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Offered by:

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To: Subst. Senate Bill No. 322

File No. 382

Cal. No. 265

"AN ACT CONNECTING THE PUBLIC TO BEHAVIORAL HEALTH CARE SERVICES."

1 After the last section, add the following and renumber sections and
2 internal references accordingly:

3 "Sec. 501. Section 38a-478c of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective January 1, 2016*):

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

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

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

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

43 (3) A written statement of the types of financial arrangements or
44 contractual provisions that the managed care organization has with
45 hospitals, utilization review companies, physicians, preferred provider

46 networks and any other health care providers including, but not
47 limited to, compensation based on a fee-for-service arrangement, a
48 risk-sharing arrangement or a capitated risk arrangement;

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

78 (5) A summary of the procedures used by managed care

79 organizations to credential providers; [and]

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

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

108 (8) A state-wide report on the number, by licensure type, of health
109 care providers who provide treatment of substance use disorders, co-
110 occurring disorders and mental disorders, who, in the calendar year
111 immediately preceding for the initial report and since the last report

112 submitted to the commissioner for subsequent reports, (A) have
113 applied for in-network status and the percentage of those who were
114 accepted for such status, and (B) no longer participate in the network;

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

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

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

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

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

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

141 (e) The information required under subdivision (6) of subsection (a)

142 of this section shall be posted on the Insurance Department's Internet
143 web site.

144 Sec. 502. Section 38a-478*l* of the 2014 supplement to the general
145 statutes is repealed and the following is substituted in lieu thereof
146 (*Effective January 1, 2016*):

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

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

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

170 (A) "State medical loss ratio" means the ratio of incurred claims to
171 earned premiums for the prior calendar year for managed care plans
172 issued in the state. Claims shall be limited to medical expenses for

173 services and supplies provided to enrollees and shall not include
174 expenses for stop loss coverage, reinsurance, enrollee educational
175 programs or other cost containment programs or features;

176 (B) "Federal medical loss ratio" has the same meaning as provided
177 in, and shall be calculated in accordance with, the Patient Protection
178 and Affordable Care Act, P.L. 111-148, as amended from time to time,
179 and regulations adopted thereunder.

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

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

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

203 (2) Such data shall be collected in a manner consistent with the

204 National Committee for Quality Assurance Health Plan Employer Data
205 and Information Set (HEDIS) measures.

206 (d) The commissioner shall test market a draft of the consumer
207 report card prior to its publication and distribution. As a result of such
208 test marketing, the commissioner may make any necessary
209 modification to its form or substance. The Insurance Department shall
210 prominently display a link to the consumer report card on the
211 department's Internet web site.

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

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	<i>January 1, 2016</i>	38a-478c
Sec. 502	<i>January 1, 2016</i>	38a-478l