Updates to Certain Life and Health Insurance Regulations

SECTION 1

Sections 38a-193-1 to 38a-193-3, inclusive, of the Regulations of Connecticut State Agencies are amended to read as follows:

38a-193-1 Definitions

As used in sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with section [38a-193-2(d)] 38a-193-2(c) of the Regulations of Connecticut State Agencies;

(2) "Commissioner" means the Insurance Commissioner of the State of Connecticut;

(3) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required;

[(4) "Domestic health care center" means a health care center domiciled in Connecticut;

(5) "Foreign health care center" means a health care center that is licensed to do business in Connecticut under section 38a-41 of the Connecticut General Statutes but is not domiciled in Connecticut;]

[(6)](4) "Health care center" means a "health care center" as defined in section 38a-175 of the Connecticut General Statutes. This definition does not include an organization that is licensed as an insurance company under section 38a-41 of the Connecticut General Statutes and that is otherwise subject to the financial requirements of section 38a-72 of the Connecticut General Statutes;

[(7)](5) "NAIC" means the National Association of Insurance Commissioners;

[(8)](6) "RBC" means risk-based capital;

[(9)](7) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

[(10)](8) "RBC level" means a health care center's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(A) "Company Action Level RBC" means, with respect to any health care center, the product of 2.0 and its Authorized Control Level RBC;

(B) "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC;

(C) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions; and

(D) "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC;

[(11)](9) "RBC plan" means a comprehensive financial plan containing the elements specified in section 38a-193-3(b) of the Regulations of Connecticut State Agencies. If the commissioner rejects the RBC plan, and it is revised by the health care center, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan;"

[(12)](10) "RBC report" means the report required in section 38a-193-2 of the Regulations of Connecticut State Agencies; and

[(13)](11) "Total adjusted capital" means the sum of: a health care center's statutory capital and surplus and such other items, if any, as the RBC instructions may provide.

38a-193-2 RBC reports

(a) Every [domestic] health care center shall, on or prior to each March 1 (the "filing date"), prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a [domestic] health care center shall file its RBC report[:

(1) With] with the NAIC in accordance with the RBC instructions[; and

(2) with the insurance commissioner in any state in which the health care center is authorized to do business, if the insurance commissioner has notified the health care center of its request in writing, in which case the health care center shall file its RBC report not later than the later of: fifteen (15) days from the receipt of notice to file its RBC report with that state; or the filing date].

(b) A health care center's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula may be adjusted for the covariance between the risks set forth in subdivisions (1) to (4), inclusive, of this subsection. The formula shall take the following into account, determined in each case by applying the factors in the manner set forth in the RBC instructions.

(1) Asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and such other relevant risks as are set forth in the RBC instructions.

(c) If a [domestic] health care center files a RBC report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health care center of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an "adjusted RBC report."

38a-193-3 Company action level event

(a) As used in [Sections] sections 38a-193-1 to 38a-198-13, inclusive, of the Regulations of Connecticut State Agencies, "Company Action Level Event" means any of the following events:

(1) The filing of an RBC report by a health care center that indicates that the health care center's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(2) notification by the commissioner to the health care center of an adjusted RBC report that indicates an event in subdivision (1) of this subsection, provided the health care center does not challenge the adjusted RBC report under section 38a-193-7 of the Regulations of Connecticut State Agencies; or

(3) if, pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, a health care center challenges an adjusted RBC report that indicates the event in subdivision (1) of this subsection, the notification by the commissioner to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(b) In the event of a Company Action Level Event, the health care center shall prepare and submit to the commissioner a RBC plan that shall:

(1) Identify the conditions that contribute to the Company Action Level Event;

(2) contain proposals of corrective actions that the health care center intends to take and that would be expected to result in the elimination of the Company Action Level Event;

(3) provide projections of the health care center's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(4) identify the key assumptions impacting the health care center's projections and the sensitivity of the projections to the assumptions; and

(5) identify the quality of, and problems associated with, the health care center's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted not later than forty-five (45) days after the Company Action Level Event; or if the health care center challenges an adjusted RBC report pursuant to section 38a-193-7 of the Regulations of Connecticut State Agencies, not later than forty-five (45) days after notification to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(d) Not later than sixty (60) days after the submission by a health care center of an RBC plan to the commissioner, the commissioner shall notify the health care center whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the health care center shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the health care center shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner not later than forty-five (45) days after the notification from the commissioner; or if the health care center challenges the notification from the commissioner under section 38a-193-7 of the Regulations of Connecticut State Agencies, not later than forty-five (45) days after a notification to the health care center that the commissioner has, after a hearing, rejected the health care center's challenge.

(e) In the event of a notification by the commissioner to a health care center that the health care center's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, subject to the health care center's right to a hearing under section 38a-193-7 of the Regulations of Connecticut State Agencies, specify in the notification that the notification constitutes a Regulatory Action Level Event.

