



House of Representatives

File No. 679

General Assembly

February Session, 2014

(Reprint of File No. 207)

Substitute House Bill No. 5373
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 24, 2014

**AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY
MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE
COMPANIES TO THE INSURANCE DEPARTMENT.**

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

1 Section 1. Section 38a-478c of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2016*):

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

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

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

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

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

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

76 (5) A summary of the procedures used by managed care
77 organizations to credential providers; [and]

78 (6) A report on claims denial data for lives covered in the state for
79 the prior calendar year, in a format prescribed by the commissioner,
80 that includes: (A) The total number of claims received; (B) the total

81 number of claims denied; (C) the total number of denials that were
82 appealed; (D) the total number of denials that were reversed upon
83 appeal; (E) (i) the reasons for the denials, including, but not limited to,
84 "not a covered benefit", "not medically necessary" and "not an eligible
85 enrollee", (ii) the total number of times each reason was used, and (iii)
86 the percentage of the total number of denials each reason was used;
87 and (F) other information the commissioner deems necessary; [.]

88 (7) A report, by county, on: (A) The estimated prevalence of
89 substance use disorders, as described in section 17a-458, among
90 covered children, young adults and adults; (B) the number and
91 percentage of covered children, young adults and adults, who received
92 covered treatment of a substance use disorder, by level of care
93 provided; (C) the median length of a covered treatment provided to
94 covered children, young adults and adults, for a substance use
95 disorder, by level of care provided; (D) the per member per month
96 claim expenses for covered children, young adults and adults who
97 received covered treatment of substance use disorders; and (E) the
98 number of in-network health care providers who provide treatment of
99 substance use disorders, by level of care and the percentage of such
100 providers who are accepting new clients under such managed care
101 organization's plan or plans. For purposes of this subdivision,
102 "children" means individuals less than sixteen years of age, "young
103 adults" means individuals sixteen years of age or older but less than
104 twenty-six years of age and "adults" means individuals twenty-six
105 years of age or older;

106 (8) A state-wide report on the number, by licensure type, of health
107 care providers who provide treatment of substance use disorders, co-
108 occurring disorders and mental disorders, who, in the calendar year
109 immediately preceding for the initial report and since the last report
110 submitted to the commissioner for subsequent reports, (A) have
111 applied for in-network status and the percentage of those who were
112 accepted for such status, and (B) no longer participate in the network;

113 (9) A state-wide report on the number, by level of care provided, of

114 health care facilities that provide treatment of substance use disorders,
115 co-occurring disorders and mental disorders, that, in the calendar year
116 immediately preceding for the initial report and since the last report
117 submitted to the commissioner for subsequent reports, (A) have
118 applied for in-network status and the percentage of those that were
119 accepted for such status, and (B) no longer participate in the network;

120 (10) A report identifying and explaining factors that may be
121 negatively impacting covered individuals' access to treatment of
122 substance use disorders, including, but not limited to, screening
123 procedures, the supply state-wide of certain categories of health care
124 providers, health care provider capacity limitations and provider
125 reimbursement rates; and

126 (11) Plans and ongoing or completed activities to address the factors
127 identified in subdivision (10) of this subsection.

128 (b) The information required pursuant to subdivisions (1) to (6),
129 inclusive, of subsection (a) of this section shall be consistent with the
130 data required by the National Committee for Quality Assurance
131 (NCQA) for its Health Plan Employer Data and Information Set
132 (HEDIS).

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

135 (d) No managed care organization shall be liable for a claim arising
136 out of the submission of any information concerning complaints
137 concerning providers, provided the managed care organization
138 submitted the information in good faith.

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

142 Sec. 2. Section 38a-478l of the 2014 supplement to the general
143 statutes is repealed and the following is substituted in lieu thereof

144 (Effective January 1, 2016):

145 (a) Not later than October fifteenth of each year, the Insurance
146 Commissioner, after consultation with the Commissioner of Public
147 Health, shall develop and distribute a consumer report card on all
148 managed care organizations. The commissioner shall develop the
149 consumer report card in a manner permitting consumer comparison
150 across organizations.

151 (b) (1) The consumer report card shall be known as the "Consumer
152 Report Card on Health Insurance Carriers in Connecticut" and shall
153 include (A) all health care centers licensed pursuant to chapter 698a,
154 (B) the fifteen largest licensed health insurers that use provider
155 networks and that are not included in subparagraph (A) of this
156 subdivision, (C) the state medical loss ratio of each such health care
157 center or licensed health insurer, (D) the federal medical loss ratio of
158 each such health care center or licensed health insurer, (E) the
159 information required under [subdivision] subdivisions (6) and (7) of
160 subsection (a) of section 38a-478c, as amended by this act, and (F) the
161 information [concerning mental health services, as specified in]
162 required under subsection (c) of this section for each such licensed
163 health insurer. The insurers selected pursuant to subparagraph (B) of
164 this subdivision shall be selected on the basis of Connecticut direct
165 written health premiums from such network plans.

