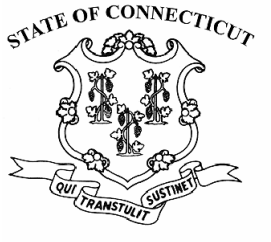

Substitute House Bill No. 6308

Public Act No. 11-58

AN ACT CONCERNING HEALTHCARE REFORM.

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

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

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

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

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

(4) "Nonstate public employee" means any employee or elected

officer of a nonstate public employer.

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

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

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

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

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

(b) (1) The Comptroller shall require nonstate public employers and nonprofit employers that elect to obtain coverage under a partnership plan to participate in such plan for not less than two-year intervals. An

employer may apply for renewal prior to the expiration of each interval.

(2) The Comptroller shall develop procedures by which:

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

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

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

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

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

(d) Nothing in this section or sections 3 and 4 of this act shall require

the Comptroller to offer coverage to every employer seeking coverage under sections 3 and 4 of this act from every partnership plan offered by the Comptroller.

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

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

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

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

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

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

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

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

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

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

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

(3) (A) Except as specified in subparagraph (D) of this subdivision, if a nonstate public employer or a nonprofit employer submits an application for coverage for less than all of its respective employees, or indicates in the application the employer will offer other health plans to employees who are offered a partnership plan, the Comptroller shall forward such application to a health care actuary not later than five business days after receiving such application. Not later than sixty days after receiving such application, such actuary shall notify the Comptroller whether, as a result of the employees included in such application or other factors, the application will shift a significant part of such employer's employees' medical risks to the partnership plan. Such actuary shall provide, in writing, to the Comptroller the specific reasons for such actuary's finding, including a summary of all information relied upon in making such a finding.

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

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

(D) If an employer included less than all of its employees in its application for coverage because of (i) the decision by individual employees to decline coverage from their employer for themselves or their dependents, or (ii) the employer's decision not to offer coverage

to temporary, part-time or durational employees, the Comptroller shall not forward such employer's application to a health care actuary.

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

(1) Actuarial standards to assess the shift in medical risks of an employer's employees to a partnership plan. The Comptroller shall present such standards to the Health Care Cost Containment Committee for its review, evaluation and approval prior to the use of such standards; and

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

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

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

(b) (1) If an employer seeks coverage for all of such employer's retirees in accordance with this section and all of such employer's employees in accordance with section 3 of this act, the Comptroller

shall accept such application upon the terms and conditions applicable to the partnership plan, for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin, pending acceptance by such employer of the terms and conditions of such plan.

(2) Except as specified in subdivision (5) of this subsection, if a nonstate public employer or a nonprofit employer seeks coverage for less than all of its respective retirees, regardless of whether the employer is seeking coverage for all of such employer's active employees, the Comptroller shall forward such application to a health care actuary not later than five business days after receiving such application. Not later than sixty days after receiving such application, such actuary shall notify the Comptroller whether, as a result of the retirees included in such application or other factors, the application will shift a significant part of such employer's retirees' medical risks to the partnership plan. Such actuary shall provide, in writing, to the Comptroller the specific reasons for such actuary's finding, including a summary of all information relied upon in making such a finding.

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

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

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

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

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

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

(b) The Comptroller may charge each employer participating in a partnership plan an administrative fee calculated on a per member per month basis, in accordance with the actuarial standards developed under subsection (b) of section 3 of this act and subsection (c) of section 4 of this act. In addition, the Comptroller may charge a fluctuating reserves fee the Comptroller deems necessary and in accordance with

the actuarial standards developed under subsection (b) of section 3 of this act and subsection (c) of section 4 of this act to ensure adequate claims reserves.

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

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

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

(2) (A) If a nonstate public employer fails to make premium payments or premium equivalent payments as required by this section, the Comptroller may direct the State Treasurer, or any other officer of the state who is the custodian of any moneys made available by grant, allocation or appropriation payable to such nonstate public employer, to withhold the payment of such moneys until the amount of the premium or premium equivalent or interest due has been paid to the Comptroller, or until the State Treasurer or such custodial officer determines that arrangements have been made, to the satisfaction of the State Treasurer, for the payment of such premium or premium

equivalent and interest. Such moneys shall not be withheld if such withholding will adversely affect the receipt of any federal grant or aid in connection with such moneys.

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

(3) The Comptroller may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any premium or premium equivalent, interest costs, paid claim expenses or equitable relief from a terminated employer.

Sec. 6. (NEW) (*Effective July 1, 2011*) (a) There is established a Nonstate Public Health Care Advisory Committee. The committee shall make advisory recommendations to the Health Care Cost Containment Committee concerning health care coverage for nonstate public employees. The advisory committee shall consist of nonstate public employers and employees participating in a partnership plan and shall include the following members appointed by the Comptroller: (1) Three municipal employer representatives, one of whom represents towns with populations of one hundred thousand or more, one of whom represents towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents towns with populations under twenty thousand; (2) three municipal employee representatives, one of whom represents employees in towns with populations of one hundred thousand or more, one of whom represents employees in towns with populations

of at least twenty thousand but under one hundred thousand, and one of whom represents employees in towns with populations under twenty thousand; (3) three board of education employers, one of whom represents towns with populations of one hundred thousand or more, one of whom represents towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents towns with populations under twenty thousand; and (4) three board of education employee representatives, one of whom represents towns with populations of one hundred thousand or more, one of whom represents towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents towns with populations under twenty thousand.

(b) There is established a Nonprofit Health Care Advisory Committee. The committee shall make advisory recommendations to the Health Care Cost Containment Committee concerning health care coverage for nonprofit employees. The advisory committee shall consist of nonprofit employers and their respective employees participating in a partnership plan and shall include the following members appointed by the Comptroller: (1) Three nonprofit employer representatives; and (2) three nonprofit employee representatives.

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

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

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

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

(b) Not later than October first, annually, each employer that sponsors a fully-insured group health insurance policy for its active employees, early retirees and retirees that provides coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes shall submit electronically to the Comptroller, in a form prescribed by the Comptroller, the following information: For the two policy years immediately preceding, the percentage increase or decrease in the policy or plan costs, calculated as the total premium costs, inclusive of any premiums or contributions paid by active employees, early retirees and retirees, divided by the total number of active employees, early retirees and retirees covered by such policy.

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

(a) As used in this section:

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

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

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

(b) Each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), **[**and**]** (12) and (16) of section 38a-469 shall:

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

(A) Complete and accurate medical, dental and pharmaceutical

utilization data, as applicable;

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

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

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

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

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

(c) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the employer more than once in any twelve-month period.

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

employer.

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

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

(f) If a subpoena or other similar demand related to information **[**disclosed**]** provided pursuant to subsection (b) of this section is issued in connection with a judicial proceeding to an employer that receives such information, such employer shall immediately notify the insurer, health care center, hospital service corporation, medical service corporation or other entity that **[**disclosed**]** provided such information to such employer of such subpoena or demand. Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall have standing to file an application or motion with the court of competent jurisdiction to quash or modify such subpoena. Upon the filing of such application or motion by such insurer, health care center, hospital service corporation, medical service corporation or other entity, the subpoena or similar demand shall be stayed without penalty to the parties, pending a hearing on such application or motion and until the court enters an order sustaining, quashing or modifying such subpoena or demand.

