2754 is necessary due to the failure of the covered person or the covered
2755 person's authorized representative to provide information necessary to
2756 make a determination on the request, the health carrier shall:

2757 (i) Specifically describe in the notice of extension the required
2758 information necessary to complete the request; and

2759 (ii) Provide the covered person and, if applicable, the covered
2760 person's authorized representative with not less than forty-five
2761 calendar days after the date of receipt of the notice to provide the

2762 specified information.

2763 (B) If the covered person or the covered person's authorized
2764 representative fails to submit the specified information before the end
2765 of the period of the extension, the health carrier may deny certification
2766 of the benefit requested.

2767 (c) With respect to an urgent care request:

2768 (1) Unless the covered person or the covered person's authorized
2769 representative has failed to provide information necessary for the
2770 health carrier to make a determination, the health carrier shall make a
2771 determination as soon as possible, taking into account the covered
2772 person's medical condition, but not later than seventy-two hours after
2773 the health carrier receives such request, provided, if the urgent care
2774 request is a concurrent review request to extend a course of treatment
2775 beyond the initial period of time or the number of treatments, such
2776 request is made at least twenty-four hours prior to the expiration of the
2777 prescribed period of time or number of treatments;

2778 (2) (A) If the covered person or the covered person's authorized
2779 representative has failed to provide information necessary for the
2780 health carrier to make a determination, the health carrier shall notify
2781 the covered person or the covered person's representative, as
2782 applicable, as soon as possible, but not later than twenty-four hours
2783 after the health carrier receives such request.

2784 (B) The health carrier shall provide the covered person or the
2785 covered person's authorized representative, as applicable, a reasonable
2786 period of time to submit the specified information, taking into account
2787 the covered person's medical condition, but not less than forty-eight
2788 hours after notifying the covered person or the covered person's
2789 authorized representative, as applicable.

2790 (3) The health carrier shall notify the covered person and, if
2791 applicable, the covered person's authorized representative of its
2792 determination as soon as possible, but not later than forty-eight hours

2793 after the earlier of (A) the date on which the covered person and the
2794 covered person's authorized representative, as applicable, provides the
2795 specified information to the health carrier, or (B) the date on which the
2796 specified information was to have been submitted.

2797 (d) (1) Whenever a health carrier receives a review request from a
2798 covered person or a covered person's authorized representative that
2799 fails to meet the health carrier's filing procedures, the health carrier
2800 shall notify the covered person and, if applicable, the covered person's
2801 authorized representative of such failure not later than five calendar
2802 days after the health carrier receives such request, except that for an
2803 urgent care request, the health carrier shall notify the covered person
2804 and, if applicable, the covered person's authorized representative of
2805 such failure not later than twenty-four hours after the health carrier
2806 receives such request.

2807 (2) If the health carrier provides such notice orally, the health carrier
2808 shall provide confirmation in writing to the covered person and the
2809 covered person's health care professional of record not later than five
2810 calendar days after providing the oral notice.

2811 (e) Each health carrier shall provide promptly to a covered person
2812 and, if applicable, the covered person's authorized representative a
2813 notice of an adverse determination. Such notice may be provided in
2814 writing or by electronic means and shall set forth, in a manner
2815 calculated to be understood by the covered person or the covered
2816 person's authorized representative:

2817 (1) Information sufficient to identify the benefit request or claim
2818 involved, including the date of service, if applicable, the health care
2819 professional and the claim amount;

2820 (2) The specific reason or reasons for the adverse determination and
2821 a description of the health carrier's standard, if any, that was used in
2822 reaching the denial;

2823 (3) Reference to the specific health benefit plan provisions on which

2824 the determination is based;

2825 (4) A description of any additional material or information
2826 necessary for the covered person to perfect the benefit request or claim,
2827 including an explanation of why the material or information is
2828 necessary to perfect the request or claim;

2829 (5) A description of the health carrier's internal grievance process
2830 that includes (A) the health carrier's expedited review procedures, (B)
2831 any time limits applicable to such process or procedures, (C) the
2832 contact information for the organizational unit designated to
2833 coordinate the review on behalf of the health carrier, and (D) a
2834 statement that the covered person or, if applicable, the covered
2835 person's authorized representative is entitled, pursuant to the
2836 requirements of the health carrier's internal grievance process, to (i)
2837 submit written comments, documents, records and other material
2838 relating to the covered person's benefit request for consideration by the
2839 individual or individuals conducting the review, and (ii) receive from
2840 the health carrier, free of charge upon request, reasonable access to and
2841 copies of all documents, records and other information relevant to the
2842 covered person's benefit request;

2843 (6) If the adverse determination is based on a health carrier's
2844 internal rule, guideline, protocol or other similar criterion, (A) the
2845 specific rule, guideline, protocol or other similar criterion, or (B) a
2846 statement that a specific rule, guideline, protocol or other similar
2847 criterion of the health carrier was relied upon to make the adverse
2848 determination and that a copy of such rule, guideline, protocol or other
2849 similar criterion will be provided to the covered person free of charge
2850 upon request, and instructions for requesting such copy;

2851 (7) If the adverse determination is based on medical necessity or an
2852 experimental or investigational treatment or similar exclusion or limit,
2853 the written statement of the scientific or clinical rationale for the
2854 adverse determination and (A) an explanation of the scientific or
2855 clinical rationale used to make the determination that applies the terms

2856 of the health benefit plan to the covered person's medical
2857 circumstances, or (B) a statement that an explanation will be provided
2858 to the covered person free of charge upon request, and instructions for
2859 requesting a copy of such explanation; and

2860 (8) A statement explaining the right of the covered person to contact
2861 the commissioner's office or the Office of the Healthcare Advocate at
2862 any time for assistance or, upon completion of the health carrier's
2863 internal grievance process, to file a civil suit in a court of competent
2864 jurisdiction. Such statement shall include the contact information for
2865 said offices.

2866 (f) If the adverse determination is a rescission, the health carrier
2867 shall include with the advance notice of the application for rescission
2868 required to be sent to the covered person, a written statement that
2869 includes:

2870 (1) Clear identification of the alleged fraudulent act, practice or
2871 omission or the intentional misrepresentation of material fact;

2872 (2) An explanation as to why the act, practice or omission was
2873 fraudulent or was an intentional misrepresentation of a material fact;

2874 (3) A disclosure that the covered person or the covered person's
2875 authorized representative may file immediately, without waiting for
2876 the date such advance notice of the proposed rescission ends, a
2877 grievance with the health carrier to request a review of the adverse
2878 determination to rescind coverage, pursuant to sections 58 and 59 of
2879 this act;

2880 (4) A description of the health carrier's grievance procedures
2881 established under sections 58 and 59 of this act, including any time
2882 limits applicable to those procedures; and

2883 (5) The date such advance notice of the proposed rescission ends
2884 and the date back to which the coverage will be retroactively
2885 rescinded.

2886 (g) (1) Whenever a health carrier fails to strictly adhere to the
2887 requirements of this section with respect to making utilization review
2888 and benefit determinations of a benefit request or claim, the covered
2889 person shall be deemed to have exhausted the internal grievance
2890 process of such health carrier and may file a request for an external
2891 review in accordance with the provisions of section 60 of this act,
2892 regardless of whether the health carrier asserts it substantially
2893 complied with the requirements of this section or that any error it
2894 committed was de minimis.

2895 (2) A covered person who has exhausted the internal grievance
2896 process of a health carrier may, in addition to filing a request for an
2897 external review, pursue any available remedies under state or federal
2898 law on the basis that the health carrier failed to provide a reasonable
2899 internal grievance process that would yield a decision on the merits of
2900 the claim.

2901 Sec. 58. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
2902 establish and maintain written procedures for (A) the review of
2903 grievances of adverse determinations that were based, in whole or in
2904 part, on medical necessity, (B) the expedited review of grievances of
2905 adverse determinations of urgent care requests, including concurrent
2906 review urgent care requests involving an admission, availability of
2907 care, continued stay or health care service for a covered person who
2908 has received emergency services but has not been discharged from a
2909 facility, and (C) notifying covered persons or covered persons'
2910 authorized representatives of such adverse determinations.

2911 (2) Each health carrier shall file with the commissioner a copy of
2912 such procedures, including all forms used to process requests, and any
2913 subsequent material modifications to such procedures.

2914 (3) In addition to a copy of such procedures, each health carrier shall
2915 file annually with the commissioner, as part of its annual report
2916 required under subsection (e) of section 55 of this act, a certificate of
2917 compliance stating that the health carrier has established and

2918 maintains grievance procedures for each of its health benefit plans that
2919 are fully compliant with the provisions of sections 54 to 66, inclusive,
2920 of this act.

2921 (b) (1) A covered person or a covered person's authorized
2922 representative may file a grievance of an adverse determination that
2923 was based, in whole or in part, on medical necessity with the health
2924 carrier not later than one hundred eighty calendar days after the
2925 covered person or the covered person's authorized representative, as
2926 applicable, receives the notice of an adverse determination.

2927 (2) For prospective or concurrent urgent care requests, a covered
2928 person or a covered person's authorized representative may make a
2929 request for an expedited review orally or in writing.

2930 (c) (1) (A) When conducting a review of an adverse determination
2931 under this section, the health carrier shall ensure that such review is
2932 conducted in a manner to ensure the independence and impartiality of
2933 the individual or individuals involved in making the review decision.

2934 (B) If the adverse determination involves utilization review, the
2935 health carrier shall designate an appropriate clinical peer or peers to
2936 review such adverse determination. Such clinical peer or peers shall
2937 not have been involved in the initial adverse determination.

2938 (C) The individual or individuals conducting a review under this
2939 section shall take into consideration all comments, documents, records
2940 and other information relevant to the covered person's benefit request
2941 that is the subject of the adverse determination under review, that are
2942 submitted by the covered person or the covered person's authorized
2943 representative, regardless of whether such information was submitted
2944 or considered in making the initial adverse determination.

2945 (D) Prior to issuing a decision, the health carrier shall provide free
2946 of charge to the covered person or the covered person's authorized
2947 representative, as applicable, any new or additional evidence relied
2948 upon and any new or additional scientific or clinical rationale used by

2949 the health carrier in connection with the grievance. Such evidence and
2950 rationale shall be provided sufficiently in advance of the date the
2951 health carrier is required to issue a decision to permit the covered
2952 person or the covered person's authorized representative, as
2953 applicable, a reasonable opportunity to respond prior to such date.

2954 (2) If the review under subdivision (1) of this subsection is an
2955 expedited review, all necessary information, including the health
2956 carrier's decision, shall be transmitted between the health carrier and
2957 the covered person or the covered person's authorized representative,
2958 as applicable, by telephone, facsimile, electronic means or any other
2959 expeditious method available.

2960 (3) If the review under subdivision (1) of this subsection is an
2961 expedited review of a grievance involving an adverse determination of
2962 a concurrent review urgent care request, the treatment shall be
2963 continued without liability to the covered person until the covered
2964 person has been notified of the review decision.

2965 (d) (1) The health carrier shall notify the covered person and, if
2966 applicable, the covered person's authorized representative, in writing
2967 or by electronic means, of its decision within a reasonable period of
2968 time appropriate to the covered person's medical condition, but not
2969 later than:

2970 (A) For prospective review and concurrent review requests, thirty
2971 calendar days after the health carrier receives the grievance;

2972 (B) For retrospective review requests, sixty calendar days after the
2973 health carrier receives the grievance; and

2974 (C) For expedited review requests, seventy-two hours after the
2975 health carrier receives the grievance.

2976 (2) The time periods set forth in subdivision (1) of this subsection
2977 shall apply regardless of whether all of the information necessary to
2978 make a decision accompanies the filing.

2979 (e) The notice required under subsection (d) of this section shall set
2980 forth, in a manner calculated to be understood by the covered person
2981 or the covered person's authorized representative:

2982 (1) The titles and qualifying credentials of the individual or
2983 individuals participating in the review process;

2984 (2) Information sufficient to identify the claim involved with respect
2985 to the grievance, including the date of service, if applicable, the health
2986 care professional and the claim amount;

2987 (3) A statement of such individual's or individuals' understanding
2988 of the covered person's grievance;

2989 (4) The individual's or individuals' decision in clear terms and the
2990 health benefit plan contract basis or scientific or clinical rationale for
2991 such decision in sufficient detail for the covered person to respond
2992 further to the health carrier's position;

2993 (5) Reference to the evidence or documentation used as the basis for
2994 the decision;

2995 (6) For a decision that upholds the adverse determination:

2996 (A) The specific reason or reasons for the final adverse
2997 determination, including the denial code and its corresponding
2998 meaning, as well as a description of the health carrier's standard, if
2999 any, that was used in reaching the denial;

3000 (B) Reference to the specific health benefit plan provisions on which
3001 the decision is based;

3002 (C) A statement that the covered person may receive from the health
3003 carrier, free of charge and upon request, reasonable access to and
3004 copies of, all documents, records and other information relevant to the
3005 adverse determination under review;

3006 (D) If the final adverse determination is based on a health carrier's

3007 internal rule, guideline, protocol or other similar criterion, (i) the
3008 specific rule, guideline, protocol or other similar criterion, or (ii) a
3009 statement that a specific rule, guideline, protocol or other similar
3010 criterion of the health carrier was relied upon to make the final adverse
3011 determination and that a copy of such rule, guideline, protocol or other
3012 similar criterion will be provided to the covered person free of charge
3013 upon request and instructions for requesting such copy;

3014 (E) If the final adverse determination is based on medical necessity
3015 or an experimental or investigational treatment or similar exclusion or
3016 limit, the written statement of the scientific or clinical rationale for the
3017 final adverse determination and (i) an explanation of the scientific or
3018 clinical rationale used to make the determination that applies the terms
3019 of the health benefit plan to the covered person's medical
3020 circumstances, or (ii) a statement that an explanation will be provided
3021 to the covered person free of charge upon request and instructions for
3022 requesting a copy of such explanation;

3023 (F) A statement describing the procedures for obtaining an external
3024 review of the final adverse determination;

3025 (7) If applicable, the following statement: "You and your plan may
3026 have other voluntary alternative dispute resolution options such as
3027 mediation. One way to find out what may be available is to contact
3028 your state Insurance Commissioner."; and

3029 (8) A statement disclosing the covered person's right to contact the
3030 commissioner's office or the Office of the Healthcare Advocate at any
3031 time. Such disclosure shall include the contact information for said
3032 offices.

3033 (f) (1) Whenever a health carrier fails to strictly adhere to the
3034 requirements of this section with respect to receiving and resolving
3035 grievances involving an adverse determination, the covered person
3036 shall be deemed to have exhausted the internal grievance process of
3037 such health carrier and may file a request for an external review,
3038 regardless of whether the health carrier asserts that it substantially

3039 complied with the requirements of this section, or that any error it
3040 committed was de minimis.

3041 (2) A covered person who has exhausted the internal grievance
3042 process of a health carrier may, in addition to filing a request for an
3043 external review, pursue any available remedies under state or federal
3044 law on the basis that the health carrier failed to provide a reasonable
3045 internal grievance process that would yield a decision on the merits of
3046 the claim.

3047 Sec. 59. (NEW) (*Effective July 1, 2011*) (a) Each health carrier shall
3048 establish and maintain written procedures (1) for the review of
3049 grievances of adverse determinations that were not based on medical
3050 necessity, and (2) notifying covered persons or covered persons'
3051 authorized representatives of such adverse determinations.

3052 (b) (1) A covered person or the covered person's authorized
3053 representative may file a grievance of an adverse determination that
3054 was not based on medical necessity with the health carrier not later
3055 than one hundred eighty calendar days after the covered person or the
3056 covered person's representative, as applicable, receives the notice of an
3057 adverse determination.

3058 (2) The health carrier shall notify the covered person and, if
3059 applicable, the covered person's authorized representative not later
3060 than three business days after the health carrier receives a grievance
3061 that the covered person or the covered person's authorized
3062 representative, as applicable, is entitled to submit written material to
3063 the health carrier to be considered when conducting a review of the
3064 grievance.

3065 (3) (A) Upon receipt of a grievance, a health carrier shall designate
3066 an individual or individuals to conduct a review of the grievance.

3067 (B) The health carrier shall not designate the same individual or
3068 individuals who denied the claim or handled the matter that is the
3069 subject of the grievance to conduct the review of the grievance.

3070 (C) The health carrier shall provide the covered person and, if
3071 applicable, the covered person's authorized representative with the
3072 name, address and telephone number of the individual or the
3073 organizational unit designated to coordinate the review on behalf of
3074 the health carrier.

