



# House of Representatives

General Assembly

**File No. 274**

February Session, 2010

Substitute House Bill No. 5303

*House of Representatives, April 1, 2010*

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## ***AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA.***

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

1 Section 1. Section 38a-478c of the 2010 supplement to the general  
2 statutes is repealed and the following is substituted in lieu thereof  
3 (*Effective July 1, 2010*):

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

6 (1) A report on its quality assurance plan that includes, but is not  
7 limited to, information on complaints related to providers and quality  
8 of care, on decisions related to patient requests for coverage and on  
9 prior authorization statistics. Statistical information shall be submitted  
10 in a manner permitting comparison across plans and shall include, but  
11 not be limited to: (A) The ratio of the number of complaints received to  
12 the number of enrollees; (B) a summary of the complaints received

13 related to providers and delivery of care or services and the action  
14 taken on the complaint; (C) the ratio of the number of prior  
15 authorizations denied to the number of prior authorizations requested;  
16 (D) the number of utilization review determinations made by or on  
17 behalf of a managed care organization not to certify an admission,  
18 service, procedure or extension of stay, and the denials upheld and  
19 reversed on appeal within the managed care organization's utilization  
20 review procedure; (E) the percentage of those employers or groups  
21 that renew their contracts within the previous twelve months; and (F)  
22 notwithstanding the provisions of this subsection, on or before July [1,  
23 1998, and annually thereafter] first of each year, all data required by  
24 the National Committee for Quality Assurance (NCQA) for its Health  
25 Plan Employer Data and Information Set (HEDIS). If an organization  
26 does not provide information for the National Committee for Quality  
27 Assurance for its Health Plan Employer Data and Information Set, then  
28 it shall provide such other equivalent data as the commissioner may  
29 require by regulations adopted in accordance with the provisions of  
30 chapter 54. The commissioner shall find that the requirements of this  
31 subdivision have been met if the managed care plan has received a  
32 one-year or higher level of accreditation by the National Committee for  
33 Quality Assurance and has submitted the Health Plan Employee Data  
34 Information Set data required by subparagraph (F) of this subdivision.

35 (2) A model contract that contains the provisions currently in force  
36 in contracts between the managed care organization and preferred  
37 provider networks in this state, and the managed care organization  
38 and participating providers in this state and, upon the commissioner's  
39 request, a copy of any individual contracts between such parties,  
40 provided the contract may withhold or redact proprietary fee schedule  
41 information.

42 (3) A written statement of the types of financial arrangements or  
43 contractual provisions that the managed care organization has with  
44 hospitals, utilization review companies, physicians, preferred provider  
45 networks and any other health care providers including, but not  
46 limited to, compensation based on a fee-for-service arrangement, a

47 risk-sharing arrangement or a capitated risk arrangement.

48 (4) Such information as the commissioner deems necessary to  
49 complete the consumer report card required pursuant to section 38a-  
50 478l, as amended by this act. Such information may include, but need  
51 not be limited to: (A) The organization's characteristics, including its  
52 model, its profit or nonprofit status, its address and telephone number,  
53 the length of time it has been licensed in this and any other state, its  
54 number of enrollees and whether it has received any national or  
55 regional accreditation; (B) a summary of the information required by  
56 subdivision (3) of this section, including any change in a plan's rates  
57 over the prior three years, its medical loss ratio, as defined in  
58 subsection (b) of section 38a-478l, as amended by this act, how it  
59 compensates health care providers and its premium level; (C) a  
60 description of services, the number of primary care physicians and  
61 specialists, the number and nature of participating preferred provider  
62 networks and the distribution and number of hospitals, by county; (D)  
63 utilization review information, including the name or source of any  
64 established medical protocols and the utilization review standards; (E)  
65 medical management information, including the provider-to-patient  
66 ratio by primary care provider and speciality care provider, the  
67 percentage of primary and speciality care providers who are board  
68 certified, and how the medical protocols incorporate input as required  
69 in section 38a-478e; (F) the quality assurance information required to  
70 be submitted under the provisions of subdivision (1) of subsection (a)  
71 of this section; (G) the status of the organization's compliance with the  
72 reporting requirements of this section; (H) whether the organization  
73 markets to individuals and Medicare recipients; (I) the number of  
74 hospital days per thousand enrollees; and (J) the average length of  
75 hospital stays for specific procedures, as may be requested by the  
76 commissioner.

77 (5) A summary of the procedures used by managed care  
78 organizations to credential providers.

