



General Assembly

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Raised Bill No. 6854

LCO No. 3459



Referred to Committee on PROGRAM REVIEW AND INVESTIGATIONS

Introduced by:
(PRI)

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE REPORTING OF CERTAIN DATA BY MANAGED CARE COMPANIES 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 Section 38a-478c of the general statutes is repealed and the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 and

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

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

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

128 (d) No managed care organization shall be liable for a claim arising
129 out of the submission of any information concerning complaints
130 concerning providers, provided the managed care organization
131 submitted the information in good faith.

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

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 Section 38a-478l of the general statutes is repealed and the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

137 (a) Not later than October fifteenth of each year, the Insurance
138 Commissioner, after consultation with the Commissioner of Public
139 Health, shall develop and distribute a consumer report card on all
140 managed care organizations. The commissioner shall develop the
141 consumer report card in a manner permitting consumer comparison

142 across organizations.

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

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

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

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

170 (c) [With respect to mental health services, the consumer report card
171 shall include information or measures with respect to the percentage of
172 enrollees receiving mental health services, utilization of mental health

173 and chemical dependence services, inpatient and outpatient
174 admissions, discharge rates and average lengths of stay.] (1) On or
175 before May first of each year, each health insurer that provides
176 coverage as set forth in section 38a-488a or 38a-514 shall submit to the
177 commissioner:

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

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

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

196 (d) The commissioner shall test market a draft of the consumer
197 report card prior to its publication and distribution. As a result of such
198 test marketing, the commissioner may make any necessary
199 modification to its form or substance. The Insurance Department shall
200 prominently display a link to the consumer report card on the
201 department's Internet web site.

202 (e) The commissioner shall analyze annually the data submitted
203 under subparagraphs (E) and (F) of subdivision (1) of subsection (b) of

204 this section for the accuracy of, trends in and statistically significant
205 differences in such data among the health care centers and licensed
206 health insurers included in the consumer report card. The
207 commissioner may investigate any such differences to determine
208 whether further action by the commissioner is warranted.

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

PRI *Joint Favorable*