Sec. 11. (NEW) (*Effective from passage*) (a) The Office of Health

Reform and Innovation established under subsection (b) of section 13 of this act shall convene a working group to develop a plan to implement a state-wide multipayer data initiative to enhance 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. Such group shall include, but not be limited to, the Secretary of the Office of Policy and Management, the Comptroller, the Commissioners of Public Health and Social Services, the Insurance Commissioner, representatives of health insurance companies, health insurance purchasers, hospitals, consumer advocates and health care providers.

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

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

(a) As used in this section:

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

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

(b) **[**The Office of Health Care Access division of the Department of Public Health shall require**]** Each short-term acute care general or children's **[**hospitals to submit such data, including discharge data, as it deems necessary**]** hospital shall submit patient identifiable inpatient

discharge data and emergency department data to the Office of Health Care Access division of the Department of Public Health to fulfill the responsibilities of the office. Such data shall include data taken from patient medical record abstracts and **[**hospital**]** bills. The office shall specify the timing and format of such **[**submission shall be specified by the office. The data may be submitted through a contractual arrangement with an intermediary. If the data is submitted**]** submissions including submissions by outpatient surgical facilities as provided for in subsection (c) of this section. If a hospital or outpatient surgical facility submits data through an intermediary, the hospital or the outpatient surgical facility shall ensure that such submission of data is timely and **[**that the data is**]** accurate. The office may conduct an audit of the data submitted **[**to**]** through such intermediary in order to verify its accuracy. **[**Individual patient and physician data identified by proper name or personal identification code submitted pursuant to this section shall be kept confidential, but aggregate reports from which individual patient and physician data cannot be identified shall be available to the public.**]**

(c) With respect to the submission of outpatient data, an outpatient surgical facility, as defined in section 19a-493b, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the office the data identified in subsection (c) of section 19a-634. The office shall convene a working group consisting of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. On or before February 1, 2012, the working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and

insurance and real estate. Additional reporting of outpatient data as the office deems necessary shall begin not later than July 1, 2015. On or before July 1, 2012, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers shall provide a progress report to the Department of Public Health, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that allow for the reporting of outpatient data as required by the commissioner. Until such additional reporting requirements take effect, the department may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

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

(e) Not later than October 1, 2011, the Office of Health Care Access shall enter into a memorandum of understanding with the Comptroller that shall permit the Comptroller to access the data set

forth in subsections (b) and (c) of this section, provided the Comptroller agrees, in writing, to keep individual patient and physician data identified by proper name or personal identification code and submitted pursuant to this section confidential.

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

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

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

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

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

(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 assist with implementing the Affordable Care Act, and (B) other measures which further enhance access to health care, reduce costs and improve the quality of health care in the state;

(3) Recommend and advance executive action and legislation to effectively and efficiently implement the Affordable Care Act, 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, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services, insurance and public health on the progress of state agencies concerning implementation of the Affordable Care Act;

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

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

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

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

(d) The Office of Health Reform and Innovation, in consultation with the SustiNet Health Care Cabinet established pursuant to section 14 of this act, shall, on or before August 1, 2011, convene a consumer

advisory board that consists of not less than seven members.

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

(f) The Office of Health Reform and Innovation shall maintain a central comprehensive health reform web site.

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

(h) The Office of Health Reform and Innovation, in consultation with the SustiNet Health Care Cabinet, may retain any consultants necessary to carry out the statutory responsibilities of said office. Consultants may be retained by said office for purposes that include, but are not limited to, conducting 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, commencing on January 1, 2014. Not later than October 1, 2012, the Office of Health Reform and Innovation and the SustiNet Health Care Cabinet shall make recommendations to the Governor based on the results of the analyses undertaken pursuant to this subsection.

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

(b) (1) The SustiNet Health Care Cabinet shall consist of the following members who shall be appointed on or before August 1,

2011: (A) Five appointed by the Governor, two of whom may represent the health care industry and shall serve for terms of four years, one of whom shall represent community health centers and shall serve for a term of three years, one of whom shall represent insurance producers and shall serve for a term of three years and one of whom shall be an at-large appointment and shall serve for a term of three years; (B) one appointed by the president pro tempore of the Senate, who shall be an oral health specialist engaged in active practice and shall serve for a term of four years; (C) one appointed by the majority leader of the Senate, who shall represent labor and shall serve for a term of three years; (D) one appointed by the minority leader of the Senate, who shall be an advanced practice registered nurse engaged in active practice and shall serve for a term of two years; (E) one appointed by the speaker of the House of Representatives, who shall be a consumer advocate and shall serve for a term of four years; (F) one appointed by the majority leader of the House of Representatives, who shall be a primary care physician engaged in active practice and shall serve for a term of four years; (G) one appointed by the minority leader of the House of Representatives, who shall represent the health information technology industry and shall serve for a term of three years; (H) five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one of whom shall represent faith communities, one of whom shall represent small businesses, one of whom shall represent the home health care industry, one of whom shall represent hospitals, and one of whom shall be an at-large appointment, all of whom shall serve for terms of five years; (I) the Lieutenant Governor; (J) the Secretary of the Office of Policy and Management, or the secretary's designee; the Comptroller, or the Comptroller's designee; the Special Advisor to the Governor on Healthcare Reform, or the Special Advisor's designee; the Commissioners of Social Services and Public Health, or their designees; and the Healthcare Advocate, or the Healthcare Advocate's designee, all of whom shall serve as ex-officio voting members; and (K)

the Commissioners of Children and Families, Developmental Services and Mental Health and Addiction Services, and the Insurance Commissioner or their designees, and the nonprofit liaison to the Governor, or the nonprofit liaison's designee, all of whom shall serve as ex-officio nonvoting members.

(2) Following the expiration of initial cabinet member terms, subsequent cabinet terms shall be for four years, commencing on August first of the year of the appointment. If an appointing authority fails to make an initial appointment to the cabinet or an appointment to fill a cabinet vacancy within ninety days of the date of such vacancy, the appointed cabinet members shall, by majority vote, make such appointment to the cabinet.

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

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

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

(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 as set forth in Section 1331 of the Affordable Care Act;

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

(4) Coordinate with the Office of Health Reform and Innovation concerning the effectiveness of delivery system reforms and other efforts to control health care costs, including, but not limited to, reforms and efforts implemented by state agencies;

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

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

(d) The SustiNet Health Care Cabinet may convene working groups, which include volunteer health care experts, to make recommendations concerning 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.

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

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

(i) For claims filed in paper format, sixty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall **[**(i)**]** (I) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and **[**(ii)**]** (II) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested; and

(ii) For claims filed in electronic format, twenty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) notify the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than ten days after the insurer receives a claim for payment or

reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than ten days after the insurer receives the information requested.

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

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

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

(2) At any time for the following, provided providers are given at least thirty days' advance notice by mail, electronic mail or facsimile by such organization of any such changes:

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

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

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

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

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

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

(G) As mutually agreed to by the contracting health organization and the provider. If the contracting health organization and the provider do not mutually agree, the provider's current fee schedule shall remain in force until the annual change permitted pursuant to subdivision (1) of this subsection.

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

contract.

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

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

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

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

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

(E) The provider received payment for such claim from a different insurer, payor or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy. Such provider shall have one year after the date of the cancellation, denial or return of full or partial payment to resubmit an adjusted secondary payor claim with such organization on a secondary payor basis, regardless of such organization's timely filing requirements.