3075 (c) (1) The health carrier shall notify the covered person and, if
3076 applicable, the covered person's authorized representative in writing,
3077 of its decision not later than twenty business days after the health
3078 carrier received the grievance.

3079 (2) If the health carrier is unable to comply with the time period
3080 specified in subdivision (1) of this subsection due to circumstances
3081 beyond the health carrier's control, the time period may be extended
3082 by the health carrier for up to ten business days, provided that on or
3083 before the twentieth business day after the health carrier received the
3084 grievance, the health carrier provides written notice to the covered
3085 person and, if applicable, the covered person's authorized
3086 representative of the extension and the reasons for the delay.

3087 (d) The written decision issued pursuant to subsection (c) of this
3088 section shall contain:

3089 (1) The titles and qualifying credentials of the individual or
3090 individuals participating in the review process;

3091 (2) A statement of such individual's or individuals' understanding
3092 of the covered person's grievance;

3093 (3) The individual's or individuals' decision in clear terms and the
3094 health benefit plan contract basis for such decision in sufficient detail
3095 for the covered person to respond further to the health carrier's
3096 position; and

3097 (4) Reference to the evidence or documentation used as the basis for
3098 the decision.

3099 Sec. 60. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a

3100 covered person's authorized representative may file a request for an
3101 external review or an expedited external review of an adverse
3102 determination or a final adverse determination in accordance with the
3103 provisions of this section. All requests for external review or expedited
3104 external review shall be made in writing to the commissioner. The
3105 commissioner may prescribe the form and content of such requests.

3106 (2) (A) All requests for external review or expedited external review
3107 shall be accompanied by a filing fee of twenty-five dollars, except that
3108 no covered person or covered person's authorized representative shall
3109 pay more than seventy-five dollars in a calendar year for such covered
3110 person. Any filing fee paid by a covered person's authorized
3111 representative shall be deemed to have been paid by the covered
3112 person. If the commissioner finds that the covered person is indigent
3113 or unable to pay the filing fee, the commissioner shall waive such fee.
3114 Any such fees shall be deposited in the Insurance Fund established
3115 under section 38a-52a of the general statutes.

3116 (B) The commissioner shall refund any paid filing fee to the covered
3117 person or the covered person's authorized representative, as
3118 applicable, or the health care professional if the adverse determination
3119 or the final adverse determination that is the subject of the external
3120 review request or expedited external review request is reversed or
3121 revised.

3122 (3) The health carrier that issued the adverse determination or the
3123 final adverse determination that is the subject of the external review
3124 request or the expedited external review request shall pay the
3125 independent review organization for the cost of conducting the review.

3126 (4) An external review decision, whether such review is a standard
3127 external review or an expedited external review, shall be binding on
3128 the health carrier or a self-insured governmental plan and the covered
3129 person, except to the extent such health carrier or covered person has
3130 other remedies available under federal or state law. A covered person
3131 or a covered person's authorized representative shall not file a

3132 subsequent request for an external review or an expedited external
3133 review that involves the same adverse determination or final adverse
3134 determination for which the covered person or the covered person's
3135 authorized representative already received an external review decision
3136 or an expedited external review decision.

3137 (5) Each health carrier shall maintain written records of external
3138 reviews as set forth in section 61 of this act.

3139 (6) Each independent review organization shall maintain written
3140 records as set forth in subsection (e) of section 66 of this act.

3141 (b) (1) Except as otherwise provided under subdivision (2) of this
3142 subsection or subsection (d) of this section, a covered person or a
3143 covered person's authorized representative shall not file a request for
3144 an external review or an expedited external review until the covered
3145 person or the covered person's authorized representative has
3146 exhausted the health carrier's internal grievance process.

3147 (2) A health carrier may waive its internal grievance process and the
3148 requirement for a covered person to exhaust such process prior to
3149 filing a request for an external review or an expedited external review.

3150 (c) (1) At the same time a health carrier sends to a covered person or
3151 a covered person's authorized representative a written notice of an
3152 adverse determination or a final adverse determination issued by the
3153 health carrier, the health carrier shall include a written disclosure to
3154 the covered person and, if applicable, the covered person's authorized
3155 representative of the covered person's right to request an external
3156 review.

3157 (2) The written notice shall include:

3158 (A) The following statement or a statement in substantially similar
3159 language: "We have denied your request for benefit approval for a
3160 health care service or course of treatment. You may have the right to
3161 have our decision reviewed by health care professionals who have no

3162 association with us by submitting a request for external review to the
3163 office of the Insurance Commissioner, if our decision involved making
3164 a judgment as to the medical necessity, appropriateness, health care
3165 setting, level of care or effectiveness of the health care service or
3166 treatment you requested.";

3167 (B) For a notice related to an adverse determination, a statement
3168 informing the covered person that:

3169 (i) If the covered person has a medical condition for which the time
3170 period for completion of an expedited internal review of a grievance
3171 involving an adverse determination would seriously jeopardize the life
3172 or health of the covered person or would jeopardize the covered
3173 person's ability to regain maximum function, the covered person or the
3174 covered person's authorized representative may (I) file a request for an
3175 expedited external review, or (II) file a request for an expedited
3176 external review if the adverse determination involves a denial of
3177 coverage based on a determination that the recommended or
3178 requested health care service or treatment is experimental or
3179 investigational and the covered person's treating health care
3180 professional certifies in writing that such recommended or requested
3181 health care service or treatment would be significantly less effective if
3182 not promptly initiated; and

3183 (ii) Such request for expedited external review may be filed at the
3184 same time the covered person or the covered person's authorized
3185 representative files a request for an expedited internal review of a
3186 grievance involving an adverse determination, except that the
3187 independent review organization assigned to conduct the expedited
3188 external review shall determine whether the covered person shall be
3189 required to complete the expedited internal review of the grievance
3190 prior to conducting the expedited external review;

3191 (C) For a notice related to a final adverse determination, a statement
3192 informing the covered person that:

3193 (i) If the covered person has a medical condition for which the time

3194 period for completion of an external review would seriously
3195 jeopardize the life or health of the covered person or would jeopardize
3196 the covered person's ability to regain maximum function, the covered
3197 person or the covered person's authorized representative may file a
3198 request for an expedited external review; or

3199 (ii) If the final adverse determination concerns (I) an admission,
3200 availability of care, continued stay or health care service for which the
3201 covered person received emergency services but has not been
3202 discharged from a facility, the covered person or the covered person's
3203 authorized representative may file a request for an expedited external
3204 review, or (II) a denial of coverage based on a determination that the
3205 recommended or requested health care service or treatment is
3206 experimental or investigational and the covered person's treating
3207 health care professional certifies in writing that such recommended or
3208 requested health care service or treatment would be significantly less
3209 effective if not promptly initiated, the covered person or the covered
3210 person's authorized representative may file a request for an expedited
3211 external review;

3212 (D) (i) A copy of the description of both the standard and expedited
3213 external review procedures the health carrier is required to provide,
3214 highlighting the provisions in the external review procedures that give
3215 the covered person or the covered person's authorized representative
3216 the opportunity to submit additional information and including any
3217 forms used to process an external review or an expedited external
3218 review;

3219 (ii) As part of any forms provided under subparagraph (D)(i) of this
3220 subdivision, an authorization form or other document approved by the
3221 commissioner that complies with the requirements of 45 CFR 164.508,
3222 as amended from time to time, by which the covered person shall
3223 authorize the health carrier and the covered person's treating health
3224 care professional to release, transfer or otherwise divulge, in
3225 accordance with sections 38a-975 to 38a-999a, inclusive, of the general
3226 statutes, the covered person's protected health information including

3227 medical records for purposes of conducting an external review or an
3228 expedited external review.

3229 (d) (1) A covered person or a covered person's authorized
3230 representative may file a request for an expedited external review of an
3231 adverse determination or a final adverse determination with the
3232 commissioner, except that an expedited external review shall not be
3233 provided for a retrospective review request of an adverse
3234 determination or a final adverse determination.

3235 (2) Such request may be filed at the time the covered person
3236 receives:

3237 (A) An adverse determination, if:

3238 (i) (I) The covered person has a medical condition for which the time
3239 period for completion of an expedited internal review of the adverse
3240 determination would seriously jeopardize the life or health of the
3241 covered person or would jeopardize the covered person's ability to
3242 regain maximum function; or

3243 (II) The denial of coverage is based on a determination that the
3244 recommended or requested health care service or treatment is
3245 experimental or investigational and the covered person's treating
3246 health care professional certifies in writing that such recommended or
3247 requested health care service or treatment would be significantly less
3248 effective if not promptly initiated; and

3249 (ii) The covered person or the covered person's authorized
3250 representative has filed a request for an expedited internal review of
3251 the adverse determination; or

3252 (B) A final adverse determination if:

3253 (i) The covered person has a medical condition where the time
3254 period for completion of a standard external review would seriously
3255 jeopardize the life or health of the covered person or would jeopardize
3256 the covered person's ability to regain maximum function;

3257 (ii) The final adverse determination concerns an admission,
3258 availability of care, continued stay or health care service for which the
3259 covered person received emergency services but has not been
3260 discharged from a facility; or

3261 (iii) The denial of coverage is based on a determination that the
3262 recommended or requested health care service or treatment is
3263 experimental or investigational and the covered person's treating
3264 health care professional certifies in writing that such recommended or
3265 requested health care service or treatment would be significantly less
3266 effective if not promptly initiated.

3267 (3) Such covered person or covered person's authorized
3268 representative shall not be required to file a request for an external
3269 review prior to, or at the same time as, the filing of a request for an
3270 expedited external review and shall not be precluded from filing a
3271 request for an external review, within the time periods set forth in
3272 subsection (e) of this section, if the request for an expedited external
3273 review is determined to be ineligible for such review.

3274 (e) (1) Not later than one hundred twenty calendar days after a
3275 covered person or a covered person's authorized representative
3276 receives a notice of an adverse determination or a final adverse
3277 determination, the covered person or the covered person's authorized
3278 representative may file a request for an external review or an
3279 expedited external review with the commissioner in accordance with
3280 this section.

3281 (2) Not later than one business day after the commissioner receives
3282 a request that is complete, the commissioner shall send a copy of such
3283 request to the health carrier that issued the adverse determination or
3284 the final adverse determination that is the subject of the request.

3285 (3) Not later than (A) five business days after the health carrier
3286 receives the copy of an external review request, or (B) one calendar day
3287 after the health carrier receives the copy of an expedited external
3288 review request, from the commissioner, the health carrier shall

3289 complete a preliminary review of the request to determine whether:

3290 (A) The individual is or was a covered person under the health
3291 benefit plan at the time the health care service was requested or, in the
3292 case of an external review of a retrospective review request, was a
3293 covered person in the health benefit plan at the time the health care
3294 service was provided;

3295 (B) The health care service that is the subject of the adverse
3296 determination or the final adverse determination is a covered service
3297 under the covered person's health benefit plan but for the health
3298 carrier's determination that the health care service is not covered
3299 because it does not meet the health carrier's requirements for medical
3300 necessity, appropriateness, health care setting, level of care or
3301 effectiveness;

3302 (C) If the health care service or treatment is experimental or
3303 investigational:

3304 (i) Is a covered benefit under the covered person's health benefit
3305 plan but for the health carrier's determination that the service or
3306 treatment is experimental or investigational for a particular medical
3307 condition;

3308 (ii) Is not explicitly listed as an excluded benefit under the covered
3309 person's health benefit plan;

3310 (iii) The covered person's treating health care professional has
3311 certified that one of the following situations is applicable:

3312 (I) Standard health care services or treatments have not been
3313 effective in improving the medical condition of the covered person;

3314 (II) Standard health care services or treatments are not medically
3315 appropriate for the covered person; or

3316 (III) There is no available standard health care service or treatment
3317 covered by the health carrier that is more beneficial than the

3318 recommended or requested health care service or treatment; and

3319 (iv) The covered person's treating health care professional:

3320 (I) Has recommended a health care service or treatment that the
3321 health care professional certifies, in writing, is likely to be more
3322 beneficial to the covered person, in the health care professional's
3323 opinion, than any available standard health care services or treatments;
3324 or

3325 (II) Is a licensed, board certified or board eligible health care
3326 professional qualified to practice in the area of medicine appropriate to
3327 treat the covered person's condition and has certified in writing that
3328 scientifically valid studies using accepted protocols demonstrate that
3329 the health care service or treatment requested by the covered person
3330 that is the subject of the adverse determination or the final adverse
3331 determination is likely to be more beneficial to the covered person than
3332 any available standard health care services or treatments;

3333 (D) The covered person has exhausted the health carrier's internal
3334 grievance process or the covered person or the covered person's
3335 authorized representative has filed a request for an expedited external
3336 review as provided under subsection (d) of this section; and

3337 (E) The covered person has provided all the information and forms
3338 required to process an external review or an expedited external review,
3339 including an authorization form as set forth in subparagraph (D)(ii) of
3340 subdivision (2) of subsection (c) of this section.

3341 (4) (A) Not later than (i) one business day after the preliminary
3342 review of an external review request, or (ii) the day the preliminary
3343 review of an expedited external review request is completed, the
3344 health carrier shall notify the commissioner, the covered person and, if
3345 applicable, the covered person's authorized representative in writing
3346 whether the request for an external review or an expedited external
3347 review is complete and eligible for such review. The commissioner
3348 may specify the form for the health carrier's notice of initial

3349 determination under this subdivision and any supporting information
3350 required to be included in the notice.

3351 (B) If the request:

3352 (i) Is not complete, the health carrier shall notify the commissioner
3353 and the covered person and, if applicable, the covered person's
3354 authorized representative in writing and include in the notice what
3355 information or materials are needed to perfect the request; or

3356 (ii) Is not eligible for external review or expedited external review,
3357 the health carrier shall notify the commissioner, the covered person
3358 and, if applicable, the covered person's authorized representative in
3359 writing and include in the notice the reasons for its ineligibility.

3360 (C) The notice of initial determination shall include a statement
3361 informing the covered person and, if applicable, the covered person's
3362 authorized representative that a health carrier's initial determination
3363 that the request for an external review or an expedited external review
3364 is ineligible for review may be appealed to the commissioner.

3365 (D) Notwithstanding a health carrier's initial determination that a
3366 request for an external review or an expedited external review is
3367 ineligible for review, the commissioner may determine, pursuant to
3368 the terms of the covered person's health benefit plan, that such request
3369 is eligible for such review and assign an independent review
3370 organization to conduct such review. Any such review shall be
3371 conducted in accordance with this section.

3372 (f) (1) Whenever the commissioner is notified pursuant to
3373 subparagraph (A) of subdivision (4) of subsection (e) of this section
3374 that a request is eligible for external review or expedited external
3375 review, the commissioner shall, not later than (A) one business day
3376 after receiving such notice for an external review, or (B) one calendar
3377 day after receiving such notice for an expedited external review:

3378 (i) Assign an independent review organization from the list of

3379 approved independent review organizations compiled and maintained
3380 by the commissioner pursuant to section 65 of this act to conduct the
3381 review and notify the health carrier of the name of the assigned
3382 independent review organization. Such assignment shall be done on a
3383 random basis among those approved independent review
3384 organizations qualified to conduct the particular review based on the
3385 nature of the health care service that is the subject of the adverse
3386 determination or the final adverse determination and other
3387 circumstances, including conflict of interest concerns as set forth in
3388 section 66 of this act; and

3389 (ii) Notify the covered person and, if applicable, the covered
3390 person's authorized representative in writing of the request's eligibility
3391 and acceptance for external review or expedited external review. For
3392 an external review, the commissioner shall include in such notice (I) a
3393 statement that the covered person or the covered person's authorized
3394 representative may submit, not later than five business days after the
3395 covered person or the covered person's authorized representative, as
3396 applicable, received such notice, additional information in writing to
3397 the assigned independent review organization that such organization
3398 shall consider when conducting the external review, and (II) where
3399 and how such additional information is to be submitted. If additional
3400 information is submitted later than five business days after the covered
3401 person or the covered person's authorized representative, as
3402 applicable, received such notice, the independent review organization
3403 may, but shall not be required to, accept and consider such additional
3404 information.

3405 (2) Not later than (A) five business days for an external review, or
3406 (B) one calendar day for an expedited external review, after the health
3407 carrier receives notice of the name of the assigned independent review
3408 organization from the commissioner, the health carrier or its designee
3409 utilization review company shall provide to the assigned independent
3410 review organization the documents and any information such health
3411 carrier or utilization review company considered in making the
3412 adverse determination or the final adverse determination.

