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Managed Care

Sec. 38a-478u-1. Applicability and scope

Nothing in Sections 38a-478u-1 to 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.

(Adopted effective April 5, 1999; amended August 30, 2004)

Sec. 38a-478u-2. Definitions

As used in sections 38a-478u-1 to 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 38a-478(2) of the Connecticut General Statutes;

(4) "Managed care plan" means "managed care plan" as defined in section 38a-478(3) of the Connecticut General Statutes;

(5) "Provider" means "provider" as defined in section 38a-478(4) of the Connecticut General Statutes; and

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

(Adopted effective April 5, 1999; amended August 30, 2004)

Sec. 38a-478u-3. Annual filing requirements

Each managed care organization shall file annually the information specified below.

(1) Quality Assurance Reports

(A) A summary report on its quality assurance plan inclusive of, but not limited to, information on complaints relating to providers and quality of care, decisions related to patient requests for coverage and prior authorization statistics. All information provided shall be as of the prior calendar year and shall pertain to Connecticut business only. In order for the statistical information to be provided in a manner permitting comparison across plans, each managed care organization shall be required to complete a form provided by the Insurance Department.

(B) Where Health Plan Employer Data and Information Set (HEDIS) data is required for the summary report, managed care organizations who do not provide HEDIS information to the National Committee for Quality Assurance shall have provided equivalent data upon submission of a completed consumer report card survey as required by subsection (2).

(2) Consumer Report Card

A survey based on prior calendar year information to be submitted on a form adopted by the commissioner.

(3) Model Provider Contracts

Model provider contracts that contain the provisions currently in force in the contracts with providers who participate in networks utilized in this state by the managed care organizations. In a case where a managed care organization does not contract directly with providers, the managed care organization shall also provide

written assurance that it will not enter into agreements with networks or other entities whose provider contracts violate any of the provisions of Public Act 97-99. If requested by the commissioner, a copy of any signed individual contract shall be filed but proprietary fee schedule information may be withheld or redacted.

(4) Financial Arrangements

A written description of the types of financial arrangements between the managed care organization and hospitals, utilization review companies, physicians and other entities that provide health care services or supplies to enrollees. "Financial arrangements" means the terms which are the basis for compensation for services and supplies provided to enrollees.

(Adopted effective April 5, 1999)

Sec. 38a-478u-4. Notification of primary care physician termination

Each managed care organization shall send written notice to each affected enrollee at his last known address no later than thirty days after sending or receiving notice of termination or withdrawal of a primary care physician from its network.

(Adopted effective April 5, 1999)

Sec. 38a-478u-5. Medical loss ratio

For the purposes of reporting and disclosure in accordance with Sections 4 and 8 of Public Act 97-99 as amended by Public Act 97-8, June 18 Special Session, "medical loss ratio" means the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs or other cost containment programs or features.

(Adopted effective April 5, 1999)

Sec. 38a-478u-6. Prior certification

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.

(Adopted effective August 30, 2004)

Sec. 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.

(Adopted effective April 5, 1999; renumbered from § 38a-478u-6 and amended August 30, 2004)