



General Assembly

February Session, 2016

Raised Bill No. 5447

LCO No. 1272



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS.

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

1 Section 1. Subdivision (1) of subsection (a) of section 38a-478c of the
2 2016 supplement to the general statutes is repealed and the following
3 is substituted in lieu thereof (*Effective October 1, 2016*):

4 (1) (A) A report on its quality assurance plan that includes, but is
5 not limited to, information on complaints related to providers and
6 quality of care, on decisions related to patient requests for coverage
7 and on prior authorization statistics. Statistical information shall be
8 submitted in a manner permitting comparison across plans and shall
9 include, but not be limited to: [(A)] (i) The ratio of the number of
10 complaints received to the number of enrollees; [(B)] (ii) a summary of
11 the complaints received related to providers and delivery of care or
12 services and the action taken on the complaint; [(C)] (iii) the ratio of the
13 number of prior authorizations denied to the number of prior
14 authorizations requested; [(D)] (iv) the number of utilization review
15 determinations made by or on behalf of a managed care organization

16 not to certify an admission, service, procedure or extension of stay, and
17 the denials upheld and reversed on appeal within the managed care
18 organization's utilization review procedure; [(E)] (v) the percentage of
19 those employers or groups that renew their contracts within the
20 previous twelve months; and [(F)] (vi) notwithstanding the provisions
21 of this subsection, on or before July first of each year, all data required
22 by the National Committee for Quality Assurance for its Health Plan
23 Employer Data and Information Set. If an organization does not
24 provide information for the National Committee for Quality Assurance
25 for its Health Plan Employer Data and Information Set, then it shall
26 provide such other equivalent data as the commissioner may require
27 by regulations adopted in accordance with the provisions of chapter
28 54.

29 (B) The commissioner shall find that the requirements of [this]
30 subparagraph (A) of this subdivision have been met if the managed
31 care plan has received a one-year or higher level of accreditation by the
32 National Committee for Quality Assurance or the Accreditation
33 Association for Ambulatory Health Care and has submitted the Health
34 Plan Employee Data Information Set data required by subparagraph
35 (F) of this subdivision;

36 Sec. 2. Section 38a-472f of the general statutes is repealed and the
37 following is substituted in lieu thereof (*Effective October 1, 2016*):

38 Each insurer, health care center, managed care organization or other
39 entity that delivers, issues for delivery, renews, amends or continues
40 an individual or group health insurance policy or medical benefits
41 plan, and each preferred provider network, as defined in section 38a-
42 479aa, that contracts with a health care provider, as defined in section
43 38a-478, for the purposes of providing covered health care services to
44 its enrollees, shall maintain a network of such providers that is
45 consistent with the National Committee for Quality Assurance's
46 network adequacy requirements, [or] URAC's provider network access
47 and availability standards or the Accreditation Association for

48 Ambulatory Health Care.

49 Sec. 3. Subsection (b) of section 38a-478g of the 2016 supplement to
50 the general statutes is repealed and the following is substituted in lieu
51 thereof (*Effective October 1, 2016*):

52 (b) Each managed care organization shall provide every enrollee
53 with a plan description. The plan description shall be in plain language
54 as commonly used by the enrollees and consistent with chapter 699a.
55 The plan description shall be made available to each enrollee and
56 potential enrollee prior to the enrollee's entering into the contract and
57 during any open enrollment period. The plan description shall not
58 contain provisions or statements that are inconsistent with the plan's
59 medical protocols. The plan description shall contain:

60 (1) A clear summary of the provisions set forth in subdivisions (1) to
61 (12), inclusive, of subsection (a) of this section, subdivision (3) of
62 subsection (a) of section 38a-478c and sections 38a-478j to 38a-478l,
63 inclusive;

64 (2) A statement of the number of managed care organization's
65 utilization review determinations not to certify an admission, service,
66 procedure or extension of stay, and the denials upheld and reversed on
67 appeal within the managed care organization's utilization review
68 procedure;

69 (3) A description of emergency services, the appropriate use of
70 emergency services, including the use of E 9-1-1 telephone systems,
71 any cost sharing applicable to emergency services and the location of
72 emergency departments and other settings in which participating
73 physicians and hospitals provide emergency services and post
74 stabilization care;

75 (4) Coverage of the plans, including exclusions of specific
76 conditions, ailments or disorders;

77 (5) The use of drug formularies or any limits on the availability of
78 prescription drugs and the procedure for obtaining information on the
79 availability of specific drugs covered;

80 (6) The number, types and specialties and geographic distribution of
81 direct health care providers;

82 (7) Participating and nonparticipating provider reimbursement
83 procedure;

84 (8) Preauthorization and utilization review requirements and
85 procedures, internal grievance procedures and internal and external
86 complaint procedures;

87 (9) The state medical loss ratio and the federal medical loss ratio, as
88 both terms are defined in section 38a-478*l*, as reported in the last
89 Consumer Report Card on Health Insurance Carriers in Connecticut;

90 (10) The plan's for-profit, nonprofit incorporation and ownership
91 status;

92 (11) Telephone numbers for obtaining further information,
93 including the procedure for enrollees to contact the organization
94 concerning coverage and benefits, claims grievance and complaint
95 procedures after normal business hours;

96 (12) How notification is provided to an enrollee when the plan is no
97 longer contracting with an enrollee's primary care provider;

98 (13) The procedures for obtaining referrals to specialists or for
99 consulting a physician other than the primary care physician;

100 (14) The status of the National Committee for Quality Assurance or
101 the Accreditation Association for Ambulatory Health Care
102 accreditation;

103 (15) Enrollee satisfaction information; and

104 (16) Procedures for protecting the confidentiality of medical records
105 and other patient information.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2016</i>	38a-478c(a)(1)
Sec. 2	<i>October 1, 2016</i>	38a-472f
Sec. 3	<i>October 1, 2016</i>	38a-478g(b)

Statement of Purpose:

To add the Accreditation Association for Ambulatory Health Care as a recognized accreditation organization for managed care organizations in the state.

[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.]