166 (2) For the purposes of this section and sections 38a-477c, 38a-478c,
167 as amended by this act, and 38a-478g:

168 (A) "State medical loss ratio" means the ratio of incurred claims to
169 earned premiums for the prior calendar year for managed care plans
170 issued in the state. Claims shall be limited to medical expenses for
171 services and supplies provided to enrollees and shall not include
172 expenses for stop loss coverage, reinsurance, enrollee educational
173 programs or other cost containment programs or features;

174 (B) "Federal medical loss ratio" has the same meaning as provided
175 in, and shall be calculated in accordance with, the Patient Protection

176 and Affordable Care Act, P.L. 111-148, as amended from time to time,
177 and regulations adopted thereunder.

178 (c) [With respect to mental health services, the consumer report card
179 shall include information or measures with respect to the percentage of
180 enrollees receiving mental health services, utilization of mental health
181 and chemical dependence services, inpatient and outpatient
182 admissions, discharge rates and average lengths of stay.] (1) On or
183 before May first of each year, each health insurer that provides
184 coverage as set forth in section 38a-488a or 38a-514 shall submit to the
185 commissioner:

186 (A) Data for benefit requests, utilization review of benefit requests,
187 adverse determinations and final adverse determinations, for the
188 treatment of substance use disorders, co-occurring disorders and
189 mental disorders: (i) Grouped according to levels of care, including,
190 but not limited to, inpatient, outpatient, residential care and partial
191 hospitalization; (ii) grouped by category for substance use disorders,
192 co-occurring disorders and mental disorders; and (iii) grouped by
193 children, young adults and adults. For purposes of this subparagraph,
194 "children" means individuals less than sixteen years of age, "young
195 adults" means individuals sixteen years of age or older but less than
196 twenty-six years of age and "adults" means individuals twenty-six
197 years of age or older; and

198 (B) Data for external appeals for the treatment of substance use
199 disorders, co-occurring disorders and mental disorders, as set forth in
200 subparagraphs (A)(i) to (A)(iii), inclusive, of this subdivision.

201 (2) Such data shall be collected in a manner consistent with the
202 National Committee for Quality Assurance Health Plan Employer Data
203 and Information Set (HEDIS) measures.

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

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

210 (e) The commissioner shall analyze annually the data submitted
211 under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of
212 this section for the accuracy of, trends in and statistically significant
213 differences in such data among the health care centers and licensed
214 health insurers included in the consumer report card. The
215 commissioner may investigate any such differences to determine
216 whether further action by the commissioner is warranted.

217 Sec. 3. Section 38a-1092 of the 2014 supplement to the general
218 statutes is amended by adding subsection (c) as follows (*Effective from*
219 *passage*):

220 (NEW) (c) Not later than June 30, 2014, and quarterly thereafter
221 until and including March 31, 2016, the Connecticut Health Insurance
222 Exchange board of directors shall report to the joint standing
223 committees of the General Assembly having cognizance of matters
224 relating to public health, insurance and program review on the
225 activities the exchange has undertaken and the progress the exchange
226 has made to have the all-payer claims database provide the data
227 described in subdivisions (7) to (11), inclusive, of section 38a-478c, as
228 amended by this act, and subdivision (1) of subsection (c) of section
229 38a-478l, as amended by this act. The report required under this
230 subsection may be combined with the report required under
231 subsection (a) of this section, where applicable.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2016</i>	38a-478c
Sec. 2	<i>January 1, 2016</i>	38a-478l
Sec. 3	<i>from passage</i>	38a-1092

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.

OFA Fiscal Note***State Impact:*** None***Municipal Impact:*** None***Explanation***

The bill requires managed care organizations and insurance companies to report additional data to the Insurance Department. As this concerns reporting by private entities, there is no fiscal impact.

House "A" removed a provision of the underlying bill concerning the confidentiality of certain managed care organization information. The amendment also required the Connecticut Health Insurance Exchange Board to report certain information to the General Assembly. There was no associated fiscal impact.