3413 (3) The failure of the health carrier or its designee utilization review
3414 company to provide the documents and information within the time
3415 specified in subdivision (2) of this subsection shall not delay the
3416 conducting of the review.

3417 (4) (i) If the health carrier or its designee utilization review company
3418 fails to provide the documents and information within the time period
3419 specified in subdivision (2) of this subsection, the independent review
3420 organization may terminate the review and make a decision to reverse
3421 the adverse determination or the final adverse determination.

3422 (ii) Not later than one business day after terminating the review and
3423 making the decision to reverse the adverse determination or the final
3424 adverse determination, the independent review organization shall
3425 notify the commissioner, the health carrier, the covered person and, if
3426 applicable, the covered person's authorized representative in writing
3427 of such decision.

3428 (g) (1) The assigned independent review organization shall review
3429 all the information and documents received pursuant to subsection (f)
3430 of this section. In reaching a decision, the independent review
3431 organization shall not be bound by any decisions or conclusions
3432 reached during the health carrier's utilization review process.

3433 (2) Not later than one business day after receiving any information
3434 submitted by the covered person or the covered person's authorized
3435 representative pursuant to subparagraph (B) of subdivision (1) of
3436 subsection (f) of this section, the independent review organization
3437 shall forward such information to the health carrier.

3438 (3) (A) Upon the receipt of any information forwarded pursuant to
3439 subdivision (2) of this subsection, the health carrier may reconsider its
3440 adverse determination or the final adverse determination that is the
3441 subject of the review. Such reconsideration shall not delay or terminate
3442 the review.

3443 (B) The independent review organization shall terminate the review

3444 if the health carrier decides, upon completion of its reconsideration
3445 and notice to such organization as provided in subparagraph (C) of
3446 this subdivision, to reverse its adverse determination or its final
3447 adverse determination and provide coverage or payment for the health
3448 care service or treatment that is the subject of the adverse
3449 determination or the final adverse determination.

3450 (C) Not later than one business day after making the decision to
3451 reverse its adverse determination or its final adverse determination,
3452 the health carrier shall notify the commissioner, the assigned
3453 independent review organization, the covered person and, if
3454 applicable, the covered person's authorized representative in writing
3455 of such decision.

3456 (h) In addition to the documents and information received pursuant
3457 to subsection (f) of this section, the independent review organization
3458 shall consider, to the extent the documents or information are available
3459 and the independent review organization considers them appropriate,
3460 the following in reaching a decision:

3461 (1) The covered person's medical records;

3462 (2) The attending health care professional's recommendation;

3463 (3) Consulting reports from appropriate health care professionals
3464 and other documents submitted by the health carrier, the covered
3465 person, the covered person's authorized representative or the covered
3466 person's treating health care professional;

3467 (4) The terms of coverage under the covered person's health benefit
3468 plan to ensure that the independent review organization's decision is
3469 not contrary to the terms of coverage under such health benefit plan;

3470 (5) The most appropriate practice guidelines, which shall include
3471 applicable evidence-based standards and may include any other
3472 practice guidelines developed by the federal government, national or
3473 professional medical societies, medical boards or medical associations;

3474 (6) Any applicable clinical review criteria developed and used by
3475 the health carrier or its designee utilization review company; and

3476 (7) The opinion or opinions of the independent review
3477 organization's clinical peer or peers who conducted the review after
3478 considering subdivisions (1) to (6), inclusive, of this subsection.

3479 (i) (1) The independent review organization shall notify the
3480 commissioner, the health carrier, the covered person and, if applicable,
3481 the covered person's authorized representative in writing of its
3482 decision to uphold, reverse or revise the adverse determination or the
3483 final adverse determination, not later than:

3484 (A) For external reviews, forty-five calendar days after such
3485 organization receives the assignment from the commissioner to
3486 conduct such review;

3487 (B) For external reviews involving a determination that the
3488 recommended or requested health care service or treatment is
3489 experimental or investigational, twenty calendar days after such
3490 organization receives the assignment from the commissioner to
3491 conduct such review;

3492 (C) For expedited external reviews, as expeditiously as the covered
3493 person's medical condition requires, but not later than seventy-two
3494 hours after such organization receives the assignment from the
3495 commissioner to conduct such review; and

3496 (D) For expedited external reviews involving a determination that
3497 the recommended or requested health care service or treatment is
3498 experimental or investigational, as expeditiously as the covered
3499 person's medical condition requires, but not later than five calendar
3500 days after such organization receives the assignment from the
3501 commissioner to conduct such review.

3502 (2) Such notice shall include:

3503 (A) A general description of the reason for the request for the

3504 review;

3505 (B) The date the independent review organization received the
3506 assignment from the commissioner to conduct the review;

3507 (C) The date the review was conducted;

3508 (D) The date the organization made its decision;

3509 (E) The principal reason or reasons for its decision, including what
3510 applicable evidence-based standards, if any, were used as a basis for its
3511 decision;

3512 (F) The rationale for the organization's decision;

3513 (G) Reference to the evidence or documentation, including any
3514 evidence-based standards, considered by the organization in reaching
3515 its decision; and

3516 (H) For a review involving a determination that the recommended
3517 or requested health care service or treatment is experimental or
3518 investigational:

3519 (i) A description of the covered person's medical condition;

3520 (ii) A description of the indicators relevant to determining whether
3521 there is sufficient evidence to demonstrate that (I) the recommended or
3522 requested health care service or treatment is likely to be more
3523 beneficial to the covered person than any available standard health
3524 care services or treatments, and (II) the adverse risks of the
3525 recommended or requested health care service or treatment would not
3526 be substantially increased over those of available standard health care
3527 services or treatments;

3528 (iii) A description and analysis of any medical or scientific evidence
3529 considered in reaching the opinion;

3530 (iv) A description and analysis of any evidence-based standard; and

3531 (v) Information on whether the clinical peer's rationale for the
3532 opinion is based on the documents and information set forth in
3533 subsection (f) of this section.

3534 (3) Upon the receipt of a notice of the independent review
3535 organization's decision to reverse or revise an adverse determination
3536 or a final adverse determination, the health carrier shall immediately
3537 approve the coverage that was the subject of the adverse determination
3538 or the final adverse determination.

3539 Sec. 61. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
3540 maintain written records to document all grievances of adverse
3541 determinations it receives, including the notices and claims associated
3542 with such grievances, during a calendar year.

3543 (2) (A) Each health carrier shall maintain such records for not less
3544 than six years after the notice of an adverse determination that is the
3545 subject of a grievance was provided to a covered person or the covered
3546 person's authorized representative, as applicable, under section 57 of
3547 this act.

3548 (B) The health carrier shall make such records available for
3549 examination by covered persons, to the extent such records are
3550 permitted to be disclosed by law, the commissioner and appropriate
3551 federal oversight agencies upon request. Such records shall be
3552 maintained in a manner that is reasonably clear and accessible to the
3553 commissioner.

3554 (b) For each grievance the record shall contain, at a minimum, the
3555 following information: (1) A general description of the reason for the
3556 grievance; (2) the date the health carrier received the grievance; (3) the
3557 date of each review or, if applicable, review meeting of the grievance;
3558 (4) the resolution at each level of the grievance, if applicable; (5) the
3559 date of resolution at each such level, if applicable; and (6) the name of
3560 the covered person for whom the grievance was filed.

3561 (c) Each health carrier shall submit a report annually to the

3562 commissioner, in accordance with section 55 of this act, of the
3563 grievances it received.

3564 (d) (1) Each health carrier shall maintain written records of all
3565 requests for external reviews, whether such requests are for standard
3566 or expedited external reviews, that such health carrier receives notice
3567 of from the commissioner in a calendar year. The health carrier shall
3568 maintain such records in the aggregate by state where the covered
3569 person requesting such review resides and by each type of health
3570 benefit plan offered by the health carrier, and shall submit a report to
3571 the commissioner upon request, in a format prescribed by the
3572 commissioner.

3573 (2) Such report shall include, in the aggregate by state where the
3574 covered person requesting such review resides and by each type of
3575 health benefit plan:

3576 (A) The total number of requests for an external review, whether
3577 such requests were for a standard or expedited external review;

3578 (B) From the total number of such requests reported under
3579 subparagraph (A) of this subdivision, the number of requests
3580 determined eligible for a full external review, whether such requests
3581 were for a standard or expedited external review; and

3582 (C) Any other information the commissioner may request or
3583 require.

3584 (3) The health carrier shall retain the written records required
3585 pursuant to subdivision (1) of this subsection for not less than six years
3586 after the request for an external review or an expedited external review
3587 was received.

3588 Sec. 62. (NEW) (*Effective July 1, 2011*) The commissioner shall adopt
3589 regulations, in accordance with chapter 54 of the general statutes, to
3590 implement the provisions of sections 54 to 66, inclusive, of this act.

3591 Sec. 63. (NEW) (*Effective July 1, 2011*) (a) No utilization review

3592 company shall conduct utilization review in this state for a health
3593 benefit plan under the jurisdiction of the commissioner unless it is
3594 licensed by the commissioner. All licenses shall be renewed on an
3595 annual basis.

3596 (b) The annual license fee shall be three thousand dollars and shall
3597 be dedicated to the regulation of utilization review, except that the
3598 commissioner shall be authorized to use such funds as is necessary to
3599 (1) implement the provisions of sections 38a-91aa to 38a-91qq,
3600 inclusive, of the general statutes, and (2) contract with The University
3601 of Connecticut School of Medicine to provide any medical
3602 consultations necessary to carry out the commissioner's responsibilities
3603 under this title with respect to consumer and market conduct matters.

3604 (c) The request for licensure or renewal shall include the name,
3605 address, telephone number and normal business hours of the
3606 utilization review company, the name and telephone number of a
3607 person for the commissioner to contact. Any material changes in the
3608 information filed in accordance with this subsection shall be filed with
3609 the commissioner not later than thirty calendar days after the change.

3610 (d) The commissioner shall receive and investigate all grievances
3611 filed against utilization review companies by a covered person. The
3612 commissioner shall code, track and review all grievances. The
3613 commissioner may impose such penalties as authorized, in accordance
3614 with section 64 of this act.

3615 (e) In the absence of any contractual agreement to the contrary, the
3616 covered person or the covered person's authorized representative shall
3617 be responsible for requesting certification and for authorizing the
3618 covered person's treating health care professional to release, in a timely
3619 manner, all information necessary to conduct the review. A utilization
3620 review company shall permit the covered person, the covered person's
3621 authorized representative or the covered person's treating health care
3622 professional to assist in fulfilling that responsibility.

3623 Sec. 64. (NEW) (Effective July 1, 2011) (a) Whenever the

3624 commissioner has reason to believe that a utilization review company
3625 subject to sections 54 to 63, inclusive, of this act has been or is engaging
3626 in conduct in violation of said sections, and that a proceeding by the
3627 commissioner would be in the interest of the public, the commissioner
3628 shall issue and serve upon such company a statement of the charges in
3629 that respect and a notice of a hearing to be held at a time and place
3630 fixed in the notice, which shall not be less than thirty calendar days
3631 after the date of service. At the time and place fixed for such hearing,
3632 such company shall have an opportunity to be heard and to show
3633 cause why an order should not be made by the commissioner
3634 requiring such company to cease and desist from the alleged conduct
3635 complained of.

3636 (b) If, after such hearing, the commissioner determines that the
3637 utilization review company charged has engaged in a violation of
3638 section 57 of this act, the commissioner shall reduce the findings to
3639 writing and shall issue and cause to be served upon the utilization
3640 review company a copy of such findings and an order requiring such
3641 company to cease and desist from engaging in such violation. The
3642 commissioner may order any of the following:

3643 (1) Payment of a civil penalty of not more than one thousand five
3644 hundred dollars for each act or violation, provided such penalty shall
3645 not exceed an aggregate penalty of fifteen thousand dollars unless the
3646 company knew or reasonably should have known it was in violation of
3647 section 57 of this act, in which case the penalty shall be not more than
3648 seven thousand five hundred dollars for each act or violation, not to
3649 exceed an aggregate penalty of seventy-five thousand dollars in any
3650 six-month period;

3651 (2) Suspension or revocation of the utilization review company's
3652 license to do business in this state if it knew or reasonably should have
3653 known that it was in violation of section 57 of this act; or

3654 (3) Payment of such reasonable expenses as may be necessary to
3655 compensate the commissioner in connection with the proceedings

3656 under this subsection, which shall be dedicated exclusively to the
3657 regulation of utilization review.

3658 (c) Any company aggrieved by any such order of the commissioner
3659 may appeal therefrom in accordance with the provisions of section 4-
3660 183 of the general statutes, except venue for such appeal shall be in the
3661 judicial district of New Britain.

3662 (d) Any person who violates a cease and desist order of the
3663 commissioner made pursuant to this section and while such order is in
3664 effect shall, after notice and hearing and upon order of the
3665 commissioner, be subject to the following: (1) A civil penalty of not
3666 more than seventy-five thousand dollars; or (2) suspension or
3667 revocation of such person's license.

3668 Sec. 65. (NEW) (*Effective July 1, 2011*) (a) (1) The commissioner shall
3669 approve independent review organizations eligible to be assigned to
3670 conduct external reviews and expedited external reviews under section
3671 60 of this act.

3672 (2) The commissioner shall (A) develop an application form for the
3673 initial approval and for the reapproval of independent review
3674 organizations, and (B) maintain and periodically update a list of
3675 approved independent review organizations.

3676 (b) (1) Any independent review organization seeking to conduct
3677 external reviews and expedited external reviews under section 60 of
3678 this act shall submit the application form for approval or reapproval,
3679 as applicable, to the commissioner and shall include all documentation
3680 and information necessary for the commissioner to determine if the
3681 independent review organization satisfies the minimum qualifications
3682 established under this section.

3683 (2) An approval or reapproval shall be effective for two years,
3684 unless the commissioner determines before the expiration of such
3685 approval or reapproval that the independent review organization no
3686 longer satisfies the minimum qualifications established under this

3687 section.

3688 (3) Whenever the commissioner determines that an independent
3689 review organization has lost its accreditation or no longer satisfies the
3690 minimum requirements established under this section, the
3691 commissioner shall terminate the approval of the independent review
3692 organization and remove the independent review organization from
3693 the list of approved independent review organizations specified in
3694 subdivision (2) of subsection (a) of this section.

3695 (c) To be eligible for approval by the commissioner, an independent
3696 review organization shall:

3697 (1) Have and maintain written policies and procedures that govern
3698 all aspects of both the standard external review process and the
3699 expedited external review process set forth in section 60 of this act that
3700 include, at a minimum:

3701 (A) A quality assurance mechanism in place that ensures:

3702 (i) That external reviews and expedited external reviews are
3703 conducted within the specified time frames and required notices are
3704 provided in a timely manner;

3705 (ii) (I) The selection of qualified and impartial clinical peers to
3706 conduct such reviews on behalf of the independent review
3707 organization and the suitable matching of such peers to specific cases,
3708 and (II) employs or contracts with an adequate number of clinical
3709 peers to meet this objective;

3710 (iii) The confidentiality of medical and treatment records and
3711 clinical review criteria;

3712 (iv) That any person employed by or under contract with the
3713 independent review organization adheres to the requirements of
3714 section 60 of this act; and

3715 (B) A toll-free telephone number to receive information twenty-four

3716 hours a day, seven days a week, related to external reviews and
3717 expedited external reviews and that is capable of accepting, recording
3718 or providing appropriate instruction to incoming telephone callers
3719 during other than normal business hours;

3720 (2) Agree to maintain and provide to the commissioner the
3721 information set forth in section 66 of this act;

3722 (3) Not own or control, be a subsidiary of, be owned or controlled in
3723 any way by, or exercise control with a health benefit plan, a national,
3724 state or local trade association of health benefit plans, or a national,
3725 state or local trade association of health care professionals; and

3726 (4) Assign as a clinical peer a health care professional who meets the
3727 following minimum qualifications:

3728 (A) Is an expert in the treatment of the covered person's medical
3729 condition that is the subject of the review;

3730 (B) Is knowledgeable about the recommended health care service or
3731 treatment through recent or current actual clinical experience treating
3732 patients with the same or similar medical condition of the covered
3733 person;

3734 (C) Holds a nonrestricted license in a state of the United States and,
3735 for physicians, a current certification by a recognized American
3736 medical specialty board in the area or areas appropriate to the subject
3737 of the review; and

3738 (D) Has no history of disciplinary actions or sanctions, including
3739 loss of staff privileges or participation restrictions, that have been
3740 taken or are pending by any hospital, governmental agency or unit or
3741 regulatory body that raise a substantial question as to the clinical
3742 peer's physical, mental or professional competence or moral character.