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

(B) If such organization demands the return of full or partial

payment from a provider, the notice required under subparagraph (A) of this subdivision shall disclose to the provider (i) the amount that is demanded to be returned, (ii) the claim that is the subject of such demand, and (iii) the basis on which such return is being demanded.

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

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

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

Sec. 17. (NEW) (*Effective January 1, 2012*) Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, and each preferred provider network, as defined in section 38a-479aa of the general statutes, that contracts with a health care provider, as defined in section 38a-478 of the general statutes, for the purposes of providing covered health care services to its enrollees, shall maintain a network

of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards.

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

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

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

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

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

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

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

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

(c) Each evidence of coverage for an individual or group dental plan shall 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."

(d) Each dentist shall 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.

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

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

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

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

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

(4) "Commissioner" means the Insurance Commissioner.

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

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

(7) "Insurer" or "insurance company" means any person or

combination of persons doing any kind or form of insurance business other than a fraternal benefit society, and includes a captive insurance company, as defined in section 38a-91aa of the general statutes, a captive insurer as defined in section 38a-91k of the general statutes, a licensed insurance company, a medical service corporation, a hospital service corporation, a health care center, and a consumer dental plan that provides employee welfare benefits on a self-funded basis or as defined in section 38a-577 of the general statutes.

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

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

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

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

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

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

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

(D) An insurance producer who is licensed to sell life, annuity or

health coverage in this state, whose activities are limited exclusively to the sale of insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) "Uniform application" means the current version of the

National Association of Insurance Commissioners' Uniform Application for Third-Party Administrators.

Sec. 21. (NEW) (*Effective October 1, 2011*) (a) No person shall offer to act as or hold himself out to be a third-party administrator in this state unless such person is licensed pursuant to section 30 of this act, or is exempt from licensure pursuant to subsection (b) of this section. This requirement shall not apply to a person employed by a third-party administrator to the extent that such person's activities are under the supervision and control of the third-party administrator. The authority granted to a third-party administrator pursuant to sections 20 to 29, inclusive, of this act shall not exempt such third-party administrator's employees from the licensing requirements of chapters 701b and 702 of the general statutes.

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

(2) Nothing in this section shall authorize the commissioner to regulate a self-insured health plan subject to the Employee Retirement Income Security Act of 1974. The commissioner is authorized to regulate those activities an insurer undertakes for the administration of a self-insured health plan that do not relate to the health benefit plan and that comport with the commissioner's statutory authority to regulate insurance and the business of insurance as provided for in 29

USC 1144, as amended from time to time.

(c) No third-party administrator shall act as such without a written agreement between such third-party administrator and an insurer or other person utilizing the services of the third-party administrator, which shall be retained as part of the official records of both the third-party administrator and such insurer or other person for the duration of such agreement and for five years thereafter. The agreement shall contain all provisions required by this section, except insofar as those provisions that do not apply to the activities performed by the third-party administrator.

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

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

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

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

(4) The procedures for any withdrawals to be made by the third-party administrator from the fiduciary account established under section 26 of this act. Such procedures shall address, but not be limited to: (A) Remittance to an insurer or other person utilizing the services of

the third-party administrator who is entitled to remittance, (B) deposit in an account maintained in the name of the insurer or other person utilizing the services of the third-party administrator, (C) transfer to and deposit in a claims-paying account, with claims to be paid as provided for in subsection (d) of section 26 of this act, (D) payment to a group policyholder for remittance to the insurer or other person utilizing the services of the third-party administrator entitled to such remittance, (E) payment to the third-party administrator for its commissions, fees or charges, and (F) remittance of return premiums to the person or persons entitled to such return premiums;

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

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

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

Sec. 22. (NEW) (*Effective October 1, 2011*) (a) If an insurer or other person utilizes the services of a third-party administrator, the payment of any premiums or charges by or on behalf of an insured to the third-

party administrator shall be deemed to have been received by the insurer or other person utilizing the services of the third-party administrator.

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

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

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

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

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

(c) The commissioner shall have access for the purposes of examination, audit and inspection to books and records maintained by a third-party administrator. Any documents, materials or other information in the possession or control of the commissioner that are obtained by the commissioner from a third-party administrator, insurer, insurance producer or employee or agent thereof acting on behalf of such third-party administrator, insurer or insurance producer, in an investigation, examination or audit shall (1) be confidential by law and privileged; (2) not be subject to disclosure under section 1-210 of the general statutes; (3) not be subject to subpoena; and (4) not be subject to discovery or admissible in evidence in any private civil action. The commissioner may use such documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

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

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

(1) Share documents, materials or other information, including documents, materials or other information deemed confidential and

privileged pursuant to subsection (c) of this section, with other state, federal and international regulatory agencies, the National Association of Insurance Commissioners 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 the confidentiality and privileged status of such documents, materials or other information;

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

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

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

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

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

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

Sec. 25. (NEW) (*Effective October 1, 2011*) (a) Each insurer or other person utilizing the services of a third-party administrator shall be responsible for determining the benefits, premium rates, underwriting criteria and claims payment procedures for the lines, classes or types of insurance such third-party administrator is authorized to administer, and for securing reinsurance, if any. The insurer or other person utilizing the services of a third-party administrator shall provide to such third-party administrator, in writing, procedures pertaining to such third-party administrator's administration of benefits, premium rates, underwriting criteria and claims payment. Each insurer or other person utilizing the services of a third-party administrator shall be responsible for the competent administration of such insurer's or other

person's benefit and service programs.

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

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

(b) Each third-party administrator that deposits in a fiduciary account charges or premiums collected on behalf of or for one or more insurers or other persons utilizing the services of the third-party administrator shall keep clear records of the deposits in and withdrawals from the account on behalf of each insurer or other person utilizing the services of the third-party administrator. The third-party administrator shall keep copies of all the records and, upon request by the insurer or other person utilizing the services of the third-party administrator, shall furnish such insurer or other person

with a copy of the records of the deposits and withdrawals pertaining to such insurer or other person.

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

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

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

(b) This section shall not prevent the compensation of a third-party administrator from being based on premiums or charges collected or the number of claims paid or processed.

Sec. 28. (NEW) (*Effective October 1, 2011*) (a) When the services of a third-party administrator are utilized, such third-party administrator shall issue a benefits identification card to each insured that includes disclosure of, and relationship among, the third-party administrator,

the policyholder and the insurer or other person utilizing the services of the third-party administrator.

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

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

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

Sec. 30. (NEW) (*Effective October 1, 2011*) (a) (1) A third-party administrator applying for licensure shall execute a surety bond in an amount determined by the commissioner to be sufficient to protect insurers and other persons utilizing the services of the third-party administrator, but not less than the penal sum of five hundred thousand dollars. A third-party administrator licensed under this section shall maintain such surety bond as a condition for renewal of

such license.

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

(b) A third-party administrator applying for licensure shall submit an application to the commissioner by using the uniform application and paying a fee pursuant to section 38a-11 of the general statutes, as amended by this act. The uniform application shall include or be accompanied by the following information and documents: (1) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents; (2) the bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant; (3) a NAIC biographical affidavit for the individuals responsible for the conduct of affairs of the applicant, 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 shareholders or member holding directly or indirectly ten per cent or more of the voting stock, voting securities or voting interest of the applicant, and (D) any other person who exercises control or influence over the affairs of the applicant; (4) a statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, recordkeeping and underwriting; and (5) such other pertinent information as may be required by the commissioner.