[(f) Every domestic health care center that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health care center is authorized to do business if:

(1) The respective state has an RBC provision substantially similar to section 38a-193-8(a) of the Regulations of Connecticut State Agencies; and

(2) the insurance commissioner of that state has notified the health care center of its request for the filing in writing, in which case the health care center shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) the date on which the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.]

SECTION 2

Subsection (a) of section 38a-193-8 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) All RBC reports (to the extent the information is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analysis of a health care center performed pursuant to sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to a [domestic] health care center [or foreign health care center] that are filed with the commissioner constitute information that might be damaging to the health care center if made available to its competitors, and therefore shall be kept confidential by the commissioner pursuant to the authority of sections 38a-14, 38a-69a, 38a-913 and 38a-962c of the Connecticut General Statutes. All RBC reports and RBC plans shall be construed as "commercial or financial information given in confidence" as provided under [Conn. Gen. Stat. s] section 1-210(b)(5) of the Connecticut General Statutes. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies or any other provision of the insurance laws or regulations of this state or as provided by law.

SECTION 3

Subsection (b) of section 38a-193-9 of the Regulations of Connecticut State Agencies is amended to read as follows:

(b) The commissioner may exempt from the application of sections 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies a [domestic] health care center that: (1) [Writes direct business only in Connecticut; (2)] assumes no reinsurance in excess of five percent (5%) of direct premium written; and [(3)](2) writes direct annual premiums for comprehensive medical business of $2,000,000 or less.

SECTION 4

Sections 38a-193-10 and 38a-193-12 of the Regulations of Connecticut State Agencies are repealed.

SECTION 5

Section 38a-226c-2 of the Regulations of Connecticut State Agencies is amended to read as follows:

As used in sections 38a-226c-1 to 38a-226c-10, inclusive, of the [regulations] Regulations of Connecticut State Agencies:

(a) "Adverse determination" means a determination by a utilization review company not to certify an admission, service, procedure or extension of stay because, based upon the information provided, the request does not meet the utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness[.];

(b) "Business day" means a day during which the state government of Connecticut conducts regular business[.];

(c) "Commissioner" means the Insurance Commissioner[.];

(d) "Enrollee" means "enrollee" as defined in section 38a-226 of the [general statutes.] Connecticut General Statutes. For purposes of pursuing an appeal only, the term "enrollee" shall include any person the enrollee has designated as his or her legal representative;

(e) "Managed care organization" means "managed care organization" as defined in section 38a-478 of the [general statutes.] Connecticut General Statutes;

(f) "New information" means information that has not been previously made available to a utilization review company or a managed care organization for consideration when determining whether to certify an admission, service, procedure or extension of stay[.];

(g) "Patient medical records" means all information, including personally identifiable information, that relates to an individual's health care history, diagnosis, condition, treatment or evaluation that is obtained from any source[.];

(h) "Personally identifiable information" means any data that identifies a particular patient. Personally identifiable information includes an individual's name, address and social security number[.];

(i) "Provider of record" or "Provider" means "provider of record" or "provider" as defined in section 38a-226 of the [general statutes.] Connecticut General Statutes or a provider providing treatment or care to the enrollee and acting on behalf of an enrollee, with the enrollee's written consent;

(j) "Utilization review" means "utilization review" as defined in section 38a-226 of the [general statutes.] Connecticut General Statutes;

(k) "Utilization review company" means "utilization review company" as defined in section 38a-226 of the [general statutes] Connecticut General Statutes.

SECTION 6

Section 38a-226c-4 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) [Each] Pursuant to sections 38a-226c(a)(1)(E) and 38a-226c(a)(2) of the Connecticut General Statutes, each utilization review company shall maintain, and provide with each notice of a determination not to certify an admission, service, procedure or extension of stay, and make available upon request, a written description of the appeal procedure by which either the enrollee or the provider of record acting on behalf of the enrollee with the enrollee's written consent, may seek review of adverse determinations regarding certification of an admission, service, procedure or extension of stay. The procedures and written description for appeals shall include the following:

(1) A reasonable period within which an appeal [shall] must be filed to be considered by the utilization review company[.],

(2) Except as provided in subsection [(d)](e) of this section, each utilization review company shall make review staff available by toll-free telephone, at least forty (40) hours per week during normal business hours. The utilization review company shall maintain records of duty rosters or other written documentation evidencing the required level of staffing[.], and

(3) Notification, in bold print, that an appeal of a determination not to certify an admission, service, procedure or extension of stay to the commissioner pursuant to section 38a-478n of the Connecticut General Statutes, must be submitted to the commissioner within 30 days of receipt of a final written notice of a determination by the utilization review company.