3743 (d) (1) An independent review organization that is accredited by a
3744 nationally recognized private accrediting entity that has independent
3745 review accreditation standards that the commissioner has determined

3746 are equivalent to or exceed the minimum qualifications of this section
3747 shall be presumed to be in compliance with this section.

3748 (2) The commissioner shall initially review and periodically review
3749 the independent review organization accreditation standards of a
3750 nationally recognized private accrediting entity to determine whether
3751 such entity's standards are, and continue to be, equivalent to or exceed
3752 the minimum qualifications established under this section. The
3753 commissioner may accept a review conducted by the National
3754 Association of Insurance Commissioners for the purpose of the
3755 determination under this subdivision.

3756 (3) Upon request, a nationally recognized private accrediting entity
3757 shall make its current independent review organization accreditation
3758 standards available to the commissioner or the National Association of
3759 Insurance Commissioners in order for the commissioner to determine
3760 if such entity's standards are equivalent to or exceed the minimum
3761 qualifications established under this section. The commissioner may
3762 exclude any private accrediting entity that is not reviewed by the
3763 National Association of Insurance Commissioners.

3764 Sec. 66. (NEW) (*Effective July 1, 2011*) (a) The commissioner shall not
3765 assign an independent review organization, and no independent
3766 review organization shall assign a clinical peer, to conduct an external
3767 review or an expedited external review of a specified case if such
3768 organization or clinical peer has a material professional, familial or
3769 financial conflict of interest with any of the following:

3770 (1) The health carrier that is the subject of such review;

3771 (2) The covered person whose treatment is the subject of such
3772 review or the covered person's authorized representative;

3773 (3) Any officer, director or management employee of the health
3774 carrier that is the subject of such review;

3775 (4) The health care provider, the health care provider's medical

3776 group or independent practice association recommending the health
3777 care service or treatment that is the subject of such review;

3778 (5) The facility at which the recommended health care service or
3779 treatment would be provided; or

3780 (6) The developer or manufacturer of the principal drug, device,
3781 procedure or other therapy being recommended for the covered
3782 person whose treatment is the subject of such review.

3783 (b) To determine whether an independent review organization or a
3784 clinical peer of the independent review organization has a material
3785 professional, familial or financial conflict of interest for purposes of
3786 subsection (a) of this section, the commissioner shall consider
3787 situations in which the independent review organization to be
3788 assigned to conduct an external review or an expedited external
3789 review of a specified case or a clinical peer to be assigned by the
3790 independent review organization to conduct such review of a specified
3791 case may have an apparent professional, familial or financial
3792 relationship or connection with a person described in subsection (a) of
3793 this section, but the characteristics of such relationship or connection
3794 are such that they are not a material professional, familial or financial
3795 conflict of interest that results in the disapproval of the independent
3796 review organization or the clinical peer from conducting such review.

3797 (c) An independent review organization shall be unbiased. In
3798 addition to any other written procedures required under section 65 of
3799 this act, an independent review organization shall establish and
3800 maintain written procedures to ensure that it is unbiased.

3801 (d) No independent review organization or clinical peer working on
3802 behalf of an independent review organization or an employee, agent or
3803 contractor of an independent review organization shall be liable in
3804 damages to any person for any opinions rendered or acts or omissions
3805 performed within the scope of the organization's or person's duties
3806 during or upon completion of an external review or an expedited
3807 external review conducted pursuant to section 60 of this act, unless

3808 such opinion was rendered or act or omission performed in bad faith
3809 or involved gross negligence.

3810 (e) (1) Each independent review organization assigned by the
3811 commissioner to conduct a review pursuant to section 60 of this act
3812 shall maintain written records of all external reviews, whether
3813 standard or expedited external reviews, conducted by such
3814 organization in a calendar year. Such organization shall maintain such
3815 records in the aggregate by state where the covered person requesting
3816 such review resides and by health carrier, and shall submit a report to
3817 the commissioner upon request, in a format prescribed by the
3818 commissioner.

3819 (2) Such report shall include, in the aggregate by state where the
3820 covered person requesting such review resides and by health carrier:

3821 (A) The total number of requests for an external review, whether
3822 such requests were for a standard or an expedited external review;

3823 (B) The number of such requests resolved and, of those resolved, the
3824 number resolved upholding the adverse determination or final adverse
3825 determination and the number resolved reversing the adverse
3826 determination or final adverse determination;

3827 (C) The average length of time for resolution;

3828 (D) A summary of the types of coverages or cases for which a
3829 review was sought;

3830 (E) The number of such reviews that were terminated as a result of
3831 reconsideration by the health carrier of its adverse determination or
3832 final adverse determination after the receipt of additional information
3833 from the covered person or the covered person's authorized
3834 representative; and

3835 (F) Any other information the commissioner may request or require.

3836 (3) Each independent review organization shall retain the written

3837 records required pursuant to subdivision (1) of this subsection for not
3838 less than six years after the assignment of an external review or an
3839 expedited external review.

3840 (f) The commissioner shall adopt regulations, in accordance with
3841 chapter 54, to carry out the provisions of this section and sections 63 to
3842 65, inclusive, of this act.

3843 Sec. 67. Section 38a-478 of the general statutes is repealed and the
3844 following is substituted in lieu thereof (*Effective July 1, 2011*):

3845 As used in this section, sections [38a-478] 38a-478a to 38a-478o,
3846 inclusive, as amended by this act, and subsection (a) of section 38a-
3847 478s, as amended by this act:

3848 [(1) "Adverse determination" means a determination by a managed
3849 care organization, health insurer or utilization review company that an
3850 admission, service, procedure or extension of stay that is a covered
3851 benefit has been reviewed and, based upon the information provided,
3852 does not meet the managed care organization's, health insurer's or
3853 utilization review company's requirements for medical necessity,
3854 appropriateness, health care setting, level of care or effectiveness, and
3855 such requested admission, service, procedure or extension of stay, or
3856 payment for such admission, service, procedure or extension of stay
3857 has been denied, reduced or terminated.]

3858 [(2)] (1) "Commissioner" means the Insurance Commissioner.

3859 [(3)] (2) "Covered benefit" or "benefit" means a health care service to
3860 which an enrollee is entitled under the terms of a health benefit plan.

3861 [(4)] (3) [Except as provided in sections 38a-478m and 38a-478n,
3862 "enrollee"] "Enrollee" means a person who has contracted for or who
3863 participates in a managed care plan for such person or such person's
3864 eligible dependents.

3865 [(5)] (4) "Health care services" means services for the diagnosis,
3866 prevention, treatment, cure or relief of a health condition, illness,

3867 injury or disease.

3868 [(6)] (5) "Managed care organization" means an insurer, health care
3869 center, hospital or medical service corporation or other organization
3870 delivering, issuing for delivery, renewing, amending or continuing any
3871 individual or group health managed care plan in this state.

3872 [(7)] (6) "Managed care plan" means a product offered by a managed
3873 care organization that provides for the financing or delivery of health
3874 care services to persons enrolled in the plan through: (A)
3875 Arrangements with selected providers to furnish health care services;
3876 (B) explicit standards for the selection of participating providers; (C)
3877 financial incentives for enrollees to use the participating providers and
3878 procedures provided for by the plan; or (D) arrangements that share
3879 risks with providers, provided the organization offering a plan
3880 described under subparagraph (A), (B), (C) or (D) of this subdivision is
3881 licensed by the Insurance Department pursuant to chapter 698, 698a or
3882 700 and the plan includes utilization review, [pursuant to sections 38a-
3883 226 to 38a-226d, inclusive] as defined in section 54 of this act.

3884 [(8)] (7) "Preferred provider network" has the same meaning as
3885 provided in section 38a-479aa, as amended by this act.

3886 [(9)] (8) "Provider" or "health care provider" means a person licensed
3887 to provide health care services under chapters 370 to 373, inclusive, 375
3888 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

3889 [(10)] "Review entity" means an entity that conducts independent
3890 external reviews of adverse determinations. Such review entities
3891 include, but are not limited to, medical peer review organizations,
3892 independent utilization review companies, provided such
3893 organizations or companies are not related to or associated with any
3894 managed care organization or health insurer, and nationally
3895 recognized health experts or institutions approved by the Insurance
3896 Commissioner.]

3897 [(11)] (9) "Utilization review" has the same meaning as provided in

3898 section [38a-226] 54 of this act.

3899 [(12)] (10) "Utilization review company" has the same meaning as
3900 provided in section [38a-226] 54 of this act.

3901 Sec. 68. Subsection (c) of section 38a-19 of the general statutes is
3902 repealed and the following is substituted in lieu thereof (*Effective July*
3903 *1, 2011*):

3904 (c) The provisions of this section shall not apply to an order or
3905 decision of the commissioner made pursuant to section [38a-477b or
3906 38a-478n] 60 of this act.

3907 Sec. 69. Subsection (b) of section 38a-477b of the general statutes is
3908 repealed and the following is substituted in lieu thereof (*Effective July*
3909 *1, 2011*):

3910 (b) An insurer or health care center shall apply for approval of such
3911 rescission, cancellation or limitation by submitting such written
3912 information to the Insurance Commissioner on an application in such
3913 form as the commissioner prescribes. Such insurer or health care center
3914 shall provide a copy of the application for such approval to the insured
3915 or the insured's representative. Not later than seven business days
3916 after receipt of the application for such approval, the insured or the
3917 insured's representative shall have an opportunity to review such
3918 application and respond and submit relevant information to the
3919 commissioner with respect to such application. Not later than fifteen
3920 business days after the submission of information by the insured or the
3921 insured's representative, the commissioner shall issue a written
3922 decision on such application. The commissioner [may] shall only
3923 approve; [such rescission, cancellation]

3924 (1) Such rescission or limitation if the commissioner finds that [(1)]
3925 (A) the insured or such insured's representative submitted the written
3926 information [submitted] on or with the insurance application that was
3927 [false] fraudulent at the time such application was made, [and] (B) the
3928 insured or such insured's representative [knew or should have known

3929 of the falsity] intentionally misrepresented information therein [.] and
3930 such [submission] misrepresentation materially affects the risk or the
3931 hazard assumed by the insurer or health care center, or [(2)] (C) the
3932 information omitted from the insurance application was [knowingly]
3933 intentionally omitted by the insured or such insured's representative [,
3934 or the insured or such insured's representative should have known of
3935 such omission,] and such omission materially affects the risk or the
3936 hazard assumed by the insurer or health care center. Such decision
3937 shall be mailed to the insured, the insured's representative, if any, and
3938 the insurer or health care center; and

3939 (2) Such cancellation in accordance with the provisions set forth in
3940 the Public Health Service Act, 42 USC 300gg et seq., as amended from
3941 time to time.

3942 Sec. 70. Section 38a-478a of the general statutes is repealed and the
3943 following is substituted in lieu thereof (*Effective July 1, 2011*):

3944 On March [1, 1999, and] first annually, [thereafter,] the Insurance
3945 Commissioner shall submit a report [.] to the Governor and to the joint
3946 standing committees of the General Assembly having cognizance of
3947 matters relating to public health and [relating to] insurance,
3948 concerning the commissioner's responsibilities under the provisions of
3949 sections [38a-226 to 38a-226d, inclusive] 54 to 61, inclusive, of this act,
3950 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as
3951 amended by this act, and 38a-993. The report shall include: (1) A
3952 summary of the quality assurance plans submitted by managed care
3953 organizations pursuant to section 38a-478c along with suggested
3954 changes to improve such plans; (2) suggested modifications to the
3955 consumer report card developed under the provisions of section 38a-
3956 478l; (3) a summary of the commissioner's procedures and activities in
3957 conducting market conduct examinations of utilization review
3958 companies and preferred provider networks, including, but not limited
3959 to: (A) The number of desk and field audits completed during the
3960 previous calendar year; (B) a summary of findings of the desk and field
3961 audits, including any recommendations made for improvements or

3962 modifications; (C) a description of complaints concerning managed
3963 care companies, and any preferred provider network that provides
3964 services to enrollees on behalf of the managed care organization,
3965 including a summary and analysis of any trends or similarities found
3966 in the managed care complaints filed by enrollees; (4) a summary of
3967 the complaints concerning managed care organizations received by the
3968 Insurance Department's Consumer Affairs Division and the
3969 commissioner under section [38a-478n] 60 of this act, including a
3970 summary and analysis of any trends or similarities found in the
3971 complaints received; (5) a summary of any violations the commissioner
3972 has found against any managed care organization or any preferred
3973 provider network that provides services to enrollees on behalf of the
3974 managed care organization; and (6) a summary of the issues discussed
3975 related to health care or managed care organizations at the Insurance
3976 Department's quarterly forums throughout the state.

3977 Sec. 71. Section 38a-478b of the general statutes is repealed and the
3978 following is substituted in lieu thereof (*Effective July 1, 2011*):

3979 (a) Each managed care organization, as defined in section 38a-478,
3980 that fails to file the data, reports or information required by sections
3981 [38a-226 to 38a-226d] 54 to 61, inclusive, of this act, 38a-478 to 38a-
3982 478u, inclusive, as amended by this act, 38a-479aa, as amended by this
3983 act, and 38a-993 shall pay a late fee of one hundred dollars per day for
3984 each day from the due date of such data, reports or information to the
3985 date of filing. Each managed care organization that files incomplete
3986 data, reports or information shall be so informed by the commissioner,
3987 shall be given a date by which to remedy such incomplete filing and
3988 shall pay said late fee commencing from the new due date.

3989 (b) On June [1, 1998, and] first annually, [thereafter,] the
3990 commissioner shall submit [,] to the Governor and to the joint standing
3991 committees of the General Assembly having cognizance of matters
3992 relating to public health and [matters relating to] insurance, a list of
3993 those managed care organizations that have failed to file any data,
3994 report or information required by sections [38a-226 to 38a-226d] 54 to

3995 61, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by
3996 this act, 38a-479aa, as amended by this act, and 38a-993.

3997 Sec. 72. Section 38a-478h of the general statutes is repealed and the
3998 following is substituted in lieu thereof (*Effective July 1, 2011*):

3999 (a) Each contract delivered, issued for delivery, renewed, amended
4000 or continued in this state [on and after October 1, 1997,] between a
4001 managed care organization and a participating provider shall require
4002 the provider to give at least sixty days' advance written notice to the
4003 managed care organization and shall require the managed care
4004 organization to give at least sixty days' advance written notice to the
4005 provider in order to withdraw from or terminate the agreement.

4006 (b) The provisions of this section shall not apply: (1) When lack of
4007 such notice is necessary for the health or safety of the enrollees; (2)
4008 when a provider has entered into a contract with a managed care
4009 organization that is found to be based on fraud or material
4010 misrepresentation; or (3) when a provider engages in any fraudulent
4011 activity related to the terms of his contract with the managed care
4012 organization.

4013 (c) No managed care organization shall take or threaten to take any
4014 action against any provider in retaliation for such provider's assistance
4015 to an enrollee under the provisions of [subsection (e) of section 38a-
4016 226c or section 38a-478n] section 60 of this act.

4017 Sec. 73. Subsection (d) of section 38a-478r of the general statutes is
4018 repealed and the following is substituted in lieu thereof (*Effective July*
4019 *1, 2011*):

4020 (d) The Insurance Commissioner [, after consultation with the
4021 working group convened pursuant to section 38a-478p,] may develop
4022 and disseminate to hospitals in this state a claims form system that will
4023 ensure that all hospitals consistently code for the presenting and
4024 diagnosis symptoms on all emergency claims.

4025 Sec. 74. Section 38a-478s of the general statutes is repealed and the
4026 following is substituted in lieu thereof (*Effective July 1, 2011*):

4027 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended
4028 by this act, or sections 54 to 61, inclusive, of this act shall be construed
4029 to apply to the arrangements of managed care organizations or health
4030 insurers offered to individuals covered under self-insured employee
4031 welfare benefit plans established pursuant to the federal Employee
4032 Retirement Income Security Act of 1974.

4033 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, as
4034 amended by this act, and sections 54 to 61, inclusive, of this act shall
4035 not apply to any plan that provides for the financing or delivery of
4036 health care services solely for the purposes of workers' compensation
4037 benefits pursuant to chapter 568.

4038 Sec. 75. Section 38a-478t of the general statutes is repealed and the
4039 following is substituted in lieu thereof (*Effective July 1, 2011*):

4040 The Commissioner of Public Health may request and shall receive
4041 any data, report or information filed with the Insurance Commissioner
4042 pursuant to the provisions of sections [38a-226 to 38a-226d, inclusive]
4043 63 and 64 of this act, 38a-478 to 38a-478u, inclusive, as amended by this
4044 act, 38a-479aa, as amended by this act, and 38a-993.