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

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

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

(f) Any license issued to a third-party administrator shall be in force until September thirtieth of each year, unless sooner revoked or

suspended as provided in this section. The license may be renewed, at the discretion of the commissioner, upon payment of the fee specified in section 38a-11 of the general statutes, as amended by this act, without the resubmission of the detailed information required in the original application.

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

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

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

the commissioner not later than October first on a form designated by the commissioner.

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

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

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

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

Sec. 33. (NEW) (*Effective October 1, 2011*) (a) The commissioner shall suspend or revoke the license of a third-party administrator, or shall issue a cease and desist order if the third-party administrator does not have a license if, after notice and hearing, the commissioner finds that the third-party administrator: (1) Is in an unsound financial condition; (2) is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or (3) has failed to pay any judgment rendered against it in this state within sixty days after the judgment has become final.

(b) The commissioner may suspend or revoke the license of a third-party administrator, or may issue a cease and desist order if the third-party administrator does not have a license if, after notice and hearing, the commissioner finds that the third-party administrator: (1) Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state; (2) (A) has refused to be examined or to produce its accounts, records and files for examination, or (B) if any individual responsible for the conduct of the affairs of the third-party administrator, including (i) members of the board of directors, board of trustees, executive committee or other governing board or committee, (ii) 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, (iii) any shareholder or member holding directly or indirectly ten per cent or more of the voting stock, voting securities or voting interest of the third-party administrator, and (iv) any other person who exercises control or influence over the affairs of the third-party administrator, has refused to provide information with respect to its affairs or to perform other legal obligations as to an examination, when required by the commissioner; (3) has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused insureds to accept less than the amount due or caused insureds to employ attorneys or bring suit

against the third-party administrator to secure full payment or settlement of such claims; (4) fails at any time to meet any qualification for which issuance of a license could have been refused had the failure then existed and been known to the commissioner; (5) has any individual who is responsible for the conduct of its affairs, including (A) 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 holding directly or indirectly ten per cent or more of its voting stock, voting securities or voting interest, and (D) any other person who exercises control or influence over its affairs, who has been convicted of or has entered a plea of guilty or nolo contendere to a felony, without regard to whether adjudication was withheld; (6) is under suspension or revocation in another state; or (7) has failed to file a timely annual report pursuant to section 32 of this act.

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

(2) At the time the commissioner issues an order pursuant to subdivision (1) of this subsection, the commissioner shall serve notice

to the third-party administrator that such third-party administrator may request a hearing not later than ten business days after the receipt of the order. If a hearing is requested, the commissioner shall schedule a hearing not later than ten business days after receipt of the request. If a hearing is not requested and the commissioner does not choose to hold one, the order shall remain in effect until modified or vacated by the commissioner.

Sec. 34. (NEW) (*Effective October 1, 2011*) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 20 to 33, inclusive, of this act.

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

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

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

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, two hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, fifty dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, two hundred twenty dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be

one thousand three hundred fifty dollars; (4) for filing any additional paper required by law, thirty dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, forty dollars; (6) for each certified copy of a license to a company, forty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, forty dollars; (8) for amending a certificate of authority, two hundred dollars; (9) for each license issued to a rating organization, two hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of fifty dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of fifty dollars for each request for any agent appointment, except that no filing fee shall be payable for a request for agent appointment by an insurance company domiciled in a state or foreign country which does not require any filing fee for a request for agent appointment for a Connecticut insurance company; (B) a fee of one hundred dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of eighty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that (i) no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company, and (ii) the fee shall be twenty dollars for each appointment issued or continued to an agent of an insurance company domiciled in a state or foreign country with a premium tax rate below Connecticut's premium tax rate; (12) with respect to insurance producers: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued; (C) a fee of eighty dollars per year, or any portion thereof, for each license renewed; and (D) a fee of

eighty dollars for any license renewed under the transitional process established in section 38a-784; (13) with respect to public adjusters: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; and (B) a fee of two hundred fifty dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of eighty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of eighty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of twenty-six dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty-six dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred fifty dollars for each license issued; and (C) a fee of two hundred fifty dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of twenty dollars for each

examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; and (B) a fee of six hundred twenty-five dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of eighty dollars for each license issued or renewed; (19) a fee of twenty-six dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, fifty dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, fifteen dollars; (C) for filing the annual report, twenty dollars; and (D) for filing any additional paper required by law, fifteen dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, fifteen dollars; (B) for each certified copy of permit, fifteen dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, fifteen dollars; (22) with respect to reinsurance intermediaries: A fee of six hundred twenty-five dollars for each license issued or renewed; (23) with respect to life settlement providers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (24) with respect to life settlement brokers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (25) with respect to preferred provider networks, a fee of two thousand seven hundred fifty dollars for each license issued or renewed; (26) with respect to rental companies, as defined in section 38a-799, a fee of eighty dollars for each permit issued or renewed; (27) with respect to medical discount plan organizations licensed under section 38a-479rr, a fee of six hundred twenty-five dollars for each license issued or renewed; (28) with respect to pharmacy benefits managers, an application fee of one hundred dollars for each registration issued or renewed; (29) with

respect to captive insurance companies, as defined in section 38a-91aa, a fee of three hundred seventy-five dollars for each license issued or renewed; **[**and**]** (30) with respect to each duplicate license issued a fee of fifty dollars for each license issued; and (31) with respect to third-party administrators, as defined in section 20 of this act, (A) a fee of five hundred dollars for each license issued, (B) a fee of three hundred fifty dollars for each license renewed, and (C) a fee of one hundred dollars for each annual report filed pursuant to section 32 of this act.

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

[Every**]** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child: **[**Marries; ceases to be a resident of the state; becomes**]** Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. **[**The residency requirement shall not apply to dependent children under nineteen years of age or full-time students attending an accredited institution of higher education.**]** Each such policy shall cover a stepchild on the same basis as a biological child.

Sec. 38. (NEW) (*Effective from passage*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child: Becomes covered under a group health plan through the dependent's own employment; or

attains the age of twenty-six. Each such policy shall cover a stepchild on the same basis as a biological child.

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

(a) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group hospitalization and medical and surgical insurance plan or plans for (1) state employees, (2) members of the General Assembly who elect coverage under such plan or plans, (3) participants in an alternate retirement program who meet the service requirements of section 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits under section 5-144 or from any state-sponsored retirement system, except the teachers' retirement system and the municipal employees retirement system, (5) judges of probate and Probate Court employees, (6) the surviving spouse, and any dependent children **[**until they reach the age of eighteen,**]** of a state police officer, a member of an organized local police department, a firefighter or a constable who performs criminal law enforcement duties who dies before, on or after June 26, 2003, as the result of injuries received while acting within the scope of such officer's or firefighter's or constable's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan. Coverage for a dependent child pursuant to this subdivision shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child: Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six, (7) employees of the Capital City Economic Development Authority established by section 32-601, and (8) the surviving spouse and dependent children of any employee of a