(b) Pursuant to sections 38a-226c(a)(1)(E) and 38a-226c(a)(2) of the Connecticut General Statutes, each utilization review company shall maintain and provide with each final written notice of a determination not to certify an admission, service, procedure or extension of stay, a statement that all internal appeals have been exhausted for that service and a copy of a pamphlet, created and made available to utilization review companies by the commissioner and reproduced by the utilization review company, containing the procedure and application to appeal to the

commissioner pursuant to section 38a-478n of the Connecticut General Statutes. The pamphlet may be created and made available to the utilization review company by the commissioner and shall be reproduced and used by the utilization review company if so made. A copy of the pamphlet shall also be available from the utilization review company to the enrollee, upon request.

[(b)](c) If the provider of record or enrollee has provided incomplete information to a utilization review company, the utilization review company shall indicate, in writing, to the provider of record and the enrollee all information that is needed to make a determination regarding certification of an admission, procedure, treatment or length of stay. Upon failure of the provider of record or enrollee to provide such information, the utilization review company shall either: (1) issue a denial of certification, in accordance with the policy of the utilization review company, based on the failure to provide requested documentation; or (2) not issue a denial of certification but rather notify the enrollee and the provider of record, in writing, that no further action will be taken on the matter, until such time as the requested information is received.

[(c)](d) An enrollee or provider of record acting on behalf of the enrollee with the enrollee's written consent, may appeal an adverse determination regarding a managed care plan in accordance with section 38a-478n of the [general statutes] Connecticut General Statutes. If the appeal is accepted for full review, the external appeals entity shall immediately notify the enrollee, [or] provider of record, and the utilization review company of their opportunity to submit the information described in subsection [(f)](g) of section 38a-478n-3 of the [regulations] Regulations of Connecticut State Agencies concerning external appeals within five (5) business days from the date of such notice, for consideration during the external appeals entity's review. The external appeals entity shall provide such notice to the enrollee, [or to the] provider of record, and to the utilization review company either by facsimile machine or by overnight service. The enrollee or provider of record shall state whether any information submitted in accordance with this subsection is new information. Upon receipt of any new information, the external appeals entity shall immediately contact the utilization review company by telephone and notify them that new information has been presented. The external appeals entity shall provide the utilization review company with the new information either by facsimile machine or by overnight service. The utilization review company shall have two (2) business days from receipt of the new information to determine whether the absence of such new information contributed to the adverse determination. If the utilization review company determines that the absence of such new information contributed to the adverse determination the utilization review company shall have the opportunity to [revise] reverse its adverse determination. The utilization review company shall promptly notify the external appeals entity of the decision. If the utilization review company's decision is to reverse its adverse determination, the external appeals entity shall promptly notify the enrollee or provider of record and the commissioner that the utilization review company has reversed the adverse determination based upon the new information. Any reversal of an adverse determination by a utilization review company based upon new information shall not be considered a reversal by the commissioner for the purposes of the reporting requirements established by section 38a-478a of the [general statutes] Connecticut General Statutes.

[(d)](e) If an enrollee has been admitted to an acute care hospital and the attending physician determines that the enrollee's life will be endangered or other serious injury or illness could occur if the patient is discharged or if treatment is delayed, the attending physician may transmit, in accordance with the standardized process developed pursuant to section 38a-478p of the [general statutes] Connecticut General Statutes, a request for an expedited review to the utilization review company. If the attending physician receives no response from the utilization review company after three hours have passed since the attending physician sent the request and all information needed to complete the review, the request shall be deemed approved. Each utilization review company shall make review staff available, daily, from 8:00 A.M. to 9:00 P.M. (eastern time) to process requests pursuant to this subsection.

SECTION 7

Section 38a-433-6(d) of the Regulations of Connecticut State Agencies is amended to read as follows:

(d) Limitations on Ownership. (1) A separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such separate account in such security valued as required by [these Regulations] sections 38a-433-1 to 38a-433-11, inclusive, of the Regulations of Connecticut State Agencies, would exceed 10% of the value of the assets of the separate account. The [Commissioner] commissioner may waive this limitation in writing if [he] the commissioner believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this [State] state.

(2) No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts, in the aggregate, will own more than 10% of the total issued and outstanding voting securities of such issuer. The [Commissioner] commissioner may waive this limitation in writing if [he] the commissioner believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders of this [State] state or jeopardize the independent operation of the issuer of such securities.

(3) The percentage limitation specified in [subsection (a) of this Section] subdivision (1) of this subsection shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the federal Investment Company Act of 1940 or other pools of investment assets if the investment policies of such investment companies or asset pools comply substantially with the provisions of [Subsection] subsection (c) of this [Section] section and other applicable portions of [this regulation] sections 38a-433-1 to 38a-433-11, inclusive, of the Regulations of Connecticut State Agencies.