79 (6) A report on claims denial data for lives covered in the state for

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

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

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

95 (d) No managed care organization shall be liable for a claim arising  
96 out of the submission of any information concerning complaints  
97 concerning providers, provided the managed care organization  
98 submitted the information in good faith.

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

102 Sec. 2. Section 38a-478l of the 2010 supplement to the general  
103 statutes is repealed and the following is substituted in lieu thereof  
104 (*Effective January 1, 2011*):

105 (a) Not later than October fifteenth of each year, the Insurance  
106 Commissioner, after consultation with the Commissioner of Public  
107 Health, shall develop and distribute a consumer report card on all  
108 managed care organizations. The commissioner shall develop the  
109 consumer report card in a manner permitting consumer comparison  
110 across organizations.

111 (b) The consumer report card shall be known as the "Consumer  
112 Report Card on Health Insurance Carriers in Connecticut" and shall  
113 include (1) all health care centers licensed pursuant to chapter 698a, (2)  
114 the fifteen largest licensed health insurers that use provider networks  
115 and that are not included in subdivision (1) of this subsection, (3) the  
116 medical loss ratio of each such health care center or licensed health  
117 insurer, (4) the information required under subdivision (6) of  
118 subsection (a) of section 38a-478c, as amended by this act, and [(4)] (5)  
119 information concerning mental health services, as specified in  
120 subsection (c) of this section. The insurers selected pursuant to  
121 subdivision (2) of this subsection shall be selected on the basis of  
122 Connecticut direct written health premiums from such network plans.  
123 For the purposes of this section and sections 38a-477c, 38a-478c, as  
124 amended by this act, and 38a-478g, "medical loss ratio" means the ratio  
125 of incurred claims to earned premiums for the prior calendar year for  
126 managed care plans issued in the state. Claims shall be limited to  
127 medical expenses for services and supplies provided to enrollees and  
128 shall not include expenses for stop loss coverage, reinsurance, enrollee  
129 educational programs or other cost containment programs or features.

130 (c) With respect to mental health services, the consumer report card  
131 shall include information or measures with respect to the percentage of  
132 enrollees receiving mental health services, utilization of mental health  
133 and chemical dependence services, inpatient and outpatient  
134 admissions, discharge rates and average lengths of stay. Such data  
135 shall be collected in a manner consistent with the National Committee  
136 for Quality Assurance Health Plan Employer Data and Information Set  
137 (HEDIS) measures.

138 (d) The commissioner shall test market a draft of the consumer  
139 report card prior to its publication and distribution. As a result of such  
140 test marketing, the commissioner may make any necessary  
141 modification to its form or substance. The Insurance Department shall  
142 prominently display a link to the consumer report card on the  
143 department's Internet web site.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2010	38a-478c
Sec. 2	January 1, 2011	38a-478l

**Statement of Legislative Commissioners:**

In section 1(e), after "web site", "and shall be included in the consumer report card required pursuant to section 38a-478l, as amended by this act" was deleted as redundant, and in section 2(b)(4), "of subsection (a)" was inserted after "subdivision (6)" for accuracy.

**INS**      *Joint Favorable Subst.-LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

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***OFA Fiscal Note***

***State Impact:*** None

***Municipal Impact:*** None

***Explanation***

The bill, which requires managed care organizations to report certain information to the Department of Insurance (DOI) for inclusion in DOI's consumer report card and website, does not result in a fiscal impact.

***The Out Years***

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis****sHB 5303*****AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA.*****SUMMARY:**

This bill adds claims denial data for the prior calendar year to the information that managed care organizations (MCOs) must report to the insurance commissioner annually by May 1. (MCOs include insurers, HMOs, hospital or medical service corporations, or other organizations issuing managed care plans in Connecticut.)

The bill requires the commissioner to post the claims denial information on the Insurance Department's website and include the data in the Consumer Report Card on Health Insurance Carriers in Connecticut, which the department publishes annually by October 15.

The bill makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2010, except the consumer report card provision is effective January 1, 2011.

**CLAIMS DENIAL DATA REPORTING**

The bill requires MCOs to report claims denial data to the insurance commissioner annually by May 1, in a format the commissioner prescribes. The data is for the prior calendar year and must relate to Connecticut residents covered by managed care plans.

The data must include the number of (1) claims received, (2) claims denied, (3) denials that were appealed, and (4) denials that were reversed on appeal. The data must also include (1) the reasons for the denials, including "not a covered benefit," "not medically necessary," and "not an eligible enrollee"; (2) the number and percentage of times

each reason was used; and (3) other information the commissioner deems necessary.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 17    Nay 2    (03/16/2010)