municipality who dies on or after October 1, 2000, as the result of injuries received while acting within the scope of such employee's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan. For purposes of this subdivision, "employee" means any regular employee or elective officer receiving pay from a municipality, "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, flood commission or authority established by special act or regional planning agency. For purposes of subdivision (6) of this subsection, "firefighter" means any person who is regularly employed and paid by any municipality for the purpose of performing firefighting duties for a municipality on average of not less than thirty-five hours per week. The minimum benefits to be provided by such plan or plans shall be substantially equal in value to the benefits that each such employee or member of the General Assembly could secure in such plan or plans on an individual basis on the preceding first day of July. The state shall pay for each such employee and each member of the General Assembly covered by such plan or plans the portion of the premium charged for such member's or employee's individual coverage and seventy per cent of the additional cost of the form of coverage and such amount shall be credited to the total premiums owed by such employee or member of the General Assembly for the form of such member's or employee's coverage under such plan or plans. On and after January 1, 1989, the state shall pay for anyone receiving benefits from any such state-sponsored retirement system one hundred per cent of the portion of the premium charged for such member's or employee's individual coverage and one hundred per cent of any additional cost for the form of coverage. The balance of any premiums payable by an individual employee or by a member of the General Assembly for the form of coverage shall be deducted from the

payroll by the State Comptroller. The total premiums payable shall be remitted by the Comptroller to the insurance company or companies or nonprofit organization or organizations providing the coverage. The amount of the state's contribution per employee for a health maintenance organization option shall be equal, in terms of dollars and cents, to the largest amount of the contribution per employee paid for any other option that is available to all eligible state employees included in the health benefits plan, but shall not be required to exceed the amount of the health maintenance organization premium.

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

(f) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group hospitalization and medical and surgical insurance plan or plans for any person who adopts a child from the state foster care system, any person who has been a foster parent for the Department of Children and Families for six months or more, a parent in a permanent family residence for six months or more, and any dependent of such adoptive parent, foster parent or parent in a permanent family residence who elects coverage under such plan or plans. The Comptroller may also arrange for inclusion of such person and any such dependent in an existing group hospitalization and medical and surgical insurance plan offered by the state. Any adoptive parent, foster parent or a parent in a permanent family residence and any dependent who elects coverage shall pay one hundred per cent of the premium charged for such coverage directly to the insurer, provided such adoptive parent, foster parent or parent and all such dependents shall be included in such group hospitalization and medical and surgical insurance plan. A person and his dependents electing coverage pursuant to this subsection shall be eligible for such coverage until no longer an

adoptive parent, a foster parent or a parent in a permanent family residence. An adoptive parent shall be eligible for such coverage until the **[**adopted child reaches the age of eighteen or, if the child has not completed a secondary education program, until such child reaches the age of twenty-one**]** coverage anniversary date on or after whichever of the following occurs first, the date on which the child: Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six. As used in this section "dependent" means a spouse or natural or adopted child if such child is wholly or partially dependent for support upon the adoptive parent, foster parent or parent in a permanent family residence.

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

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

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

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

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

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

Sec. 43. (NEW) (*Effective from passage*) (a) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state shall include a lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential health benefits, as defined in the Patient Protection and Affordable Care Act, P.L. 111-1448, as amended from time to time, or regulations adopted thereunder.

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

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

(A) Upon layoff, reduction of hours, leave of absence or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act;

(B) Upon the death of the employee, continuation of coverage for

the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;

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

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

(E) The coverage of any covered individual shall terminate: (i) As to a child, (I) as set forth in section 38 of this act. If on the date specified for termination of coverage on a child, the child is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by such insurer, center, corporation, society or other entity within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. Such insurer, center, corporation, society or other entity may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (II) for the periods set forth for such child under federal extension requirements

established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; (ii) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended from time to time; and (iii) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act;

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

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

employee.

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

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

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

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

[(b)**]** (a) In any case of the discontinuance of a group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 and delivered, issued for delivery, renewed, amended or continued in this state and the subsequent replacement of such coverage with another such policy, the succeeding carrier, in applying any deductible, coinsurance or waiting period provisions in its plan, shall give credit

for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible or coinsurance provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision.

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

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

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

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

effective date of coverage.**]**

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

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

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

shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center; and

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

Sec. 48. Subparagraph (D) of subdivision (1) of section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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

(b) (1) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include **[**(1)**]** (A) all health care centers licensed pursuant to chapter 698a, **[**(2)**]** (B) the fifteen largest licensed health insurers that use provider networks and that are not included in **[**subdivision (1)**]** subparagraph (A) of this **[**subsection**]** subdivision, **[**(3)**]** (C) the state medical loss ratio of each such health care center or licensed health insurer, **[**(4)**]** (D) the federal medical loss ratio of each such health care center or licensed health insurer, (E) the information required under subdivision (6) of subsection (a) of section 38a-478c, as amended by this act, and **[**(5)**]** (F) information concerning mental health services, as specified in subsection (c) of this section. The insurers selected pursuant to **[**subdivision (2)**]** subparagraph (B) of this **[**subsection**]**

subdivision shall be selected on the basis of Connecticut direct written health premiums from such network plans.

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

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

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

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

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

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

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

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) notwithstanding the provisions of this subsection, on or before July first of each year, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision.

(2) A model contract that contains the provisions currently in force in contracts between the managed care organization and preferred provider networks in this state, and the managed care organization

and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary fee schedule information; **[**.**]**

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

(4) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l*, as amended by this act. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this section, including any change in a plan's rates over the prior three years, its state medical loss ratio and its federal medical loss ratio, as both terms are defined in **[**subsection (b) of**]** section 38a-478*l*, as amended by this act, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and specialty care provider, the percentage of primary and specialty care providers who are board certified, and how

the medical protocols incorporate input as required in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner; **[**.**]**

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

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

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

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

(d) No managed care organization shall be liable for a claim arising out of the submission of any information concerning complaints concerning providers, provided the managed care organization

submitted the information in good faith.

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

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

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

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

(2) A statement of the number of managed care organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure;

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

stabilization care;

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

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

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

(7) Participating and nonparticipating provider reimbursement procedure;

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

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

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

(11) Telephone numbers for obtaining further information, including the procedure for enrollees to contact the organization concerning coverage and benefits, claims grievance and complaint procedures after normal business hours;

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

(13) The procedures for obtaining referrals to specialists or for

consulting a physician other than the primary care physician;

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

(15) Enrollee satisfaction information; and

(16) Procedures for protecting the confidentially of medical records and other patient information.

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

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

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

(d) No provision of the general statutes concerning a requirement of the Affordable Care Act shall be construed to supersede a provision of the general statutes that provides greater protection to an insured, except to the extent the latter prevents the application of a requirement of the Affordable Care Act.

(e) The Insurance Commissioner may adopt regulations, in

accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

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

(1) "Adverse determination" means:

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

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

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

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

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

(2) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person for the purposes of this section

and sections 55 to 66, inclusive, of this act;

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

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

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

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

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

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

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

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

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

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

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

(10) "Commissioner" means the Insurance Commissioner.

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

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

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

(14) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with

respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

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

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

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

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

(23) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified

health care services consistent with state law.

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

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

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

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

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

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

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

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

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

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

(F) Any other findings, studies or research conducted by or under

the auspices of a source comparable to those listed in subparagraphs (E)(i) to (E)(v), inclusive, of this subdivision.

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

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

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

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

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

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

(35) "Rescission" means a cancellation or discontinuance of coverage

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

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

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

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

(39) "Utilization review" means the use of a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy or efficiency of, health care services, health care procedures or health care settings. Such techniques may include the monitoring of or evaluation of (A) health care services performed

or provided in an outpatient setting, (B) the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility, (C) opportunities or requirements to obtain a clinical evaluation by a health care professional other than the one originally making a recommendation for a proposed health care service, (D) coordinated sets of activities conducted for individual patient management of serious, complicated, protracted or other health conditions, or (E) prospective review, concurrent review, retrospective review or certification.