SECTION 8

Section 38a-478n-2 of the Regulations of Connecticut State Agencies is amended to read as follows:

As used in Sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies:

(a) "Adverse determination" means a determination by a utilization review company or managed care organization not to certify either before, during, or after services are received an admission, service, procedure or extension of stay because, based upon the information provided, the request does not meet the utilization review company or managed care organization's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness[.];

(b) "Business Day" means a day during which the state government of Connecticut conducts regular business[.];

(c) "Commissioner" means the Insurance Commissioner[.];

(d) "Department" means the Insurance Department[.];

(e) "Enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents who participate in a managed care plan. For purposes of pursuing an appeal only, the term "enrollee" shall include any person the enrollee has designated as his or her legal representative;

(f) "External appeals entity" means an impartial health entity, selected by the commissioner, after consultation with the commissioner of Public Health to provide a binding decision in cases where all internal appeals within a licensed utilization review company or managed care organization have been exhausted[.];

(g) "Indigent["] individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified by the individual on a form provided by the commissioner, from the most recent federal tax return filed is less than two hundred percent of the applicable federal poverty level[.];

(h) "Internal appeals" means the procedures provided by the utilization review company or managed care organization in which either the enrollee or provider acting on behalf of an enrollee may seek review of decisions not to certify an admission, procedure, service or extension of stay[.];

(i) "Managed care organization" means "managed care organization" as defined in section [1 of Public Act 97-99.] 38a-478(2) of the Connecticut General Statutes;

(j) "Managed care plan" means "managed care plan" as defined in section [1 of Public Act 97-99.] 38a-478(3) of the Connecticut General Statutes;

(k) "Provider" means a person licensed to provide health care services of the type specified in [Chapters] chapters 370 to 373, inclusive, 375 to [383b]383c, inclusive, 384a to 384c, inclusive, of the [general statutes] Connecticut General Statutes, or [Chapter] chapter 400j of the [general statutes.] Connecticut General Statutes;

(l) "Provider of record" means the physician or other licensed practitioner identified to the utilization review company or managed care organization as having [primary] responsibility for the care, treatment and services rendered to an individual[.];

[(m) "Utilization review company" means "utilization review company" as defined in section 38a-226 of the general statutes as amended by section 15 of Public Act 97-99.

(n) "Utilization review" means "utilization review" as defined in section 38a-226 of the general statutes as amended by section 15 of Public Act 97-99.]

(m) "Utilization review" means "utilization review" as defined in section 38a-226 of the Connecticut General Statutes; and

(n) "Utilization review company" means "utilization review company" as defined in section 38a-226 of the Connecticut General Statutes.

SECTION 9

Section 38a-478n-3 of the Regulations of Connecticut State Agencies is amended to read as follows:

(a) [On or after January 1, 1998, any] Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal [appeals] mechanisms provided by a managed care organization or utilization review company to appeal [a] the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner.

(b) To appeal a [decision] denial or determination pursuant to this section [,] an enrollee or any provider acting on behalf of an enrollee shall, [within] not later than thirty (30) days [from] after receiving [a] final written notice of the denial or determination from the enrollee's managed care organization or utilization review company, file a written request [for an external appeal] with the commissioner. The [request] appeal shall be on [a form] forms prescribed by the commissioner and shall include [an executed release form,] the filing fee set forth in section 38a-478n of the general statutes, [evidence of coverage, and evidence that all internal appeals have been exhausted] and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in section 38a-478n of the general statutes. The commissioner shall waive the filing fee, on request, for individuals who demonstrate that they are indigent or unable to pay.

(c) For the purposes of sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies, not later than five (5) business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization whose enrollee is the subject of an appeal shall:

(1) provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's managed care plan is fully insured, self-funded, or otherwise funded, and

(2) If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization, except that with respect to a self-insured governmental plan, (i) the managed care organization shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy.

[(c)](d) [Following receipt of the request for external appeal, the] The commissioner shall assign the appeal to an external appeals entity for review. In making such an assignment the commissioner shall consider the level of expertise of the entity to review the particular procedure or service for which the certification was denied. The commissioner may consider recommendations regarding the choice of an appropriate entity for an appeal.

[(d)](e) Within five (5) business days of receipt of the request for appeal from the commissioner, the external appeals entity shall conduct a preliminary review of the appeal and accept it for full review if it determines that:

(1) the individual was or is an enrollee of the managed care organization;

(2) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service or benefit under the agreement provided by contract to the enrollee and any benefit limitations have not been exhausted;

(3) [the enrollee has exhausted all internal appeals mechanisms] all internal appeals have been exhausted; and

(4) the [enrollee has provided] appeal includes all information required by the commissioner [to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization and any other relevant provider].