4045 Sec. 76. Section 38a-478u of the general statutes is repealed and the
4046 following is substituted in lieu thereof (*Effective July 1, 2011*):

4047 The Insurance Commissioner may adopt regulations in accordance
4048 with the provisions of chapter 54 to implement the provisions of
4049 sections [38a-226 to 38a-226d, inclusive,] 38a-478 to 38a-478u, inclusive,
4050 as amended by this act, 38a-479aa, as amended by this act, and 38a-
4051 993.

4052 Sec. 77. Section 38a-479aa of the general statutes is repealed and the
4053 following is substituted in lieu thereof (*Effective July 1, 2011*):

4054 (a) As used in this part and subsection (b) of section 20-138b:

4055 (1) "Covered benefits" means health care services to which an
4056 enrollee is entitled under the terms of a managed care plan;

4057 (2) "Enrollee" means an individual who is eligible to receive health
4058 care services through a preferred provider network;

4059 (3) "Health care services" means health care related services or
4060 products rendered or sold by a provider within the scope of the
4061 provider's license or legal authorization, and includes hospital,
4062 medical, surgical, dental, vision and pharmaceutical services or
4063 products;

4064 (4) "Managed care organization" means (A) a managed care
4065 organization, as defined in section 38a-478, as amended by this act, (B)
4066 any other health insurer, or (C) a reinsurer with respect to health
4067 insurance;

4068 (5) "Managed care plan" means a managed care plan, as defined in
4069 section 38a-478, as amended by this act;

4070 (6) "Person" means an individual, agency, political subdivision,
4071 partnership, corporation, limited liability company, association or any
4072 other entity;

4073 (7) "Preferred provider network" means a person, which is not a
4074 managed care organization, but which pays claims for the delivery of
4075 health care services, accepts financial risk for the delivery of health
4076 care services and establishes, operates or maintains an arrangement or
4077 contract with providers relating to (A) the health care services
4078 rendered by the providers, and (B) the amounts to be paid to the
4079 providers for such services. "Preferred provider network" does not
4080 include (i) a workers' compensation preferred provider organization
4081 established pursuant to section 31-279-10 of the regulations of
4082 Connecticut state agencies, (ii) an independent practice association or
4083 physician hospital organization whose primary function is to contract
4084 with insurers and provide services to providers, (iii) a clinical
4085 laboratory, licensed pursuant to section 19a-30, whose primary

4086 payments for any contracted or referred services are made to other
4087 licensed clinical laboratories or for associated pathology services, or
4088 (iv) a pharmacy benefits manager responsible for administering
4089 pharmacy claims whose primary function is to administer the
4090 pharmacy benefit on behalf of a health benefit plan;

4091 (8) "Provider" means an individual or entity duly licensed or legally
4092 authorized to provide health care services; and

4093 (9) "Commissioner" means the Insurance Commissioner.

4094 (b) On and after May 1, 2004, no preferred provider network may
4095 enter into or renew a contractual relationship with a managed care
4096 organization unless the preferred provider network is licensed by the
4097 commissioner. On and after May 1, 2005, no preferred provider
4098 network may conduct business in this state unless it is licensed by the
4099 commissioner. Any person seeking to obtain or renew a license shall
4100 submit an application to the commissioner, on such form as the
4101 commissioner may prescribe, and shall include the filing described in
4102 this subsection, except that a person seeking to renew a license may
4103 submit only the information necessary to update its previous filing.
4104 Applications shall be submitted by March first of each year in order to
4105 qualify for the May first license issue or renewal date. The filing
4106 required from such preferred provider network shall include the
4107 following information: (1) The identity of the preferred provider
4108 network and any company or organization controlling the operation of
4109 the preferred provider network, including the name, business address,
4110 contact person, a description of the controlling company or
4111 organization and, where applicable, the following: (A) A certificate
4112 from the Secretary of the State regarding the preferred provider
4113 network's and the controlling company's or organization's good
4114 standing to do business in the state; (B) a copy of the preferred
4115 provider network's and the controlling company's or organization's
4116 financial statement completed in accordance with sections 38a-53 and
4117 38a-54, as applicable, for the end of its most recently concluded fiscal
4118 year, along with the name and address of any public accounting firm

4119 or internal accountant which prepared or assisted in the preparation of
4120 such financial statement; (C) a list of the names, official positions and
4121 occupations of members of the preferred provider network's and the
4122 controlling company's or organization's board of directors or other
4123 policy-making body and of those executive officers who are
4124 responsible for the preferred provider network's and controlling
4125 company's or organization's activities with respect to the health care
4126 services network; (D) a list of the preferred provider network's and the
4127 controlling company's or organization's principal owners; (E) in the
4128 case of an out-of-state preferred provider network, controlling
4129 company or organization, a certificate that such preferred provider
4130 network, company or organization is in good standing in its state of
4131 organization; (F) in the case of a Connecticut or out-of-state preferred
4132 provider network, controlling company or organization, a report of the
4133 details of any suspension, sanction or other disciplinary action relating
4134 to such preferred provider network, or controlling company or
4135 organization in this state or in any other state; and (G) the identity,
4136 address and current relationship of any related or predecessor
4137 controlling company or organization. For purposes of this
4138 subparagraph, "related" means that a substantial number of the board
4139 or policy-making body members, executive officers or principal
4140 owners of both companies are the same; (2) a general description of the
4141 preferred provider network and participation in the preferred provider
4142 network, including: (A) The geographical service area of and the
4143 names of the hospitals included in the preferred provider network; (B)
4144 the primary care physicians, the specialty physicians, any other
4145 contracting providers and the number and percentage of each group's
4146 capacity to accept new patients; (C) a list of all entities on whose behalf
4147 the preferred provider network has contracts or agreements to provide
4148 health care services; (D) a table listing all major categories of health
4149 care services provided by the preferred provider network; (E) an
4150 approximate number of total enrollees served in all of the preferred
4151 provider network's contracts or agreements; (F) a list of subcontractors
4152 of the preferred provider network, not including individual
4153 participating providers, that assume financial risk from the preferred

4154 provider network and to what extent each subcontractor assumes
4155 financial risk; (G) a contingency plan describing how contracted health
4156 care services will be provided in the event of insolvency; and (H) any
4157 other information requested by the commissioner; and (3) the name
4158 and address of the person to whom applications may be made for
4159 participation.

4160 (c) Any person developing a preferred provider network, or
4161 expanding a preferred provider network into a new county, pursuant
4162 to this section and subsection (b) of section 20-138b, shall publish a
4163 notice, in at least one newspaper having a substantial circulation in the
4164 service area in which the preferred provider network operates or will
4165 operate, indicating such planned development or expansion. Such
4166 notice shall include the medical specialties included in the preferred
4167 provider network, the name and address of the person to whom
4168 applications may be made for participation and a time frame for
4169 making application. The preferred provider network shall provide the
4170 applicant with written acknowledgment of receipt of the application.
4171 Each complete application shall be considered by the preferred
4172 provider network in a timely manner.

4173 (d) (1) Each preferred provider network shall file with the
4174 commissioner and make available upon request from a provider the
4175 general criteria for its selection or termination of providers. Disclosure
4176 shall not be required of criteria deemed by the preferred provider
4177 network to be of a proprietary or competitive nature that would hurt
4178 the preferred provider network's ability to compete or to manage
4179 health care services. For purposes of this section, criteria is of a
4180 proprietary or competitive nature if it has the tendency to cause
4181 providers to alter their practice pattern in a manner that would
4182 circumvent efforts to contain health care costs and criteria is of a
4183 proprietary nature if revealing the criteria would cause the preferred
4184 provider network's competitors to obtain valuable business
4185 information.

4186 (2) If a preferred provider network uses criteria that have not been

4187 filed pursuant to subdivision (1) of this subsection to judge the quality
4188 and cost-effectiveness of a provider's practice under any specific
4189 program within the preferred provider network, the preferred
4190 provider network may not reject or terminate the provider
4191 participating in that program based upon such criteria until the
4192 provider has been informed of the criteria that the provider's practice
4193 fails to meet.

4194 (e) Each preferred provider network shall permit the Insurance
4195 Commissioner to inspect its books and records.

4196 (f) Each preferred provider network shall permit the commissioner
4197 to examine, under oath, any officer or agent of the preferred provider
4198 network or controlling company or organization with respect to the
4199 use of the funds of the preferred provider network, company or
4200 organization, and compliance with (1) the provisions of this part, and
4201 (2) the terms and conditions of its contracts to provide health care
4202 services.

4203 (g) Each preferred provider network shall file with the
4204 commissioner a notice of any material modification of any matter or
4205 document furnished pursuant to this part, and shall include such
4206 supporting documents as are necessary to explain the modification.

4207 (h) Each preferred provider network shall maintain a minimum net
4208 worth of either (1) the greater of (A) two hundred fifty thousand
4209 dollars, or (B) an amount equal to eight per cent of its annual
4210 expenditures as reported on its most recent financial statement
4211 completed and filed with the commissioner in accordance with
4212 sections 38a-53 and 38a-54, as applicable, or (2) another amount
4213 determined by the commissioner.

4214 (i) Each preferred provider network shall maintain or arrange for a
4215 letter of credit, bond, surety, reinsurance, reserve or other financial
4216 security acceptable to the commissioner for the exclusive use of paying
4217 any outstanding amounts owed participating providers in the event of
4218 insolvency or nonpayment except that any remaining security may be

4219 used for the purpose of reimbursing managed care organizations in
4220 accordance with subsection (b) of section 38a-479bb. Such outstanding
4221 amount shall be at least an amount equal to the greater of (1) an
4222 amount sufficient to make payments to participating providers for two
4223 months determined on the basis of the two months within the past
4224 year with the greatest amounts owed by the preferred provider
4225 network to participating providers, (2) the actual outstanding amount
4226 owed by the preferred provider network to participating providers, or
4227 (3) another amount determined by the commissioner. Such amount
4228 may be credited against the preferred provider network's minimum
4229 net worth requirements set forth in subsection (h) of this section. The
4230 commissioner shall review such security amount and calculation on a
4231 quarterly basis.

4232 (j) Each preferred provider network shall pay the applicable license
4233 or renewal fee specified in section 38a-11. The commissioner shall use
4234 the amount of such fees solely for the purpose of regulating preferred
4235 provider networks.

4236 (k) In no event, including, but not limited to, nonpayment by the
4237 managed care organization, insolvency of the managed care
4238 organization, or breach of contract between the managed care
4239 organization and the preferred provider network, shall a preferred
4240 provider network bill, charge, collect a deposit from, seek
4241 compensation, remuneration or reimbursement from, or have any
4242 recourse against an enrollee or an enrollee's designee, other than the
4243 managed care organization, for covered benefits provided, except that
4244 the preferred provider network may collect any copayments,
4245 deductibles or other out-of-pocket expenses that the enrollee is
4246 required to pay pursuant to the managed care plan.

4247 (l) Each contract or agreement between a preferred provider
4248 network and a participating provider shall contain a provision that if
4249 the preferred provider network fails to pay for health care services as
4250 set forth in the contract, the enrollee shall not be liable to the
4251 participating provider for any sums owed by the preferred provider

4252 network or any sums owed by the managed care organization because
4253 of nonpayment by the managed care organization, insolvency of the
4254 managed care organization or breach of contract between the managed
4255 care organization and the preferred provider network.

4256 (m) Each utilization review determination made by or on behalf of a
4257 preferred provider network shall be made in accordance with [sections
4258 38a-226 to 38a-226d, inclusive, except that any initial appeal of a
4259 determination not to certify an admission, service, procedure or
4260 extension of stay shall be conducted in accordance with subdivision (7)
4261 of subsection (a) of section 38a-226c, and any subsequent appeal shall
4262 be referred to the managed care organization on whose behalf the
4263 preferred provider network provides services. The managed care
4264 organization shall conduct the subsequent appeal in accordance with
4265 said subdivision] section 57 of this act.

4266 (n) The requirements of subsections (h) and (i) of this section shall
4267 not apply to a consortium of federally qualified health centers funded
4268 by the state, providing services only to recipients of programs
4269 administered by the Department of Social Services. The Commissioner
4270 of Social Services shall adopt regulations, in accordance with chapter
4271 54, to establish criteria to certify any such federally qualified health
4272 center, including, but not limited to, minimum reserve fund
4273 requirements.

4274 Sec. 78. Subsection (d) of section 38a-479bb of the general statutes is
4275 repealed and the following is substituted in lieu thereof (*Effective July*
4276 *1, 2011*):

4277 (d) Each managed care organization shall ensure that any contract it
4278 has with a preferred provider network includes:

4279 (1) A provision that requires the preferred provider network to
4280 provide to the managed care organization at the time a contract is
4281 entered into, annually, and upon request of the managed care
4282 organization, (A) the financial statement completed in accordance with
4283 sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as

4284 amended by this act; (B) documentation that satisfies the managed care
4285 organization that the preferred provider network has sufficient ability
4286 to accept financial risk; (C) documentation that satisfies the managed
4287 care organization that the preferred provider network has appropriate
4288 management expertise and infrastructure; (D) documentation that
4289 satisfies the managed care organization that the preferred provider
4290 network has an adequate provider network taking into account the
4291 geographic distribution of enrollees and participating providers and
4292 whether participating providers are accepting new patients; (E) an
4293 accurate list of participating providers; and (F) documentation that
4294 satisfies the managed care organization that the preferred provider
4295 network has the ability to ensure the delivery of health care services as
4296 set forth in the contract;

4297 (2) A provision that requires the preferred provider network to
4298 provide to the managed care organization a quarterly status report that
4299 includes (A) information updating the financial statement completed
4300 in accordance with sections 38a-53 and 38a-54, as applicable, and
4301 section 38a-479aa, as amended by this act; (B) a report showing
4302 amounts paid to those providers who provide health care services on
4303 behalf of the managed care organization; (C) an estimate of payments
4304 due providers but not yet reported by providers; (D) amounts owed to
4305 providers for that quarter; and (E) the number of utilization review
4306 determinations not to certify an admission, service, procedure or
4307 extension of stay made by or on behalf of the preferred provider
4308 network and the outcome of such determination on appeal;

4309 (3) A provision that requires the preferred provider network to
4310 provide notice to the managed care organization not later than five
4311 business days after (A) any change involving the ownership structure
4312 of the preferred provider network; (B) financial or operational
4313 concerns arise regarding the financial viability of the preferred
4314 provider network; or (C) the preferred provider network's loss of a
4315 license in this or any other state;

4316 (4) A provision that if the managed care organization fails to pay for

4317 health care services as set forth in the contract, the enrollee will not be
4318 liable to the provider or preferred provider network for any sums
4319 owed by the managed care organization or preferred provider
4320 network;

4321 (5) A provision that the preferred provider network shall include in
4322 all contracts between the preferred provider network and participating
4323 providers a provision that if the preferred provider network fails to
4324 pay for health care services as set forth in the contract, for any reason,
4325 the enrollee shall not be liable to the participating provider or
4326 preferred provider network for any sums owed by the preferred
4327 provider network or any sums owed by the managed care
4328 organization because of nonpayment by the managed care
4329 organization, insolvency of the managed care organization or breach of
4330 contract between the managed care organization and the preferred
4331 provider network;

4332 (6) A provision requiring the preferred provider network to provide
4333 information to the managed care organization, satisfactory to the
4334 managed care organization, regarding the preferred provider
4335 network's reserves for financial risk;

4336 (7) A provision that (A) the preferred provider network or managed
4337 care organization shall post and maintain a letter of credit, bond,
4338 surety, reinsurance, reserve or other financial security acceptable to the
4339 commissioner, in order to satisfy the risk accepted by the preferred
4340 provider network pursuant to the contract, in an amount calculated in
4341 accordance with subsection (i) of section 38a-479aa, as amended by this
4342 act, (B) the managed care organization shall determine who posts and
4343 maintains the security required under subparagraph (A) of this
4344 subdivision, and (C) in the event of insolvency or nonpayment, such
4345 security shall be used by the preferred provider network, or other
4346 entity designated by the commissioner, solely for the purpose of
4347 paying any outstanding amounts owed participating providers, except
4348 that any remaining security may be used for the purpose of
4349 reimbursing the managed care organization for any payments made by

4350 the managed care organization to participating providers on behalf of
4351 the preferred provider network;

4352 (8) A provision under which the managed care organization is
4353 permitted, at the discretion of the managed care organization, to pay
4354 participating providers directly and in lieu of the preferred provider
4355 network in the event of insolvency or mismanagement by the
4356 preferred provider network and that payments made pursuant to this
4357 subdivision may be made or reimbursed from the security posted
4358 pursuant to subsection (b) of this section;

4359 (9) A provision transferring and assigning contracts between the
4360 preferred provider network and participating providers to the
4361 managed care organization for the provision of future services by
4362 participating providers to enrollees, at the discretion of the managed
4363 care organization, in the event the preferred provider network (A)
4364 becomes insolvent, (B) otherwise ceases to conduct business, as
4365 determined by the commissioner, or (C) demonstrates a pattern of
4366 nonpayment of authorized claims, as determined by the commissioner,
4367 for a period in excess of ninety days;

4368 (10) A provision that each contract or agreement between the
4369 preferred provider network and participating providers shall include a
4370 provision transferring and assigning contracts between the preferred
4371 provider network and participating providers to the managed care
4372 organization for the provision of future health care services by
4373 participating providers to enrollees, at the discretion of the managed
4374 care organization, in the event the preferred provider network (A)
4375 becomes insolvent, (B) otherwise ceases to conduct business, as
4376 determined by the commissioner, or (C) demonstrates a pattern of
4377 nonpayment of authorized claims, as determined by the commissioner,
4378 for a period in excess of ninety days;

4379 (11) A provision that the preferred provider network shall pay for
4380 the delivery of health care services and operate or maintain
4381 arrangements or contracts with providers in a manner consistent with

4382 the provisions of law that apply to the managed care organization's
4383 contracts with enrollees and providers; and

4384 (12) A provision that the preferred provider network shall ensure
4385 that utilization review determinations are made in accordance with
4386 [sections 38a-226 to 38a-226d, inclusive, except that any initial appeal
4387 of a determination not to certify an admission, service, procedure or
4388 extension of stay shall be made in accordance with subdivision (7) of
4389 subsection (a) of section 38a-226c. In cases where an appeal to reverse a
4390 determination not to certify is unsuccessful, the preferred provider
4391 network shall refer the case to the managed care organization which
4392 shall conduct the subsequent appeal, if any, in accordance with said
4393 subdivision] section 57 of this act.