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

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

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

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

(2) Such document shall describe the following:

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

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

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

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

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

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

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

(d) Each health carrier shall:

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

(A) Its utilization review and benefit determination procedures;

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

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

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

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

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

(2) Inform its covered persons, at the time of initial enrollment and

at least annually thereafter, of its grievance procedures. This requirement may be fulfilled by including such procedures in an enrollment agreement or update to such agreement;

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

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

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

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

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

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

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

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

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

(ii) The number of covered lives;

(iii) The total number of grievances received;

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

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

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

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

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

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

(2) Each utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are

evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 55 of this act to assure such program's ongoing effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner. Each health carrier shall make its clinical review criteria available upon request to authorized government agencies.

(b) Each health carrier shall:

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

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

(3) Provide covered persons and participating providers with access to its utilization review staff through a toll-free telephone number or any other free calling option 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, processes for assessing member satisfaction and risk management; and

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

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

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

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

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

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

condition shall be deemed an urgent care request.

(b) With respect to a nonurgent care request:

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

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

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

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

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

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

(i) Specifically describe in the notice of extension the required

information necessary to complete the request; and

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

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

(c) With respect to an urgent care request:

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

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

(B) The health carrier shall provide the covered person or the covered person's authorized representative, as applicable, a reasonable period of time to submit the specified information, taking into account

the covered person's medical condition, but not less than forty-eight hours after notifying the covered person or the covered person's authorized representative, as applicable.

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

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

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

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

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

(2) The specific reason or reasons for the adverse determination and a description of the health carrier's standard, if any, that was 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 necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

(5) A description of the health carrier's internal grievance process that includes (A) the health carrier's expedited review procedures, (B) any time limits applicable to such process or procedures, (C) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (D) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to (i) submit written comments, documents, records and other material relating to the covered person's benefit request for consideration by the individual or individuals conducting the review, and (ii) receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records and other information relevant to the covered person's benefit 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 a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, and instructions for requesting such 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 the scientific or clinical rationale for the adverse determination and (A) an explanation of the scientific or clinical 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 upon request, and instructions for requesting a copy of such explanation; and

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

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

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

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

(3) A disclosure that the covered person or the covered person's

authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, pursuant to sections 58 and 59 of this act;

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

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

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

(2) 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 merits of the claim.

Sec. 58. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall establish and maintain written procedures for (A) the review of grievances of adverse determinations that were based, in whole or in

part, on medical necessity, (B) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility, and (C) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

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

(3) In addition to a copy of such procedures, each health carrier shall file annually with the commissioner, as part of its annual report required under subsection (e) of section 55 of this act, a certificate of compliance stating that the health carrier has established and maintains grievance procedures for each of its health benefit plans that are fully compliant with the provisions of sections 54 to 66, inclusive, of this act.

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

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

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of

the individual or individuals involved in making the review decision.

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

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

(D) Prior to issuing a decision, the health carrier shall provide free of charge to the covered person or the covered person's authorized representative, as applicable, any new or additional evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

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

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of

a concurrent review urgent care request, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

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

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

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

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

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

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

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

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

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

(4) The individual's or individuals' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for such 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) For a decision that upholds the adverse determination:

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

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

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

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

(E) 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 (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances, or (ii) a statement that an explanation will be provided to the covered person free of charge upon request and instructions for requesting a copy of such explanation;

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

(7) 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

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

(f) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.

(2) 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 merits of

the claim.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 60. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a covered person's authorized representative may file a request for an external review or an expedited external review of an adverse determination or a final adverse determination in accordance with the

provisions of this section. All requests for external review or expedited external review shall be made in writing to the commissioner. The commissioner may prescribe the form and content of such requests.

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

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

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

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

review that involves the same adverse determination or final adverse determination for which the covered person or the covered person's authorized representative already received an external review decision or an expedited external review decision.

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

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

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

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

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

(2) The written notice shall include:

(A) The following statement or a statement in substantially similar language: "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.";

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

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

(ii) Such request for expedited external review may be filed at the same time the covered person or the covered person's authorized representative 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 shall determine whether the covered person shall be required to complete the expedited internal review of the grievance prior to conducting the expedited external review;

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

(i) If the covered person has a medical condition for which the time period for completion of an external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or

(ii) If 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, the covered person or the covered person's authorized representative may file a request for an expedited external review, or (II) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may file a request for an expedited external review;

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

(ii) As part of any forms provided under subparagraph (D)(i) of this subdivision, an authorization form or other document approved by the

commissioner that complies with the requirements of 45 CFR 164.508, as amended from time to time, by which the covered person shall authorize the health carrier and the covered person's treating health care professional to release, transfer or otherwise divulge, in accordance with sections 38a-975 to 38a-999a, inclusive, of the general statutes, the covered person's protected health information including medical records for purposes of conducting an external review or an expedited external review.

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

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

(A) An adverse determination, if:

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

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

(ii) The covered person or the covered person's authorized

representative has filed a request for an expedited internal review of the adverse determination; or

(B) A final adverse determination if:

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

(ii) The final adverse 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

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

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

(e) (1) Not later than one hundred twenty calendar days after a covered person or a covered person's authorized representative receives a notice of an adverse determination or a final adverse determination, the covered person or the covered person's authorized representative may file a request for an external review or an

expedited external review with the commissioner in accordance with this section.

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

(3) Not later than (A) five business days after the health carrier receives the copy of an external review request, or (B) one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

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

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

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

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

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

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

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

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

(III) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and

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

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

(II) 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 service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(D) The covered person has exhausted the health carrier's internal grievance process or the covered person or the covered person's

authorized representative has filed a request for an expedited external review as provided under subsection (d) of this section; and

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

(4) (A) Not later than (i) one business day after the preliminary review of an external review request, or (ii) the day the preliminary review of an expedited external review request is completed, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing whether the request for an external review or an expedited external review is complete and eligible for such review. The commissioner may specify the form for the health carrier's notice of initial determination under this subdivision and any supporting information required to be included in the notice.

(B) If the request:

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

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

(C) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the request for an external review or an expedited external review

is ineligible for review may be appealed to the commissioner.

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

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

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 65 of this act to conduct the review and notify the health carrier of the name of the assigned independent review organization. Such assignment shall be done on a random basis among those approved independent review organizations qualified to conduct the particular review based on the nature of the health care service that is the subject of the adverse determination or the final adverse determination and other circumstances, including conflict of interest concerns as set forth in section 66 of this act; and

(ii) Notify the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the commissioner shall include in such notice (I) a statement that the covered person or the covered person's authorized

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

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

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

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

(ii) Not later than one business day after terminating the review and making the decision to reverse the adverse determination or the final

adverse determination, the independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of such decision.

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

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

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

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

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

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

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

(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, the covered person, the covered person's authorized representative or the covered person's treating health care professional;

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

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

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

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

(i) (1) The independent review organization shall notify the

commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

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

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

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

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

(2) Such notice shall include:

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

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

(C) The date the review was conducted;

(D) The date the organization made its decision;

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

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

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

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

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

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

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

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

(v) Information on whether the clinical peer's rationale for the opinion is based on the documents and information set forth in

subsection (f) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 62. (NEW) (*Effective July 1, 2011*) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to

implement the provisions of sections 54 to 66, inclusive, of this act.