[(e)](f) Upon completion of the preliminary review, the external appeals entity shall notify the commissioner, and the enrollee or provider of record, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons [therefor] therefore. If the appeal is accepted for full review, the entity shall immediately notify either by facsimile machine or by overnight service, the enrollee or provider of record and the managed care organization or utilization review company of their opportunity to submit the information specified in subsection [(f)](g) of this section within five (5) business days from the date of such notice for consideration during its review.

[(f)](g) Upon acceptance of the appeal for review, the external appeals entity shall conduct a full review to determine whether the adverse determination should be reversed, revised, or sustained. Such review shall be performed by a provider who is a specialist in the field related to the

condition that is the subject of the appeal. The reviewing provider may take into consideration:

(1) pertinent medical records,

(2) consulting physician reports,

(3) practice guidelines developed by the [Federal] federal government, national, state or local medical societies, boards or associations, and

(4) clinical protocols or practice guidelines developed by the utilization review company or managed care organization.

[(g)](h) The external appeals entity shall complete its review and forward its decision to affirm, revise, or reverse the adverse determination to the commissioner within thirty (30) business days of completion of the preliminary review together with a report of its review. The external appeals entity may request an extension of time from the commissioner within which to complete its review as may be necessary due to circumstances beyond its control. If an extension is granted, the external appeals entity shall provide written notice to the enrollee or provider, setting forth the status of its review, the specific reasons for the delay and the anticipated date of completion of the review.

[(h)](i) The commissioner may reassign an appeal to another external appeals entity if [he] the commissioner determines (1) that a conflict of interest exists which may negatively impact the objectivity of the entity to which the appeal was initially assigned or (2) that the entity to which an appeal was assigned is unable to complete its review within a reasonable time.

[(i)](j) The commissioner shall accept the decision of the external appeals entity[,] and notify the enrollee or provider and the utilization review company or managed care organization of the decision, which shall be binding. The report of the external appeals entity's review shall be made available to the enrollee or provider and the utilization review company or managed care organization. The decision of the external appeals entity shall not be construed as authorizing services in excess of those [which] that are provided for in the enrollee's managed care plan.

(k) The request for appeal submitted by the enrollee or provider of record, the associated materials received by the managed care organization or utilization review company, the decision of the external appeals entity, and communication by and between the commissioner, the external appeals entity and the enrollee shall be maintained as confidential information protected by section 38a-8 of the Connecticut General Statutes.

SECTION 10

The Regulations of Connecticut State Agencies are amended by adding new section 38a-478m-1 as follows:

NEW **38a-478m-1 Notice to Enrollees**

Each managed care organization required to submit a notice to enrollees pursuant to section 38a-478m(1) of the Connecticut General Statutes shall maintain and provide with each final written notice of a determination not to certify an admission, service, procedure or extension of stay based on medical necessity, a statement that all internal appeals have been exhausted for that service and a copy of a pamphlet, created and made available to the managed care organization by the commissioner and reproduced by the managed care organization, containing the procedure and application to appeal to the commissioner pursuant to section 38a-478n of the Connecticut General Statutes. A copy of the pamphlet shall also be available from the managed care organization to the enrollee, upon request.

SECTION 11

Section 38a-478u-1 of the Regulations of Connecticut State Agencies is amended to read as follows:

Nothing in Sections 38a-478u-1 to [38a-478u-6] 38a-478u-7, inclusive, shall be construed to apply to the arrangements of managed care organizations offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974, or to any plan providing health care solely for workers' compensation benefits.

SECTION 12

Section 38a-478u-2 of the Regulations of Connecticut State Agencies is amended to read as follows:

As used in [Sections] sections 38a-478u-1 to [38a-478u-6] 38a-478u-7, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Commissioner means the Insurance Commissioner[.];

(2) "Enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents who participate in a managed care plan[.];

(3) "Managed care organization" means "managed care organization" as defined in section [1 of Public Act 97-99 as amended.] 38a-478(2) of the Connecticut General Statutes;

(4) "Managed care plan" means "managed care plan" as defined in section [1 of Public Act 97-99 as amended.] 38a-478(3) of the Connecticut General Statutes;

(5) "Provider" means "provider" as defined in section [1 of Public Act 97-99 as amended.] 38a-478(4) of the Connecticut General Statutes; and

(6) "Utilization review" means "utilization review" as defined in section 38a-226 of the [general statutes as amended by Public Act 97-99] Connecticut General Statutes.

SECTION 13

The Regulations of Connecticut State Agencies are amended by adding new sections 38a-478u-6 and 38a-478u-7 as follows:

38a-478u-6 [Separability] Prior certification

[If any provision of Sections 38a-478u-1 to 38a-478u-6 or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the provisions of these regulations,and the application of such provision to other persons or circumstances shall not be affected thereby.] Each managed care plan that requires preauthorization procedures may require enrollees to obtain prior certification or preauthorization for covered services provided (1) such services are clearly identified in the policy or certificate, and (2) the maximum penalty assessed to the enrollee if the enrollee fails to obtain the required prior certification or preauthorization for services ultimately determined to be medically necessary is limited to the lesser of five hundred dollars or fifty percent of the scheduled benefit in the policy or certificate.