The Out Years***State Impact:*** None***Municipal Impact:*** None

OLR Bill Analysis**sHB 5373 (as amended by House "A")******AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE ORGANIZATIONS AND HEALTH INSURANCE COMPANIES TO THE INSURANCE DEPARTMENT.*****SUMMARY:**

Beginning January 1, 2016, this bill expands the information that (1) managed care organizations (MCOs) and health insurers must report to the insurance commissioner by May 1 annually and (2) the insurance commissioner must publish by October 15 annually in the Consumer Report Card on Health Insurance Carriers in Connecticut. The information to be reported and published relates to substance use and mental disorders.

An MCO that fails to file the required information is subject to a fine of \$100 for each day the report is late (CGS § 38a-478b). The bill does not specify a penalty for health insurers who fail to file the required information, thus, the general statutory penalty applies. That penalty allows the commissioner to fine the insurer up to \$15,000 (CGS § 38a-2).

The bill also requires the Connecticut Health Insurance Exchange (HIX) board of directors, by June 30, 2014 and through March 31, 2016, to report quarterly to the Insurance and Real Estate, Public Health, and Program Review and Investigations committees on the progress HIX has made to have the all-payer claims database (APCD) provide the substance use and mental disorder data that the bill requires MCOs and health insurers to report beginning in 2016. The APCD is a database that HIX is developing, to which insurers, HMOs, and other entities must report insurance claims information. The bill allows the

HIX board to combine this quarterly report with other quarterly reports the law already requires.

*House Amendment "A" eliminates a provision that allows an MCO to ask the insurance commissioner to consider certain information confidential and not subject to disclosure under the Freedom of Information Act. It limits the (1) types of health insurers that must report substance use and mental disorder information to the commissioner and (2) information the commissioner must publish in his annual report card. It also (1) changes the effective date for the MCO and health insurer reporting requirements from October 1, 2014 to January 1, 2016, (2) adds the HIX quarterly reporting requirement, and (3) makes technical changes.

EFFECTIVE DATE: Upon passage for the HIX quarterly reporting requirement, and January 1, 2016 for the remaining provisions.

MANAGED CARE ORGANIZATION

By law, an "MCO" is an insurer, health care center (i.e., HMO), hospital or medical service corporation, or other organization delivering, issuing, renewing, amending, or continuing an individual or group health managed care plan in the state. A "managed care plan" is a product an MCO offers that finances or delivers health care services to plan enrollees through a network of participating providers.

The bill requires MCOs to report to the insurance commissioner by May 1 annually, by county, the:

1. estimated prevalence of substance use disorders among covered children (under age 16), young adults (age 16 to 25), and adults (age 26 and older);
2. number and percentage of covered children, young adults, and adults who received covered treatment for a substance use disorder, by level of care provided (e.g., inpatient, outpatient, residential care, and partial hospitalization);

3. median length of covered treatment provided to covered children, young adults, and adults for a substance use disorder, by level of care provided;
4. per-member, per-month claim expenses for covered children, young adults, and adults who received covered treatment for substance use disorders; and
5. number of in-network health care providers who provide substance use disorder treatment, by level of care, and the percentage of such providers who are accepting new clients under the MCO's plans.

The bill requires the commissioner to include the above information in his annual Consumer Report Card on Health Insurance Carriers in Connecticut.

The bill also requires MCOs to report to the commissioner by May 1 annually:

1. the number, by licensure type, of health care providers who treat substance use disorders, co-occurring disorders, and mental disorders, who, in the preceding calendar year (a) applied for in-network status, and the percentage who were accepted, and (b) no longer participated in the network;
2. the number, by level of care provided, of health care facilities that treat substance use disorders, co-occurring disorders, and mental disorders, that, in the preceding calendar year (a) applied for in-network status, and the percentage that were accepted, and (b) no longer participated in the network; and
3. factors that may negatively affect covered enrollees' access to substance use disorder treatment, including screening procedures, the supply of health care providers and their capacity limitations, and provider reimbursement rates, and plans and ongoing or completed activities to address those

factors.

HEALTH INSURER

The bill requires each health insurer that provides coverage for the diagnosis and treatment of mental or nervous conditions under state law to report to the insurance commissioner, by May 1 annually, data on benefit requests, utilization review of benefit requests, adverse determinations, final adverse determinations, and external appeals, for the treatment of substance use disorders, co-occurring disorders, and mental disorders. The information must be grouped by (1) the level of care, (2) category, and (3) age group (i.e., children, young adult, and adults).

The bill requires the commissioner to include this information in his annual Consumer Report Card on Health Insurance Carriers in Connecticut for the 15 largest licensed health insurers.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 11 Nay 0 (03/13/2014)

Insurance and Real Estate Committee

Joint Favorable

Yea 15 Nay 2 (04/08/2014)