Sec. 63. (NEW) (*Effective July 1, 2011*) (a) No utilization review company shall conduct utilization review in this state for a health benefit plan under the jurisdiction of the commissioner unless it is licensed by the commissioner. All licenses shall be renewed on an annual basis.

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

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

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

(e) In the absence of any contractual agreement to the contrary, the covered person or the covered person's authorized representative shall be responsible for requesting certification and for authorizing the covered person's treating health care professional to release, in a timely

manner, all information necessary to conduct the review. A utilization review company shall permit the covered person, the covered person's authorized representative or the covered person's treating health care professional to assist in fulfilling that responsibility.

Sec. 64. (NEW) (*Effective July 1, 2011*) (a) Whenever the commissioner has reason to believe that a utilization review company subject to sections 54 to 63, inclusive, of this act has been or is engaging in conduct in violation of said sections, and that a proceeding by the commissioner would be in the interest of the public, the commissioner shall issue and serve upon such company a statement of the charges in that respect and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than thirty calendar days after the date of service. At the time and place fixed for such hearing, such company shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring such company to cease and desist from the alleged conduct complained of.

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

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

six-month period;

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

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

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

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

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

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

(b) (1) Any independent review organization seeking to conduct external reviews and expedited external reviews under section 60 of

this act shall submit the application form for approval or reapproval, as applicable, to the commissioner and shall include all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under this section.

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

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

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

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

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

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

(ii) (I) The selection of qualified and impartial clinical peers to

conduct such reviews on behalf of the independent review organization and the suitable matching of such peers to specific cases, and (II) employs or contracts with an adequate number of clinical peers to meet this objective;

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

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

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

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

(3) 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

(4) 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 review;

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

person;

(C) Holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the 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 the clinical peer's physical, mental or professional competence or moral character.

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

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

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the National Association of Insurance Commissioners in order for the commissioner to determine if such entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may

exclude any private accrediting entity that is not reviewed by the National Association of Insurance Commissioners.

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

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

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

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

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

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

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

(b) To determine whether an independent review organization or a clinical peer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of subsection (a) of this section, the commissioner shall consider situations in which the independent review organization to be assigned to conduct an external review or an expedited external

review of a specified case or a clinical peer to be assigned by the independent review organization to conduct such review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subsection (a) of this section, but the characteristics of such relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer from conducting such review.

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

(d) No independent review organization or clinical peer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be 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 during or upon completion of an external review or an expedited external review conducted pursuant to section 60 of this act, unless such opinion was rendered or act or omission performed in bad faith or involved gross negligence.

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

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

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

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

(C) The average length of time for resolution;

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

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

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

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

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

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

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

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

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

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

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

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

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

[(7)**]** (6) "Managed care plan" means a product offered by a managed

care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and the plan includes utilization review, **[**pursuant to sections 38a-226 to 38a-226d, inclusive**]** as defined in section 54 of this act.

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

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

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

[(11)**]** (9) "Utilization review" has the same meaning as provided in section **[**38a-226**]** 54 of this act.

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

Sec. 68. Subsection (c) of section 38a-19 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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

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

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

(1) Such rescission or limitation if the commissioner finds that **[**(1)**]** (A) the insured or such insured's representative submitted the written information **[**submitted**]** on or with the insurance application that was **[**false**]** fraudulent at the time such application was made, **[**and**]** (B) the insured or such insured's representative **[**knew or should have known of the falsity**]** intentionally misrepresented information therein **[**,**]** and such **[**submission**]** misrepresentation materially affects the risk or the hazard assumed by the insurer or health care center, or **[**(2)**]** (C) the

information omitted from the insurance application was **[**knowingly**]** intentionally omitted by the insured or such insured's representative **[**, or the insured or such insured's representative should have known of such omission,**]** and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center; and

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

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

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

care companies, and any preferred provider network that provides services to enrollees on behalf of the managed care organization, including a summary and analysis of any trends or similarities found in the managed care complaints filed by enrollees; (4) a summary of the complaints concerning managed care organizations received by the Insurance Department's Consumer Affairs Division and the commissioner under section **[**38a-478n**]** 60 of this act, including a summary and analysis of any trends or similarities found in the complaints received; (5) a summary of any violations the commissioner has found against any managed care organization or any preferred provider network that provides services to enrollees on behalf of the managed care organization; and (6) a summary of the issues discussed related to health care or managed care organizations at the Insurance Department's quarterly forums throughout the state.

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

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

(b) On June **[**1, 1998, and**]** first annually, **[**thereafter,**]** the commissioner shall submit **[**,**]** to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to public health and **[**matters relating to**]** insurance, a list of those managed care organizations that have failed to file any data,

report or information required by sections **[**38a-226 to 38a-226d**]** 54 to 61, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993.

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

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

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

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

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

(d) The Insurance Commissioner **[**, after consultation with the working group convened pursuant to section 38a-478p,**]** may develop and disseminate to hospitals in this state a claims form system that will

ensure that all hospitals consistently code for the presenting and diagnosis symptoms on all emergency claims.

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

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

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

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

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

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

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

993.

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

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

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

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

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

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

(5) "Managed care plan" means a managed care plan, as defined in section 38a-478, as amended by this act;

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

(7) "Preferred provider network" means a person, which is not a managed care organization, but which pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services

rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

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

(9) "Commissioner" means the Insurance Commissioner.

(b) On and after May 1, 2004, no preferred provider network may enter into or renew a contractual relationship with a managed care organization unless the preferred provider network is licensed by the commissioner. On and after May 1, 2005, no preferred provider network may conduct business in this state unless it is licensed by the commissioner. Any person seeking to obtain or renew a license shall submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. Applications shall be submitted by March first of each year in order to qualify for the May first license issue or renewal date. The filing required from such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of

the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider

network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; (G) a contingency plan describing how contracted health care services will be provided in the event of insolvency; and (H) any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

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

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

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

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

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

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

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

(i) Each preferred provider network shall maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for two months determined on the basis of the two months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner. Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section. The commissioner shall review such security amount and calculation on a quarterly basis.

(j) Each preferred provider network shall pay the applicable license or renewal fee specified in section 38a-11. The commissioner shall use

the amount of such fees solely for the purpose of regulating preferred provider networks.

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

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

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

said subdivision**]** section 57 of this act.

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

Sec. 78. Subsection (d) of section 38a-479bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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

(1) A provision that requires the preferred provider network to provide to the managed care organization at the time a contract is entered into, annually, and upon request of the managed care organization, (A) the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as amended by this act; (B) documentation that satisfies the managed care organization that the preferred provider network has sufficient ability to accept financial risk; (C) documentation that satisfies the managed care organization that the preferred provider network has appropriate management expertise and infrastructure; (D) documentation that satisfies the managed care organization that the preferred provider network has an adequate provider network taking into account the geographic distribution of enrollees and participating providers and whether participating providers are accepting new patients; (E) an accurate list of participating providers; and (F) documentation that satisfies the managed care organization that the preferred provider

network has the ability to ensure the delivery of health care services as set forth in the contract;

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

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

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

(5) A provision that the preferred provider network shall include in all contracts between the preferred provider network and participating providers a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, for any reason,

the enrollee shall not be liable to the participating provider or preferred provider network for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network;

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

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

(8) A provision under which the managed care organization is permitted, at the discretion of the managed care organization, to pay participating providers directly and in lieu of the preferred provider network in the event of insolvency or mismanagement by the

preferred provider network and that payments made pursuant to this subdivision may be made or reimbursed from the security posted pursuant to subsection (b) of this section;

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

(10) A provision that each contract or agreement between the preferred provider network and participating providers shall include a provision transferring and assigning contracts between the preferred provider network and participating providers to the managed care organization for the provision of future health care services by participating providers to enrollees, at the discretion of the managed care organization, in the event the preferred provider network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of ninety days;

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

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

[sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be made in accordance with subdivision (7) of subsection (a) of section 38a-226c. In cases where an appeal to reverse a determination not to certify is unsuccessful, the preferred provider network shall refer the case to the managed care organization which shall conduct the subsequent appeal, if any, in accordance with said subdivision**]** section 57 of this act.