4394 Sec. 79. Section 38a-479ee of the general statutes is repealed and the
4395 following is substituted in lieu thereof (*Effective July 1, 2011*):

4396 (a) If the Insurance Commissioner determines that a preferred
4397 provider network or managed care organization, or both, has not
4398 complied with any applicable provision of this part [, sections 38a-226
4399 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
4400 amended by this act, the commissioner may (1) order the preferred
4401 provider network or managed care organization, or both if both have
4402 not complied, to cease and desist all operations in violation of this part
4403 or said sections; (2) terminate or suspend the preferred provider
4404 network's license; (3) institute a corrective action against the preferred
4405 provider network or managed care organization, or both if both have
4406 not complied; (4) order the payment of a civil penalty by the preferred
4407 provider network or managed care organization, or both if both have
4408 not complied, of not more than one thousand dollars for each and
4409 every act or violation; (5) order the payment of such reasonable
4410 expenses as may be necessary to compensate the commissioner in
4411 conjunction with any proceedings held to investigate or enforce
4412 violations of this part [, sections 38a-226 to 38a-226d, inclusive,] or
4413 sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6)
4414 use any of the commissioner's other enforcement powers to obtain

4415 compliance with this part [, sections 38a-226 to 38a-226d, inclusive,] or
4416 sections 38a-815 to 38a-819, inclusive, as amended by this act. The
4417 commissioner may hold a hearing concerning any matter governed by
4418 this part [, sections 38a-226 to 38a-226d, inclusive,] or sections 38a-815
4419 to 38a-819, inclusive, as amended by this act, in accordance with
4420 section 38a-16. Subject to the same confidentiality and liability
4421 protections set forth in subsections (c) and (k) of section 38a-14, the
4422 commissioner may engage the services of attorneys, appraisers,
4423 independent actuaries, independent certified public accountants or
4424 other professionals and specialists to assist the commissioner in
4425 conducting an investigation under this section, the cost of which shall
4426 be borne by the managed care organization or preferred provider
4427 network, or both, that is the subject of the investigation.

4428 (b) If a preferred provider network fails to comply with any
4429 applicable provision of this part [, sections 38a-226 to 38a-226d,
4430 inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended by this
4431 act, the commissioner may assign or require the preferred provider
4432 network to assign its rights and obligations under any contract with
4433 participating providers in order to ensure that covered benefits are
4434 provided.

4435 (c) The commissioner shall receive and investigate (1) any grievance
4436 filed against a preferred provider network or managed care
4437 organization, or both, by an enrollee or an enrollee's designee
4438 concerning matters governed by this part [, sections 38a-226 to 38a-
4439 226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended
4440 by this act, or (2) any referral from the Office of the Healthcare
4441 Advocate pursuant to section 38a-1041, as amended by this act. The
4442 commissioner shall code, track and review such grievances and
4443 referrals. The preferred provider network or managed care
4444 organization, or both, shall provide the commissioner with all
4445 information necessary for the commissioner to investigate such
4446 grievances and referrals. The information collected by the
4447 commissioner pursuant to this section shall be maintained as
4448 confidential and shall not be disclosed to any person except (A) to the

4449 extent necessary to carry out the purposes of this part [, sections 38a-
4450 226 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
4451 amended by this act, (B) as allowed under this title, (C) to the
4452 Healthcare Advocate, and (D) information concerning the nature of
4453 any grievance or referral and the commissioner's final determination
4454 shall be a public record, as defined in section 1-200, provided no
4455 personal information, as defined in section 38a-975, shall be disclosed.
4456 The commissioner shall report to the Healthcare Advocate on the
4457 resolution of any matter referred to the commissioner by the
4458 Healthcare Advocate.

4459 Sec. 80. Section 38a-479ff of the general statutes is repealed and the
4460 following is substituted in lieu thereof (*Effective July 1, 2011*):

4461 No health insurer, health care center, utilization review company, as
4462 defined in section [38a-226] 54 of this act, or preferred provider
4463 network, as defined in section 38a-479aa, as amended by this act, shall
4464 take or threaten to take any adverse personnel or coverage-related
4465 action against any enrollee, provider or employee in retaliation for
4466 such enrollee, provider or employee (1) filing a complaint with the
4467 Insurance Commissioner or the Office of the Healthcare Advocate, or
4468 (2) disclosing information to the Insurance Commissioner concerning
4469 any violation of this part [, sections 38a-226 to 38a-226d, inclusive,] or
4470 sections 38a-815 to 38a-819, inclusive, as amended by this act, unless
4471 such disclosure violates the provisions of chapter 705 or the privacy
4472 provisions of the federal Health Insurance Portability and
4473 Accountability Act of 1996, [(P.L. 104-191) (HIPAA)] P.L. 104-191, as
4474 amended from time to time, or regulations adopted thereunder. Any
4475 enrollee, provider or employee who is aggrieved by a violation of this
4476 section may bring a civil action in the Superior Court to recover
4477 damages and attorneys' fees and costs.

4478 Sec. 81. Section 38a-483c of the general statutes is repealed and the
4479 following is substituted in lieu thereof (*Effective July 1, 2011*):

4480 (a) Each individual health insurance policy delivered, issued for

4481 delivery, renewed, amended or continued in this state on or after
4482 January 1, 2000, shall define the extent to which it provides coverage
4483 for experimental treatments.

4484 (b) No such health insurance policy may deny a procedure,
4485 treatment or the use of any drug as experimental if such procedure,
4486 treatment or drug, for the illness or condition being treated, or for the
4487 diagnosis for which it is being prescribed, has successfully completed a
4488 phase III clinical trial of the federal Food and Drug Administration.

4489 (c) Any person who has been diagnosed with a condition that
4490 creates a life expectancy in that person of less than two years and who
4491 has been denied an otherwise covered procedure, treatment or drug on
4492 the grounds that it is experimental may request an expedited appeal as
4493 provided in section [38a-226c] 58 of this act and may appeal a denial
4494 thereof to the Insurance Commissioner in accordance with the
4495 procedures established in section [38a-478n] 60 of this act.

4496 [(d) For the purposes of conducting an appeal pursuant to section
4497 38a-478n on the grounds that an otherwise covered procedure,
4498 treatment or drug is experimental, the basis of such an appeal shall be
4499 the medical efficacy of such procedure, treatment or drug. The entity
4500 conducting the review may consider whether the procedure, treatment
4501 or drug (1) has been approved by the National Institute of Health or
4502 the American Medical Association, (2) is listed in the United States
4503 Pharmacopoeia Drug Information Guide for Health Care Professionals
4504 (USP-DI), the American Medical Association Drug Evaluations (AMA-
4505 DE), or the American Society of Hospital Pharmacists' American
4506 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
4507 currently in a phase III clinical trial of the federal Food and Drug
4508 Administration.]

4509 Sec. 82. Section 38a-513b of the general statutes is repealed and the
4510 following is substituted in lieu thereof (*Effective July 1, 2011*):

4511 (a) Each group health insurance policy delivered, issued for
4512 delivery, renewed, amended or continued in this state on or after

4513 January 1, 2000, shall define the extent to which it provides coverage
4514 for experimental treatments.

4515 (b) No such health insurance policy may deny a procedure,
4516 treatment or the use of any drug as experimental if such procedure,
4517 treatment or drug, for the illness or condition being treated, or for the
4518 diagnosis for which it is being prescribed, has successfully completed a
4519 phase III clinical trial of the federal Food and Drug Administration.

4520 (c) Any person who has been diagnosed with a condition that
4521 creates a life expectancy in that person of less than two years and who
4522 has been denied an otherwise covered procedure, treatment or drug on
4523 the grounds that it is experimental may request an expedited appeal as
4524 provided in section [38a-226c] 58 of this act and may appeal a denial
4525 thereof to the Insurance Commissioner in accordance with the
4526 procedures established in section [38a-478n] 60 of this act.

4527 [(d) For the purposes of conducting an appeal pursuant to section
4528 38a-478n on the grounds that an otherwise covered procedure,
4529 treatment or drug is experimental, the basis of such an appeal shall be
4530 the medical efficacy of such procedure, treatment or drug. The entity
4531 conducting the review may consider whether the procedure, treatment
4532 or drug (1) has been approved by the National Institute of Health or
4533 the American Medical Association, (2) is listed in the United States
4534 Pharmacopoeia Drug Information Guide for Health Care Professionals
4535 (USP-DI), the American Medical Association Drug Evaluations (AMA-
4536 DE), or the American Society of Hospital Pharmacists' American
4537 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
4538 currently in a phase III clinical trial of the federal Food and Drug
4539 Administration.]

4540 Sec. 83. Subsection (c) of section 38a-504f of the general statutes is
4541 repealed and the following is substituted in lieu thereof (*Effective July*
4542 *1, 2011*):

4543 (c) The insured, or the provider with the insured's written consent,
4544 may appeal any denial of coverage for medical necessity to an external,

4545 independent review pursuant to section [38a-478n] 60 of this act. Such
4546 external review shall be conducted by a properly qualified review
4547 agent whom the department has determined does not have a conflict
4548 of interest regarding the cancer clinical trial.

4549 Sec. 84. Subsection (c) of section 38a-542f of the general statutes is
4550 repealed and the following is substituted in lieu thereof (*Effective July*
4551 *1, 2011*):

4552 (c) The insured, or the provider with the insured's written consent,
4553 may appeal any denial of coverage for medical necessity to an external,
4554 independent review pursuant to section [38a-478n] 60 of this act. Such
4555 external review shall be conducted by a properly qualified review
4556 agent whom the department has determined does not have a conflict
4557 of interest regarding the cancer clinical trial.

4558 Sec. 85. Subdivision (22) of section 38a-816 of the general statutes is
4559 repealed and the following is substituted in lieu thereof (*Effective July*
4560 *1, 2011*):

4561 (22) Any violation of [section 38a-478m] sections 57 to 59, inclusive,
4562 of this act.

4563 Sec. 86. Subdivision (3) of section 38a-1040 of the general statutes is
4564 repealed and the following is substituted in lieu thereof (*Effective July*
4565 *1, 2011*):

4566 (3) "Managed care plan" means a product offered by a managed care
4567 organization that provides for the financing or delivery of health care
4568 services to persons enrolled in the plan through: (A) Arrangements
4569 with selected providers to furnish health care services; (B) explicit
4570 standards for the selection of participating providers; (C) financial
4571 incentives for enrollees to use the participating providers and
4572 procedures provided for by the plan; or (D) arrangements that share
4573 risks with providers, provided the organization offering a plan
4574 described under subparagraph (A), (B), (C) or (D) of this subdivision is
4575 licensed by the Insurance Department pursuant to chapter 698, 698a or

4576 700 and that the plan includes utilization review, [pursuant to sections
4577 38a-226 to 38a-226d, inclusive] as defined in section 54 of this act.

4578 Sec. 87. Subsections (b) and (c) of section 38a-1041 of the general
4579 statutes are repealed and the following is substituted in lieu thereof
4580 (*Effective July 1, 2011*):

4581 (b) The Office of the Healthcare Advocate may:

4582 (1) Assist health insurance consumers with managed care plan
4583 selection by providing information, referral and assistance to
4584 individuals about means of obtaining health insurance coverage and
4585 services;

4586 (2) Assist health insurance consumers to understand their rights and
4587 responsibilities under managed care plans;

4588 (3) Provide information to the public, agencies, legislators and
4589 others regarding problems and concerns of health insurance
4590 consumers and make recommendations for resolving those problems
4591 and concerns;

4592 (4) Assist consumers with the filing of complaints and appeals,
4593 including filing appeals with a managed care organization's internal
4594 appeal or grievance process and the external appeal process
4595 established under [section 38a-478n] sections 57 to 60, inclusive, of this
4596 act;

4597 (5) Analyze and monitor the development and implementation of
4598 federal, state and local laws, regulations and policies relating to health
4599 insurance consumers and recommend changes it deems necessary;

4600 (6) Facilitate public comment on laws, regulations and policies,
4601 including policies and actions of health insurers;

4602 (7) Ensure that health insurance consumers have timely access to the
4603 services provided by the office;

4604 (8) Review the health insurance records of a consumer who has
4605 provided written consent for such review;

4606 (9) Create and make available to employers a notice, suitable for
4607 posting in the workplace, concerning the services that the Healthcare
4608 Advocate provides;

4609 (10) Establish a toll-free number, or any other free calling option, to
4610 allow customer access to the services provided by the Healthcare
4611 Advocate;

4612 (11) Pursue administrative remedies on behalf of and with the
4613 consent of any health insurance consumers;

4614 (12) Adopt regulations, pursuant to chapter 54, to carry out the
4615 provisions of sections 38a-1040 to 38a-1050, inclusive, as amended by
4616 this act; and

4617 (13) Take any other actions necessary to fulfill the purposes of
4618 sections 38a-1040 to 38a-1050, inclusive, as amended by this act.

4619 (c) The Office of the Healthcare Advocate shall make a referral to
4620 the Insurance Commissioner if the Healthcare Advocate finds that a
4621 preferred provider network may have engaged in a pattern or practice
4622 that may be in violation of sections [38a-226 to 38a-226d, inclusive,]
4623 38a-479aa to 38a-479gg, inclusive, as amended by this act, or 38a-815 to
4624 38a-819, inclusive, as amended by this act.

4625 Sec. 88. (*Effective July 1, 2011*) Notwithstanding the provisions of
4626 sections 38a-183, 38a-481 and 38a-513 of the general statutes, a health
4627 carrier, as defined in section 1 of this act, shall certify to the Insurance
4628 Commissioner, in a form and manner prescribed by said
4629 commissioner, that any forms or endorsements relating to utilization
4630 review, the health carrier's internal grievance process, external review
4631 or expedited external review that are filed by such health carrier
4632 pursuant to section 38a-183, 38a-481 or 38a-513 of the general statutes
4633 for use on or after July 1, 2011, are in compliance with sections 54 to 66,

4634 inclusive, of this act and the Patient Protection and Affordable Care
 4635 Act, P.L. 111-148, as amended from time to time, and any regulations
 4636 adopted thereunder. Upon receipt by said commissioner of such filing
 4637 and certification, the health carrier may use such forms or
 4638 endorsements until such time as said commissioner, after notice and
 4639 hearing, disapproves their use. A health carrier may use the
 4640 certification procedure as set forth in this section until June 30, 2012.