(NEW) **38a-478u-7 Separability**

If any provision of sections 38a-478u-1 to 38a-478u-7, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the provisions of sections 38a-478u-1 to 38a-478u-7, inclusive, of the Regulations of Connecticut State Agencies, and the application of such provision to other persons or circumstances shall not be affected thereby.

SECTION 14

Section 38a-505-7(G) of the Regulations of Connecticut State Agencies is amended to read as follows:

(G) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition except as follows:

(1) Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction except as set forth in section 38a-488a of the Connecticut General Statutes;

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in [Section 38a-505-9 (F)] section 38a-505-9(F) of the Regulations of Connecticut State Agencies;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the Armed Forces or units auxiliary thereto;

(b) Suicide (sane or [insance] insane), attempted suicide or intentionally self-inflicted injury except with respect to individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the Connecticut General Statutes;

(c) Aviation;

(d) With respect to short-term renewable policies, inter-scholastic sports;

(5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

(6) Treatment provided in a government hospital, benefits provided under Medicare or other governmental program (except Medicaid), any state or federal [workmen's] workers' compensation, employers liability or occupational disease law, or the basic reparations benefits of any motor vehicle no-fault law, services rendered by employees of hospitals, laboratories or other institutions, services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(7) Dental care or treatment except as set forth in sections 38a-491, 38a-491a, and 38a-491b, inclusive, of the Connecticut General Statutes;

(8) Eye glasses, hearing aids and examination for the prescription or fitting thereof except as set forth in section 38a-490b of the Connecticut General Statutes;

(9) Rest cures, custodial care, transportation and routine physical examinations; and

(10) Territorial limitations.

SECTION 15

Section 38a-546-1 to 38a-546-3, inclusive, of the Regulations of Connecticut State Agencies is amended to read as follows:

38a-546-1 Applicability and scope

Section 38a-546-1 to [38a-546-6] 38a-546-5, inclusive, of the Regulations of Connecticut State Agencies, shall apply to all group insurance policies [and subscriber contracts] in effect, [on or after January 1, 1985 and to all group insurance policies and subscriber contracts] delivered, or issued for delivery in this [State on or after January 1, 1985.] state. The

provisions of section 38a-546-5(a) of the Regulations of Connecticut State Agencies shall be effective for all covered persons whose group health insurance plan terminates on or after the effective date of section 38a-546-1 to 38a-546-5, inclusive, of the Regulations of Connecticut State Agencies.

38a-546-2 [Definition] Definitions

[The term "group" for purposes of sections 38a-546-1 to 38a-546-6, inclusive, means a benefit plan, other than "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:

(a) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;

(b) The coverage is not available to the general public and can be obtained and maintained only because of the covered person's employment or membership in or connection with the particular organization or group;

(c) There are arrangements for bulk payment of premiums or subscription charges to the insurer or non-profit services corporation; and

(d) There is sponsorship of the plan by the employer, union or association.]

As used in section 38a-546-1 to section 38a-546-4, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Carrier" means a health care center, insurer, hospital and medical service corporation or other entity responsible for the payment of benefits or provision of services under a group contract;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Group disability income protection policy" means a contract for coverage of the type specified in subdivision (5) of section 38a-469 of the Connecticut General Statutes that by its terms limits eligibility to members or employees of a specified group;

(4) "Group health insurance policy" means a contract for coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469 of the Connecticut General Statutes that by its terms limits eligibility to members or employees of a specified group;

(5) "Group hospital confinement indemnity policy" means a contract for coverage of the type specified in subdivision (3) of section 38a-469 of the Connecticut General Statutes that by its terms limits eligibility to members or employees of a specified group;

(6) "Group insurance policy" means any group health insurance policies, group life plans, group disability income protection policies, and their associated subscriber contracts, certificates, or agreements, if any; and

(7) "Group life plan" means a contract for life insurance issued to members or employees of a specified group as set forth in section 38a-431 of the Connecticut General Statutes.

38a-546-3 Effective date of discontinuance for nonpayment of premium or subscription charges

(a) If a [policy or contract subject to these rules and regulations] group insurance policy provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(b) If the actions of the carrier after the end of the grace period indicate that it considered the policy or contract as continuing in force beyond the end of the grace period (such as by not denying claims for losses beginning after the end of the grace period), the carrier shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

SECTION 16

Section 38a-546-5 of the Regulations of Connecticut State Agencies is amended to read as follows:

38a-546-5 Group [Extension] extension of benefits, continuation of benefits, conversion, and pre-existing conditions

(a) Extension of benefits. [Every] In accordance with section 38a-546 of the Connecticut General Statutes, every group [policy or other contract subject to sections 38a-546-1 to 38a-546-6, inclusive,] insurance policy [must] shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group [policy or contract] insurance policy, as [required by the following paragraphs of this section.] follows:

[(b)](1) In the case of a group life plan [which] that contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group insurance policy shall not operate to terminate such extension.

