

# State of Connecticut



THOMAS R. SULLIVAN  
INSURANCE COMMISSIONER

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JULY 2, 2007

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: NOTICE OF NEW OR MODIFIED BENEFITS REQUIRED TO BE PROVIDED

The legislature enacted several new laws that impact group and individual health insurance policies delivered or issued for delivery in Connecticut. All entities are reminded that all policy forms are subject to prior approval. Policies are reviewed in the order of date received by the Insurance Department. For policy forms that are already approved, you are asked to file an endorsement or amendatory rider to be attached to the approved policy in order to expedite the review process. Entities should file a red lined version as well as two clean copies along with a postage paid envelope of sufficient size to receive a stamped copy.

PA 07-67 An Act Concerning Hospitalization at an Out of Network Facility During Treatment in Cancer Clinical Trials

This act requires that hospitalization that is a routine patient care cost during treatment in a clinical trial include treatment at an out-of-network facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial. Such treatment at an out-of-network hospital shall be made available by the out-of-network hospital and the insurer or health care center at no greater cost to the insured person than if such treatment was available in-network. This change is effective May 30, 2007.

PA 07-75 An Act Concerning Medical Necessity and External Appeals

Sections 1 and 2 of this act requires that the following definition of medical necessity be included in all health insurance policies 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, renewed, continued or amended on or after January 1, 2008:

“Medically necessary” or “medical necessity” means health care services that a physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.’

“Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgement.

Any insurer, health care center, hospital and medical service corporation or other entity that has entered into any national settlement agreement will not be required to include the statutory definition of medical necessity until the expiration of any such agreement.

Section 3 of this act extends the time period for an enrollee or provider from thirty to sixty days after receiving final written notice of a denial from a managed care organization to submit an external appeal to the Insurance Commissioner.

Please contact the Insurance Department Life and Health Division at [ctinsdept@ct.gov](mailto:ctinsdept@ct.gov) with any questions about the Public Acts discussed in this notice.



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Thomas R. Sullivan  
Insurance Commissioner