4641 Sec. 89. Sections 38a-226 to 38a-226d, inclusive, 38a-478m, 38a-478n
 4642 and 38a-478p of the general statutes are repealed. (*Effective July 1, 2011*)

4643 Sec. 90. Sections 19a-710 to 19a-723, inclusive, of the general statutes
 4644 are repealed. (*Effective September 1, 2011*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2011</i>	New section
Sec. 2	<i>July 1, 2011</i>	New section
Sec. 3	<i>July 1, 2011</i>	New section
Sec. 4	<i>July 1, 2011</i>	New section
Sec. 5	<i>July 1, 2011</i>	New section
Sec. 6	<i>July 1, 2011</i>	New section
Sec. 7	<i>July 1, 2011</i>	New section
Sec. 8	<i>from passage</i>	New section
Sec. 9	<i>July 1, 2011</i>	New section
Sec. 10	<i>July 1, 2011</i>	38a-513f
Sec. 11	<i>from passage</i>	New section
Sec. 12	<i>July 1, 2011</i>	19a-654
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>from passage</i>	New section
Sec. 15	<i>January 1, 2012</i>	38a-816(15)(B)
Sec. 16	<i>January 1, 2012</i>	38a-479b
Sec. 17	<i>January 1, 2012</i>	New section
Sec. 18	<i>January 1, 2012</i>	New section
Sec. 19	<i>January 1, 2012</i>	New section
Sec. 20	<i>October 1, 2011</i>	New section
Sec. 21	<i>October 1, 2011</i>	New section
Sec. 22	<i>October 1, 2011</i>	New section

Sec. 23	<i>October 1, 2011</i>	New section
Sec. 24	<i>October 1, 2011</i>	New section
Sec. 25	<i>October 1, 2011</i>	New section
Sec. 26	<i>October 1, 2011</i>	New section
Sec. 27	<i>October 1, 2011</i>	New section
Sec. 28	<i>October 1, 2011</i>	New section
Sec. 29	<i>October 1, 2011</i>	New section
Sec. 30	<i>October 1, 2011</i>	New section
Sec. 31	<i>October 1, 2011</i>	New section
Sec. 32	<i>October 1, 2011</i>	New section
Sec. 33	<i>October 1, 2011</i>	New section
Sec. 34	<i>October 1, 2011</i>	New section
Sec. 35	<i>October 1, 2011</i>	38a-15(a)
Sec. 36	<i>October 1, 2011</i>	38a-11(a)
Sec. 37	<i>from passage</i>	38a-497
Sec. 38	<i>from passage</i>	New section
Sec. 39	<i>from passage</i>	5-259(a)
Sec. 40	<i>from passage</i>	5-259(f)
Sec. 41	<i>from passage</i>	38a-476(b)
Sec. 42	<i>from passage</i>	New section
Sec. 43	<i>from passage</i>	New section
Sec. 44	<i>from passage</i>	New section
Sec. 45	<i>from passage</i>	38a-546
Sec. 46	<i>from passage</i>	38a-564(17)
Sec. 47	<i>from passage</i>	38a-477b(b)
Sec. 48	<i>from passage</i>	38a-567(1)(D)
Sec. 49	<i>January 1, 2012</i>	38a-478l(b)
Sec. 50	<i>January 1, 2012</i>	38a-477c
Sec. 51	<i>January 1, 2012</i>	38a-478c
Sec. 52	<i>January 1, 2012</i>	38a-478g(b)
Sec. 53	<i>from passage</i>	New section
Sec. 54	<i>July 1, 2011</i>	New section
Sec. 55	<i>July 1, 2011</i>	New section
Sec. 56	<i>July 1, 2011</i>	New section
Sec. 57	<i>July 1, 2011</i>	New section
Sec. 58	<i>July 1, 2011</i>	New section
Sec. 59	<i>July 1, 2011</i>	New section
Sec. 60	<i>July 1, 2011</i>	New section
Sec. 61	<i>July 1, 2011</i>	New section
Sec. 62	<i>July 1, 2011</i>	New section

Sec. 63	<i>July 1, 2011</i>	New section
Sec. 64	<i>July 1, 2011</i>	New section
Sec. 65	<i>July 1, 2011</i>	New section
Sec. 66	<i>July 1, 2011</i>	New section
Sec. 67	<i>July 1, 2011</i>	38a-478
Sec. 68	<i>July 1, 2011</i>	38a-19(c)
Sec. 69	<i>July 1, 2011</i>	38a-477b(b)
Sec. 70	<i>July 1, 2011</i>	38a-478a
Sec. 71	<i>July 1, 2011</i>	38a-478b
Sec. 72	<i>July 1, 2011</i>	38a-478h
Sec. 73	<i>July 1, 2011</i>	38a-478r(d)
Sec. 74	<i>July 1, 2011</i>	38a-478s
Sec. 75	<i>July 1, 2011</i>	38a-478t
Sec. 76	<i>July 1, 2011</i>	38a-478u
Sec. 77	<i>July 1, 2011</i>	38a-479aa
Sec. 78	<i>July 1, 2011</i>	38a-479bb(d)
Sec. 79	<i>July 1, 2011</i>	38a-479ee
Sec. 80	<i>July 1, 2011</i>	38a-479ff
Sec. 81	<i>July 1, 2011</i>	38a-483c
Sec. 82	<i>July 1, 2011</i>	38a-513b
Sec. 83	<i>July 1, 2011</i>	38a-504f(c)
Sec. 84	<i>July 1, 2011</i>	38a-542f(c)
Sec. 85	<i>July 1, 2011</i>	38a-816(22)
Sec. 86	<i>July 1, 2011</i>	38a-1040(3)
Sec. 87	<i>July 1, 2011</i>	38a-1041(b) and (c)
Sec. 88	<i>July 1, 2011</i>	New section
Sec. 89	<i>July 1, 2011</i>	Repealer section
Sec. 90	<i>September 1, 2011</i>	Repealer section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: See Below

Municipal Impact: See Below

Explanation

Sections 1 through 8 of the bill require the Comptroller, beginning January 1, 2012, to establish the "partnership plan". The Comptroller is required to offer coverage under the partnership plan to 1) non-profit employers, their employees and retirees¹ and 2) nonstate public employers, their employees and retirees². The Comptroller may establish the partnership plan on a fully insured or risk-pooled basis, which may include pooling the partnership plan with the state employee and retiree health plan. The State Employee Bargaining Agent Coalition (SEBAC), the Health Care Cost Containment Committee, and the Secretary of the Office of Policy and Management would need to approve pooling the partnership plan with the state employee plan and any changes made to the state employee and retiree health plan as a result of the bill's provisions.

Participation would be voluntary, with a two year minimum term. The plan would open enrollment to nonstate public employers beginning July 1, 2012 and to nonprofit employers on January 1, 2013.

The following table provides information on the potential

¹ In order to be eligible, non-profit employers must have a purchase of service contract with a state agency or receives 50% or more of its gross annual revenue from grants or funding from the state, federal government, municipality or a combination thereof.

² Nonstate public employers include a municipality, boards of education, quasi-public agencies or public libraries.

populations eligible to enroll in the partnership plan:

	Estimated Population ³
Non-State Public Employer Pool ⁽¹⁾	577,949
Nonprofit Employer Pool ⁽²⁾	174,342

Source: The Dept. of Labor

The partnership plan may result in a fiscal impact to the state and the state employee health plan as a result of the following factors: 1) the impact to the existing pool, 2) actuarial costs, 3) additional staff, and 4) loss of revenue.

Impact to the Existing Pool

If the partnership plan is pooled with the state employee and retiree health plan there may be a cost to the state employee and retiree health plan. The current cost of the state employee and retiree health plan is based on the demographics and claims experience of the existing pool. To the extent that additional lives affect the claims loss ratio, the cost of the state employee and retiree health plan would be directly impacted. The bill proposes immediate acceptance of any employer group that applies in its entirety for coverage. Partial groups applying for coverage are to be reviewed by a health care actuary. If it is determined that the partial group would adversely affect the state pool, the group shall be denied coverage. In so doing, the provisions seek to address a potentially negative impact to the state employee pool by preventing an employer from shifting a significantly disproportionate share of its medical risk to the state employee plan. If the partnership plan were established as a separate, fully-insured plan, there would be no impact on the existing pool.

As of July 1, 2010, the state employee health plan converted from fully insured to self-insured and now pays the total cost of claims on

³ (1) Figures include dependents and retirees. (2) Figures do not include dependents or retirees, for which information is unavailable.

an incurred basis. Therefore, a monthly premium equivalent is estimated based on the anticipated annual claims. The state employee plan would incur a cost or savings to the extent that actual claims costs are more or less than the premium equivalent being charged to employers.

The state spent approximately \$1.1 billion in FY 10 on state employee and retiree health costs. Based on the FY 12 estimated requirements a 1% change in claims cost would equal approximately \$12.4 million dollars; a 5% change in claims costs would equal approximately \$62.1 million dollars. The Plan currently covers 202,157 lives.

It should be noted that the state does not currently have stop loss insurance or a reserve. Any additional costs may be mitigated by the fluctuating reserve fee that the Comptroller has the option to charge employers as explained below.

Actuarial Costs

The Comptroller may incur actuarial costs irrespective of whether the partnership plan is established on a fully-insured or risk-pooled basis. As previously discussed, the bill requires the Comptroller to permit enrollment for those employers who choose to enroll their entire workforce in the partnership plan. In the event the employer chooses to enroll only a portion of its workforce the Comptroller is required to forward the application to a health care actuary. In addition, the Comptroller must work with a healthcare actuary to:

- 1) establish actuarial standards to assess:
 - a) the shift in medical risk
 - b) administrative fees
 - c) fluctuating reserve fees, and

2) establish premiums or premium equivalents

To the extent that the premiums and fees established by the Comptroller in consultation with the actuary are insufficient to cover the costs of the partnership plan, the state may be liable for any additional costs.

It is assumed that the cost of actuarial services would be passed through to the employers; however to the extent they are not fully charged to participating employers there may be a cost to the state. The Comptroller spent approximately \$900,000 in FY 10 on actuarial services.

Additional Staff

The Comptroller may need two additional Retirement and Benefits Officers. The necessity of additional staff would depend on the degree to which eligible employers chose to enroll their employees and retirees in the partnership plan. The annual salaries and fringe benefits associated with two additional positions is \$185,117. P.A. 11-6 (the biennial budget) included \$185,117 and two positions in FY 12 and FY 13 for this provision.

Loss of Revenue

Pursuant to CGS Sec. 12-202 nonstate public employers currently offering health coverage through private health insurers are required to pay an Insurance Premium Tax to the state of 1.75% per contract or policy.⁴ To the degree that the bill results in non-state public employers shifting their participation in fully-insured health plans to the state employee health plan, the state would experience a revenue loss from the Insurance Premiums Tax (policies written on behalf of

⁴ The state currently collects approximately \$8 million a year from the premium tax on health insurance policies procured by municipalities.

the state and MEHIP are not subject to this tax).⁵

Impact on Nonstate Public Employers

There may be a cost or a savings to nonstate public employers from joining the partnership plan. Potential costs or savings would be related to: 1) premiums, 2) administrative and fluctuating reserve fees and 4) the Insurance Premiums Tax. It is unlikely that any employers whose current premiums and administrative costs are lower than the premiums of the partnership plan would choose to join.

Premiums

Employers would be required to pay monthly premiums to the Comptroller. The Comptroller will establish premiums with the assistance of an actuary. The bill maintains, it would be up to the employer to determine cost sharing provisions with employees, pursuant to their current practice.

As a point of reference, the state employee and retiree health plan, total annual premiums range from \$5,320 to \$9,928 for individual coverage and \$14,364 to \$26,807 for family coverage. Municipal employers in the state, on average, cover approximately 90% of the premium for individual coverage and 87% for family coverage.⁶ Under the state employee plan this would equate an employer's cost of \$4,788 to \$8,935 for each employee enrolled in an individual plan, and \$12,497 to \$23,322 for each employee enrolled in a family plan.

As previously stated, the premium related costs to municipalities under the partnership plan will be established by the Comptroller. For employers who choose to enroll in the partnership plan, there would

⁵ Current law exempts new or renewed contracts or policies written to provide coverage to municipal employees under a plan procured pursuant to CGS 5-259(i) from the premiums tax. Therefore, MEHIP participants are currently exempt from the premiums tax. As a result, there would not be a loss to the premiums tax should MEHIP participating non-state public employers shift coverage to the state employee health plan.

⁶ CT Public Sector Healthcare Cost & Benefit Survey, 2009.

be a cost to municipalities if the cost of premiums is more than what they are currently paying and a savings if the cost were less.

For illustrative purposes, the table below provides a comparison of current average annual premium rates within various public and private sectors.

		Average Annual Premium Rates			
	Employer	Single Coverage	Employee Share	Family Coverage	Employee Share
National*	Small Firms	\$5,169	15%	\$13,735	32%
	Large Firms	\$5,104	19%	\$14,161	25%
Regional*					
	Northeast	\$5,252	19%	\$14,117	24%
State+	State of Connecticut	\$7,009	7%	\$18,925	14%
	CT Cities & Towns	\$8,000	10%	\$21,300	10%
Local**	CT Boards of Education	\$8,000	13%	\$21,300	13%

*National and Regional PPO plan data obtained from 2010 Employer Health Benefit Survey. + State POE health plan data obtained from Office of the State Comptroller. ** Local data obtained from CT Public Sector Healthcare Cost & Benefit Survey 2009.

In addition, the Municipal Employer Health Insurance Plan (MEHIP) currently provides health insurance for groups that are similar to those served by the partnership plan. Annual premiums range from \$3,300 to \$10,956 for individual coverage and \$23,232 to \$45,564 for family coverage.

Fees and the Insurance Premium Tax

The bill allows the Comptroller to charge participating employers a per member per month administrative fee and a fluctuating reserve fee in addition to premiums. The amount of the administrative fee would be determined by the Comptroller in consultation with the actuary. There may be a savings to nonstate public employers if the administrative fees under the plan are less than what they are

currently paying. Employers may be able to achieve administrative economies of scale from joining the partnership plan.

In addition, the Comptroller may charge a fluctuating reserves fee in an amount necessary to ensure adequate claims reserves. It is common practice to establish a reserve consisting of approximately two months' worth of anticipated claims costs. These reserve costs could range from approximately \$85-\$313 per member per month.

Fully insured municipalities who currently offer health coverage through a private health insurer will save from not having to pay the Insurance Premiums Tax.

Lastly, municipalities are already permitted to join the state prescription drug plan, there are no additional bulk purchasing savings associated with the bill that cannot already be achieved.

Section 9 requires, as of July 1, 2011, all fully insured municipalities, school districts, and special taxing districts with fifty or more employees to report annually to the Comptroller information on their health insurance plans. The information is limited to the percentage increase or decrease in the policy or plan costs for the two preceding policy years. This is not anticipated to result in a fiscal impact to the state or municipalities.

Section 10 requires an insurer to provide the health plan information to insured municipalities, school districts, special taxing districts free of charge. Municipalities may provide this information to the Comptroller. This may result in a savings to municipalities who currently pay a fee for this information.

Section 11 convenes a working group and requires the Office of Health Reform and Innovation to submit to report to the General Assemble. The provisions of this section do not result in a fiscal impact

Section 12 does not result in a fiscal impact to the state in FY 12 and FY 13. Nonetheless, it will result in a potential cost to the Office of

Health Care Access (OHCA, a division of the Department of Public Health) of approximately \$100,000 in subsequent years, as it requires outpatient surgical centers to submit patient data to OCHA, as it deems necessary, by 7/1/15. The bill specifies that the Department of Public Health (DPH) implement the provisions of this section within available appropriations. If the bill were to be implemented, however, costs of \$100,000 may be incurred related to the purchase of a server, software, and one database administrator (with fringe benefits) to oversee the collection, analysis, and electronic housing of patient data for approximately 200,000 outpatient surgeries annually⁷. Currently, OCHA collects and processes data from acute care and children's hospitals. Patient records from outpatient surgical facilities are not collected and processed.

There is no cost to DPH to convene a working group by 2/1/12 to address obstacles to patient-identifiable data reporting in the outpatient setting.

Section 13 establishes the Office of Healthcare Reform and Innovation within the Office of the Lieutenant Governor. PA 11-6 provides funding of \$250,000 in both FY 12 and FY 13 for three positions to staff this new office.

Section 14 establishes the Sustinet Health Care Cabinet for the purpose of advising the Governor and the Office of Health Reform and Innovation. There is no fiscal impact associated with this provision.

Sections 15 through 19 require the Department of Insurance (DOI) to develop procedures by which an insurer develops and maintains provider networks. This provision is not anticipated to result in a fiscal impact.