[(c)](2) In the case of a group [plan providing benefits for loss of time from work] disability income protection policy or [specific indemnity during hospital confinement] group hospital confinement indemnity policy, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement.

[(d)](3) In the case of a group health insurance plan [providing benefits for hospital or medical expense coverage], the extension of benefits provision [must be in keeping with subdivisions (3) and (4) of subsection 38a-554(b) of the General Statutes.] shall provide coverage set forth in subparagraphs (A), (B), and (C) of this subdivision.

(A) No succeeding carrier. When there is no succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who were confined to a health care facility or totally disabled, on the date the policy is discontinued, the group health insurance plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility and for all services related to the disabling condition, as applicable, without premium payment, according to the terms of its plan.

(i) Length of extension. The extension will apply until the date the covered individual is not confined to a health care facility, or for those not confined to a health care facility - not totally disabled, or the date that is twelve calendar months following the date the policy was discontinued, whichever is earlier.

(ii) Submission of claim. Extension of benefits will be available provided that evidence of the facility confinement, if any, and any disabling condition is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

(B) Succeeding carrier for person confined in a health care facility. When the group health insurance plan is replaced by a succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who were confined to a health care facility on the date the policy is discontinued, the prior group health plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility, without premium payment.

(i) Length of extension. The extension will apply until the date the covered individual is not confined to a health care facility, or the date that is twelve calendar months following the date the policy was discontinued, whichever is earlier.

(ii) Submission of claim. Extension of benefits will be available provided that evidence of facility confinement and any disabling condition is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

(iii) Transition of care. The succeeding carrier shall be responsible for all other coverage for the individual, including transition of care benefits that provide the individual with a reasonable opportunity to use their current health care provider(s) for a period of time that is clinically appropriate for the treatment of the condition related to the confinement. During the transitional period, benefits under the succeeding carrier's plan for treatment of the condition related to the confinement will not be reduced because of lack of participation in the succeeding carrier's network or lack of certification by the succeeding carrier for services pre-certified by the prior carrier. Nothing herein shall be construed as authorizing or requiring medical necessity certification procedures between the managed care organization and the provider that are not set forth in the contract between the managed care organization and the provider.

(C) Succeeding carrier for a totally disabled person not confined in a health care facility. When the group health insurance plan is replaced by a succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who are totally disabled but not confined to a health care facility on the date the policy is discontinued, the succeeding group health plan shall provide coverage in accordance with the plan terms.

(i) Transition of care. The succeeding carrier shall be responsible for all coverage for the totally disabled individual, including transition of care benefits that provide the individual with a reasonable opportunity to use their current health care provider(s) for a period of time that is clinically appropriate for the treatment of the disabling condition. During the transitional period, benefits under the succeeding carrier's plan for treatment of the disabling condition will not be reduced because of lack of participation in the succeeding carrier's network or lack of certification by the succeeding carrier for services pre-certified by the prior carrier. Nothing herein shall be construed as authorizing or requiring medical necessity certification procedures between the managed care organization and the provider that are not set forth in the contract between the managed care organization and the provider.

(b) Continuation of benefits. Pursuant to sections 38a-546 and 38a-538 of the Connecticut General Statutes, in the case of a group health insurance plan, the continuation of benefits provision shall contain the following provisions for continuation of benefits:

(1) Regardless of an individual's eligibility for other group insurance, during an employee's absence due to illness or injury, coverage for such employee and their covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence, whichever is sooner. Such individual may be required to contribute up to that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee. This provision does not obligate the employer to pay the individual's premium if the individual does not pay the premium.

(2) In any case in which coverage has been continued pursuant to section 38a-546 of the Connecticut General Statutes, the individual may be required to pay up to the rate allowed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time (COBRA). This provision does not obligate the employer to pay the individual's premium if the individual does not pay the premium except, pursuant to section 38a-554(b)of the Connecticut General Statutes, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination of the group plan 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 the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan.

(3) Any individual whose coverage has been continued, as of the date the contract is replaced, shall be covered by the succeeding carrier's plan of benefits for the duration of the continuation of coverage period, provided that within 31 days after the date of the replacement the succeeding carrier is paid the premium necessary to continue coverage for the individual.

(c) Conversion. All group insurance policies shall include a provision explaining the conversion privileges available upon termination of coverage or at the end of an extension of benefits provision.

(d) Pre-Existing Condition. In the case of a pre-existing conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to pre-existing conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lesser of:

(1) The benefits of the new plan determined without application of the pre-existing conditions limitation, or

(2) The benefits of the prior plan.