Sec. 79. Section 38a-479ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) If the Insurance Commissioner determines that a preferred provider network or managed care organization, or both, has not complied with any applicable provision of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, the commissioner may (1) order the preferred provider network or managed care organization, or both if both have not complied, to cease and desist all operations in violation of this part or said sections; (2) terminate or suspend the preferred provider network's license; (3) institute a corrective action against the preferred provider network or managed care organization, or both if both have not complied; (4) order the payment of a civil penalty by the preferred provider network or managed care organization, or both if both have not complied, of not more than one thousand dollars for each and every act or violation; (5) order the payment of such reasonable expenses as may be necessary to compensate the commissioner in conjunction with any proceedings held to investigate or enforce violations of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6) use any of the commissioner's other enforcement powers to obtain compliance with this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act. The

commissioner may hold a hearing concerning any matter governed by this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, in accordance with section 38a-16. Subject to the same confidentiality and liability protections set forth in subsections (c) and (k) of section 38a-14, the commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists to assist the commissioner in conducting an investigation under this section, the cost of which shall be borne by the managed care organization or preferred provider network, or both, that is the subject of the investigation.

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

(c) The commissioner shall receive and investigate (1) any grievance filed against a preferred provider network or managed care organization, or both, by an enrollee or an enrollee's designee concerning matters governed by this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, or (2) any referral from the Office of the Healthcare Advocate pursuant to section 38a-1041, as amended by this act. The commissioner shall code, track and review such grievances and referrals. The preferred provider network or managed care organization, or both, shall provide the commissioner with all information necessary for the commissioner to investigate such grievances and referrals. The information collected by the commissioner pursuant to this section shall be maintained as

confidential and shall not be disclosed to any person except (A) to the extent necessary to carry out the purposes of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, (B) as allowed under this title, (C) to the Healthcare Advocate, and (D) information concerning the nature of any grievance or referral and the commissioner's final determination shall be a public record, as defined in section 1-200, provided no personal information, as defined in section 38a-975, shall be disclosed. The commissioner shall report to the Healthcare Advocate on the resolution of any matter referred to the commissioner by the Healthcare Advocate.

Sec. 80. Section 38a-479ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

No health insurer, health care center, utilization review company, as defined in section **[**38a-226**]** 54 of this act, or preferred provider network, as defined in section 38a-479aa, as amended by this act, shall take or threaten to take any adverse personnel or coverage-related action against any enrollee, provider or employee in retaliation for such enrollee, provider or employee (1) filing a complaint with the Insurance Commissioner or the Office of the Healthcare Advocate, or (2) disclosing information to the Insurance Commissioner concerning any violation of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, unless such disclosure violates the provisions of chapter 705 or the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996, **[**(P.L. 104-191) (HIPAA)**]** P.L. 104-191, as amended from time to time, or regulations adopted thereunder. Any enrollee, provider or employee who is aggrieved by a violation of this section may bring a civil action in the Superior Court to recover damages and attorneys' fees and costs.

Sec. 81. Section 38a-483c of the general statutes is repealed and the

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

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

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

(c) Any person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal as provided in section **[**38a-226c**]** 58 of this act and may appeal a denial thereof to the Insurance Commissioner in accordance with the procedures established in section **[**38a-478n**]** 60 of this act.

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

Sec. 82. Section 38a-513b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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

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

(c) Any person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal as provided in section **[**38a-226c**]** 58 of this act and may appeal a denial thereof to the Insurance Commissioner in accordance with the procedures established in section **[**38a-478n**]** 60 of this act.

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

Administration.**]**

Sec. 83. Subsection (c) of section 38a-504f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The insured, or the provider with the insured's written consent, may appeal any denial of coverage for medical necessity to an external, independent review pursuant to section **[**38a-478n**]** 60 of this act. Such external review shall be conducted by a properly qualified review agent whom the department has determined does not have a conflict of interest regarding the cancer clinical trial.

Sec. 84. Subsection (c) of section 38a-542f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The insured, or the provider with the insured's written consent, may appeal any denial of coverage for medical necessity to an external, independent review pursuant to section **[**38a-478n**]** 60 of this act. Such external review shall be conducted by a properly qualified review agent whom the department has determined does not have a conflict of interest regarding the cancer clinical trial.

Sec. 85. Subdivision (22) of section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(22) Any violation of **[**section 38a-478m**]** sections 57 to 59, inclusive, of this act.

Sec. 86. Subdivision (3) of section 38a-1040 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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

Sec. 87. Subsections (b) and (c) of section 38a-1041 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The Office of the Healthcare Advocate may:

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

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

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

(4) Assist consumers with the filing of complaints and appeals, including filing appeals with a managed care organization's internal appeal or grievance process and the external appeal process

established under **[**section 38a-478n**]** sections 57 to 60, inclusive, of this act;

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

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

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

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

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

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

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

(12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive, as amended by this act; and

(13) Take any other actions necessary to fulfill the purposes of sections 38a-1040 to 38a-1050, inclusive, as amended by this act.

(c) The Office of the Healthcare Advocate shall make a referral to the Insurance Commissioner if the Healthcare Advocate finds that a

preferred provider network may have engaged in a pattern or practice that may be in violation of sections **[**38a-226 to 38a-226d, inclusive,**]** 38a-479aa to 38a-479gg, inclusive, as amended by this act, or 38a-815 to 38a-819, inclusive, as amended by this act.

Sec. 88. (*Effective July 1, 2011*) Notwithstanding the provisions of sections 38a-183, 38a-481 and 38a-513 of the general statutes, a health carrier, as defined in section 1 of this act, shall certify to the Insurance Commissioner, in a form and manner prescribed by said commissioner, that any forms or endorsements relating to utilization review, the health carrier's internal grievance process, external review or expedited external review that are filed by such health carrier pursuant to section 38a-183, 38a-481 or 38a-513 of the general statutes for use on or after July 1, 2011, are in compliance with sections 54 to 66, inclusive, of this act and the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and any regulations adopted thereunder. Upon receipt by said commissioner of such filing and certification, the health carrier may use such forms or endorsements until such time as said commissioner, after notice and hearing, disapproves their use. A health carrier may use the certification procedure as set forth in this section until June 30, 2012.

Sec. 89. Sections 38a-226 to 38a-226d, inclusive, 38a-478m, 38a-478n and 38a-478p of the general statutes are repealed. (*Effective July 1, 2011*)

Sec. 90. Sections 19a-710 to 19a-723, inclusive, of the general statutes are repealed. (*Effective September 1, 2011*)