



General Assembly

February Session, 2010

Raised Bill No. 5303

LCO No. 1189

01189_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

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2 statutes is repealed and the following is substituted in lieu thereof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 and shall be included in the consumer report card required
102 pursuant to section 38a-478l, as amended by this act.

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104 statutes is repealed and the following is substituted in lieu thereof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

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

111 across organizations.

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

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

139 (d) The commissioner shall test market a draft of the consumer
140 report card prior to its publication and distribution. As a result of such
141 test marketing, the commissioner may make any necessary
142 modification to its form or substance. The Insurance Department shall

143 prominently display a link to the consumer report card on the
144 department's Internet web site.

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

Statement of Purpose:

To require managed care organizations to report claims denial data and to require the Insurance Department to include such data in the consumer report card and to post such data on its Internet web site.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]