(e) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier.

[(e)](f) Any applicable extension of benefits or accrued liability shall be described in [any policy or contract involved as well as in group insurance certificates] every group insurance policy. The benefits payable during any period of extension or accrued liability may be subject to the [policy's or contract's] group insurance policy regular benefit [limits] limitations (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

[(f) All carriers will be required to include a provision explaining the conversion privileges available upon termination of coverage or at the end of an extension of benefits provision.]

SECTION 17

Section 38a-546-6 of the Regulations of Connecticut State Agencies is repealed.

REGULATION

OF

5538

NAME OF AGENCY

INSURANCE DEPARTMENT

Statement of purpose:

In sections 1 to 4, to correct an erroneous cross reference within Connecticut's risk based capital requirements for health care centers and delete references to "foreign health care centers" and "domestic health care centers" because the Insurance Department does not use this distinction. In sections 5 and 6, to revise the regulations concerning utilization review companies and appeals to the Insurance Commissioner to more accurately reflect the application of section 38a-478n of the Connecticut General Statutes. In section 7, to correct an erroneous cross reference within Connecticut's variable, modified life and annuities regulation. In sections 8 and 9, to revise the external review regulations to require entities to provide certain information to the enrollee, their designee, or the Insurance Commissioner, and to modify the standard used by external review entities to review appeals. In section 10, to implement the provision of section 38a-478m of the Connecticut General Statutes to reflect the inclusion of post-service medical necessity decisions in the external appeals process. In section 11, to revise a Connecticut regulation concerning permissible policy exclusions in individual health insurance policies to reflect section 38a-488a of the Connecticut General Statutes, section 146.121(b)(2)(iii) of the federal Rules and Regulations for Health Insurance Portability and Renewability for Group Health Plans (Federal Register, vol. 66, No. 5, January 8, 2001), and other state mandated benefits. Section 38a-488a of the Connecticut General Statutes requires coverage for the diagnosis and treatment of mental or nervous conditions. The federal Rules and Regulations for Health Insurance Portability and Renewability for Group Health Plans prohibits source-of-injury exclusions, including suicide or attempted suicide, in certain health insurance policies. Sections 12 and 13 update Connecticut's managed care regulations to remove references to a public act in the definition section, and to establish a standard for services that require authorization. In sections 14 and 15, reorganize and revise Connecticut's extension of benefits, discontinuance and replacement, conversion, and pre-existing condition provisions to remove references to Connecticut's Comprehensive Health Care Plan that are confusing, remove provisions that have been incorporated into the Connecticut General Statutes, and remove sections that are obsolete because of federal laws.

CERTIFICATION

R-39 REV. 1/77

5538

Be it known that the foregoing:

☒ Regulations ☐ Emergency Regulations

Are:

☐ Adopted ☒ Amended as hereinabove stated ☐ Repealed

By the aforesaid agency pursuant to:

☒ Sections 38a-193, 38a-226c(f), 38a-433(e), 38a-478u, 38a-505, 38a-546(c) of the General Statutes.

☐ Section _____ of the General Statutes, as amended by Public Act No._____ of the _____ Public Acts.

☐ Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on, _____of the notice of the proposal to:

☐ Adopt ☒ Amend ☐ Repeal such regulations

(If applicable): ☐ And the holding of an advertised public hearing on _____day of _____20 ___

WHEREFORE, the foregoing regulations are hereby:

☐ Adopted ☒ Amended as hereinabove stated ☐ Repealed

Effective:

☒ When filed with the Secretary of the State.

(OR)

☐ The _____ day of _____, _____.

In Witness Whereof:	DATE 5/19/04	SIGNED (*Head of Board, Agency or Commission*) Susan F. Cogswell	OFFICIAL TITLE, DULY AUTHORIZED INSURANCE COMMISSIONER
Approved by the Attorney General as to legal sufficiency In accordance with Sec. 4-169, as amended, C. G. S. :		SIGNED 6/29/04	OFFICIAL TITLE, DULY AUTHORIZED Assoc. Atty. General

☐ Approved

☐ Disapproved

☐ Disapproved in part, (Indicate Section Numbers disapproved only)

☐ Rejected without prejudice.

By the Legislative Regulation Review Committee in accordance With Sec. 4-170, as amended, of the General Statutes.	DATE 8/24/04	SIGNED (*Clerk of the Legislative Regulation Review Committee*) Pamela B Booth

Two certified copies received and filed, and one such copy forwarded to the Commission on Official Legal Publications
In accordance with Section 4-172, as amended, of the General Statutes.

DATE 8-30-2004	SIGNED (*Secretary of the State*) Susan Bysiewicz	BY Barbara Hladek

INSTRUCTION

1. One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.

2. Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.

3. Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.

4. Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.