However, should the establishment of such procedures be

⁷ There are approximately 181,000 hospital outpatient surgeries each year. It is unknown how many non-hospital surgeries occur annually. An additional 19,000 are assumed.

interpreted to require DOI to oversee and regulate the implementation of such procedures, a cost may result as this function is outside the current responsibilities of the department. The scope of this potential oversight is not known. For purposes of example, should DOI have to hire one additional principal examiner, the cost and fringe benefits would be approximately \$125,000 annually.

Sections 20 through 36 require third-party administrators (TPA) to be licensed by the Insurance Department, file audited financial statements, submit to examination by the department, and pay application and annual fees. These changes result in a General Fund revenue gain of \$60,000 in FY 12 and \$66,000 in FY 13 through the Department of Insurance's (DOI's) collection of fees related to the licensing of third-party administrators (TPAs).

Under the bill, the initial license fee for TPAs would be \$500, the renewal fee would be \$350, and there would be an annual report filing fee of \$100. It is estimated that 100 TPAs would seek initial licenses and file annual reports in FY 12. In FY 13, it is estimated that 35 TPAs would seek initial licensing (\$17,500), along with 100 renewals (\$35,000), for a total of 135 TPAs licensed in the state and filing annual reports (\$13,500).

There is no fiscal impact to DOI for the licensing of TPAs as this task will be undertaken by DOI's Consumer Services Division. Likewise, it is anticipated that there would be no fiscal impact to that division for the handling of complaints related to TPAs, nor to the Market Conduct Division.

The bill's provisions will increase costs to municipalities who participate in the Municipal Employee Health Insurance Program (MEHIP). The bill's provisions increase administrative requirements and associated costs, of the Third Party Administrator (TPA) who currently provides support for the MEHIP, which are outside of the current contract. All MEHIP operating costs are the responsibility of the participants, and are recovered through MEHIP premium rates.

Participating municipalities will see a rate increase when a new contract is entered into after October 1, 2011. The magnitude of the rate increase would be contingent on the increased cost of the TPA contract.

Sections 37 through 53 make numerous changes which conform statute to federal requirements necessary for federal health care reform.

Sections 54 through 88 alter the utilization review, grievances and external appeals processes for health carriers. These changes will result in a revenue loss of \$81,500 annually to the Utilization Review Fund, a separate, non-lapsing account. This revenue loss is attributable to a reduction in licensing fees (27 licenses at \$2,500 annually) as the Insurance Department would no longer be responsible for the licensing of certain entities. This loss is partially offset by a fee increase to \$3,000 for certain remaining licensed entities.

The bill will also result in a savings to the Utilization Review Fund of approximately \$150,000 annually related to payments for reviews by independent review entities (200 reviews annually at an average cost of \$750). Under the bill, insurers would pay the cost of these reviews directly. However, these savings are partially offset by anticipated costs of \$50,000 for medical consultants necessary to assist the consumer affairs and market unit of the Department of Insurance.

Sections 89 and 90 repeal sections of the general statute to conform to the changes noted above.

House "A" struck the underlying bill in its entirety and made the changes identified herein which results in the fiscal impact explained above.

House "D" made two changes. First, subsection (d) of section 4 was changed in order for the provision of the subsection to apply to sections 1 to 14 of the bill, which does not result in a fiscal impact. Secondly, a new provision was added to section 11, requiring the

Office of Health Care Reform and Innovation to submit a report to the General Assembly, which does not result in a fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation. Pension-related costs for the identified potential additional personnel will be recognized in the state's annual required pension contribution as of FY 14.

OLR Bill Analysis**sHB 6308 (as amended by House "A" and "D")******AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP.*****SUMMARY:**

This bill:

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;
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;
3. allows employers to give certain claims data they request from health insurers to the comptroller upon his request and requires the information be kept confidential;
4. establishes the (a) Office of Health Reform and Innovation (OHRI) and (b) Sustinet Health Care Cabinet in the lieutenant governor's office;
5. requires OHRI to convene a working group concerning a statewide multipayer data initiative;
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;
7. makes a variety of changes in the laws relating to contracts between health care providers and health insurers;
 8. requires the Insurance Department to license and regulate third-party administrators (TPA);
 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; and
 10. revises the health insurance utilization review, grievance, and external appeal statutes to comply with the PPACA.

*House Amendment "A" replaces the original file (File 483), which established the Connecticut Healthcare Partnership.

*House Amendment "D" (1) adds a reporting requirement concerning OHRI's multipayer data initiative plan and (2) specifies that Sections one to 14 of House Amendment "A" do not diminish any right to retiree health insurance under a collective bargaining agreement or state law.

EFFECTIVE DATE: Various, see below.

§ 1 — DEFINITIONS

The bill 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 bill.

EFFECTIVE DATE: July 1, 2011

§ 2 — PARTNERSHIP PLANS

The bill requires the comptroller to offer coverage under a partnership plan to certain employer groups that submit an application that is approved under the bill’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 bill 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 bill requires the comptroller to develop procedures for an

employer group to (1) apply to participate in the plan, including procedures for self-insured nonstate public employers and for those that are fully insured; (2) apply for renewal; and (3) withdraw from participation. The procedures must include the terms and conditions under which a group can withdraw before the benefit period ends and 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.

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

Open Enrollment

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

Application Form

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

Taft-Hartley Exception

The bill 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 bill authorizes 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill, 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 bill 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 bill does not specify this.)

Exceptions to Actuarial Review

The bill prohibits the comptroller from forwarding to the actuary an application that proposes to cover fewer than all employees because (1) the employer will not cover temporary, part-time, or durational employees or (2) individual employees decline coverage.

Regulations Regarding Actuarial Review

The bill 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 bill states that Sections one to 14 do not diminish any right to retiree health insurance under a collective bargaining agreement or state law.

The bill 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 bill 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 bill requires an employer to pay premiums to the comptroller monthly 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill 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 bill establishes a separate, nonlapsing Partnership Plan Premium Account within 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 bill 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 under 100,000 people, and (3) one with fewer than 20,000 people. The comptroller appoints the committee members. The bill does not designate who serves as chairperson or how the chairperson is selected.

Nonprofit Health Care Advisory Committee

The bill 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. The bill does not designate who serves as chairperson or how the chairperson is selected.

EFFECTIVE DATE: July 1, 2011

§ 7 — REGULATIONS

The bill authorizes the comptroller to adopt regulations to implement and administer the partnership plans. It allows the comptroller to implement policies and procedures to administer the

plans while in the process of adopting them in regulation. 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 bill prohibits the comptroller from offering coverage under the partnership plan until (1) the HCCC provides the comptroller written approval of the bill's provisions and (2) State Employees Bargaining Agents Coalition (SEBAC) provides the House and Senate clerks written consent to incorporate the bill'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 take action within 30 days, the agreement is deemed approved (CGS § 5-278(b)).)

It specifies that nothing in the bill's 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 bill 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 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 bill, the covered employers are towns, cities, boroughs, school districts, taxing districts, 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, upon the request of an employer 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 bill 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 employees wellness initiatives and (2) is confidential and not subject to disclosure under the Freedom of Information Act (FOIA). The bill 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. The law requires OHCA to keep confidential individual patient and billing data, but permits it to disclose aggregate reports from which individual patient and physician data cannot be identified.

The bill 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 and bills.

Outpatient Data

The bill 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 data: (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 bill 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.

Additional outpatient data reporting the office deems necessary must begin by July 1, 2015. On or before 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 bill specifies that DPH cannot assess penalties for failing to submit the data.

Data Confidentiality

Under the bill, patient-identifiable data OHCA receives must be kept confidential and is not considered public records or files subject to disclosure under FOIA. OHCA may release de-identified patient data or aggregate patient data to the public in a manner consistent with the federal Health Insurance Portability and Accountability Act's (HIPAA) privacy provisions. The bill 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. It 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 nongovernmental entity.

The bill requires OCHA, 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.

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 CARE REFORM AND INNOVATION

The bill 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 ongoing 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 Affordable Care Act;
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 bill (see § 14) and convene a consumer advisory board with at least seven members.

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 bill directs state agencies to use their best efforts to provide assistance to 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 bill, 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 bill 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 for three years, (c) one representing insurance producers serving for three years, and (d) one at-large appointment and serving for three years;
2. one appointed by the Senate president pro tempore who is an oral health specialist engaged in active practice serving for four years;

3. one appointed by the Senate majority leader, representing labor and serving for three years;
4. one appointed by the Senate minority leader who is an advanced practice registered nurse engaged in active practice and serving for two years;
5. one consumer advocate appointed by the House speaker serving for four years;
6. one appointed by the House majority leader who is a primary care physician engaged in active practice serving for four years;
7. one appointed by the House minority leader representing the health information technology industry and serving for 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 and 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 and must hold its first meeting by September 1, 2011.

Cabinet Duties

The cabinet must advise the governor and OHRI on the development of 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. (a) develop a business plan for the governor and OHRI that takes into account the OHRI feasibility and risk assessments

undertaken (see § 13) and evaluates private or public mechanisms that will provide adequate health insurance products beginning on January 1, 2014, including for-and non-profit organizations, insurance cooperatives, and self-insurance and (b) submit appropriate implementation recommendations for the governor's consideration.

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 the development and implementation of 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

Current law requires health insurers to pay claims within 45 days of receiving them. The bill 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 bill requires insurers to pay paper claims within 60 days of receiving them. As under current 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 bill 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

As under existing 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 bill permits a contracting health organization (e.g., insurer or HMO) to 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 provider may decline to participate in the new insurance product by giving the contracting health organization notice of at least 30 days or the notice period set in the provider's contract.

EFFECTIVE DATE: January 1, 2012

§ 17 — PROVIDER NETWORK ADEQUACY

The bill 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 bill 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 bill 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.

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.

EFFECTIVE DATE: January 1, 2012

§ 19 — DENTIST CHARGES

Under the bill, 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 bill prohibits a dentist from charging more than his or her usual and customary rate for such noncovered services or procedures.

The bill 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 bill 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 — DEFINITIONS

Third-Party Administrator

With certain exceptions, a 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 bill 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, whose activities are limited exclusively to selling insurance;
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 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 exclusively 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 bill 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 bill 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

The bill 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 bill prohibits a person (including an entity) from offering to act as a TPA in Connecticut unless licensed or exempt from licensure under the bill. 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 bill 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.)

Entities that are exempt from TPA licensure but that perform similar services must annually register 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 bill'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 bill 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 bill, 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 is authorized to administer;

3. a requirement that the TPA render an accounting, on an agreed frequency, detailing all transactions it performs pertaining to the insurer's 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 bill 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 bill specifies that it does not limit an insurer's rights to bring suit against the TPA resulting from the TPA's 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 bill 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 bill, 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 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 bill does not prohibit the commissioner from releasing final, adjudicated actions, including TPA licenses terminated, 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 bill requires a TPA who advertises on an insurer's behalf to use only advertising that the insurer approves, in writing, before its use. 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 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, at least semiannually, conduct a review of the TPA's operations. At least one such review must be an on-site audit.

EFFECTIVE DATE: October 1, 2011

§ 26 — FIDUCIARY CAPACITY

The bill 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 bill 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 bill 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 bill 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 bill 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 bill 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.

The bill specifies that 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

§ 28 — NOTICE AND DISCLOSURE

The bill 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 policyholder and insurer.

The bill 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 bill 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 bill 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 bill 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 bill 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.

The application must include or be accompanied by the following information 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. an 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 capability for providing 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 bill requires a TPA applying for a license to make available 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 bill'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 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 bill 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 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 bill requires the commissioner to review each TPA's most recently filed annual report by September 1. After its 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 bill 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:

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 bill 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 bill authorizes the insurance commissioner to adopt implementing regulations.

EFFECTIVE DATE: October 1, 2011

§ 35 — MARKET CONDUCT EXAMINATION

The bill 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 bill 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 TO AGE 26

Under the federal PPACA, children may stay on a parent’s health insurance plan until age 26. The bill revises various insurance statutes to comply with this requirement. Current state law restricts a child’s coverage based on his or her marriage or residency status.

EFFECTIVE DATE: Upon passage

§§ 41 & 46 — PREEXISTING CONDITIONS

Under the federal PPACA, insurers cannot impose a preexisting condition limitation that excludes coverage for children under age 19. The bill revises various insurance statutes to comply with this requirement.

The bill specifies that no insurer can refuse to issue an individual health insurance plan or arrangement to children under age 19 solely on the basis that he or she has a preexisting condition.

EFFECTIVE DATE: Upon passage

§§ 42 & 43 — LIFETIME LIMITS

Under the federal PPACA, health benefit plans cannot impose lifetime limits on the dollar value of essential health benefits, to be defined by HHS. To conform to the federal requirement, the bill 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 the PPACA and related regulations.

EFFECTIVE DATE: Upon passage

§§ 44 & 45 — CONTINUATION OF COVERAGE

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

EFFECTIVE DATE: Upon passage

§§ 47 & 48 — RESCISSIONS

The federal 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 bill 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 notification 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 bill 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 the 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, versus 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 bill requires that both the state and federal medical loss ratios be disclosed.

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

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

EFFECTIVE DATE: Upon passage

§ 54 — DEFINITIONS

The bill defines numerous terms used throughout §§ 55 to 66.

EFFECTIVE DATE: July 1, 2011

§ 55 — GENERAL REQUIREMENTS

Health Carriers

The bill 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 is responsible for (1) monitoring all utilization review activities carried out by or on behalf of it and (2) ensuring that any utilization review company or other entity it contracts with to perform utilization review complies with the bill 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

A health carrier that requires utilization review must implement a utilization review 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 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 covered person may file a request for an external review of an adverse determination or a 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;
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 the covered person's 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;
3. include in materials intended for prospective covered persons a summary of its utilization review and benefit determination procedures;
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 bill (§ 8) and make the records available upon request to covered persons if the records can be disclosed under law, the commissioner, and 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.

Regulations

The bill 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 bill requires a health carrier to contract with (1) health care professionals to administer the 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 that are based on sound clinical evidence and are 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 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 by electronic means;
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 utilization review company, and (3) a process by which the health carrier evaluates the utilization review company's performance.

Necessary Information Only

When conducting utilization review, the health carrier must (1) collect only the information necessary, 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 bill requires a health carrier to maintain written procedures for (1) 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, if a health care professional with knowledge of the covered person’s medical condition determines the benefit request is an urgent care request, it will be deemed so.

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 the health carrier's 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 necessary because of the covered person's failure 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.

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 has 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. 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.

Procedural Failure

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, which may be provided 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 reaching 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 perfect 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,

contact information, and 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;

6. 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;
7. 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
8. a statement explaining the covered person's right to (a) contact the commissioner or 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.

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 adhere strictly 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

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

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 that fully comply with the bill procedures 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.

When conducting a review of an adverse determination, the health carrier must ensure that the review is conducted in a manner ensuring 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 that date.

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.

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.

For a grievance of an adverse determination involving an expedited review request, the health carrier must decide and notify the covered person of the decision within 72 hours 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 individuals' understanding of the grievance;
4. the individuals' 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, the 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 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 adhere strictly 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 provide the covered person with the name, address, and telephone number of the individual 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 comply with 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,
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

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

Under current law, a covered person requesting an external review must pay a \$25 filing fee. The bill 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 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.

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.

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 be 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 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 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 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

A health carrier must maintain written records to document 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.

EFFECTIVE DATE: July 1, 2011

§§ 62 & 66 — REGULATIONS

The bill 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 current law, the annual license fee is \$2,500. The bill increases this fee to \$3,000.

The bill 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

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

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. It must maintain at a minimum:

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

The organization must also:

1. agree to maintain and provide to the commissioner the information required by the bill;
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 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 bill 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 in 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:

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

§ 69 — POLICY RESCISSIONS

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

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

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 bill 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 bill recodifies some of the repealed sections, including penalties for a utilization review company that violates the bill's provisions.

EFFECTIVE DATE: July 1, 2011

§ 90 — REPEALED SECTIONS

The bill repeals the existing 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 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.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute Change of Reference
Yea 11 Nay 9 (03/03/2011)

Labor and Public Employees Committee

Joint Favorable Change of Reference
Yea 6 Nay 4 (03/11/2011)

Planning and Development Committee

Joint Favorable
Yea 12 Nay 8 (03/23/2011)

Appropriations Committee

Joint Favorable
Yea 34 Nay 19 (05/09/2011)

Finance, Revenue and Bonding Committee

Joint Favorable
Yea 33 Nay 18 (05/19/2011)

Government Administration and Elections Committee

Joint Favorable
Yea 9 Nay 4 (05/25/2011)