



Report to

**Governor Dannel P. Malloy
Insurance and Real Estate Committee
Public Health Committee**

**Concerning the
Regulation of Managed Care**

**By:
Thomas B. Leonardi
Insurance Commissioner
March 1, 2013**

Executive Summary

Each year the Connecticut Insurance Department (CID) has the responsibility to provide a comprehensive report on managed care organizations (MCOs) operating in Connecticut. This report is submitted to the Governor's Office as well as the Insurance and Real Estate Committee and the Public Health Committee as mandated by Conn. Gen. Stat. §38a-478a. This annual review helps ensure that the MCOs that we regulate are accountable and responsive to consumers, and that patient rights are respected and upheld.

The information in this attached Managed Care Report is a broad-based overview of the CID's regulation and enforcement activity of MCOs. The CID's overview also includes scrutiny of MCOs' compliance in their policies and consumer protections with regard to federal health care reform - Patient Protection and Affordable Care Act (PPACA).

The CID is pleased to offer this report to provide insight into the work we are doing and the tools we make available to consumers in furtherance of our regulatory mission.

Among the report highlights, CID personnel:

- Compiled the annual [Consumer Report Card](#), a comprehensive comparison of managed care organizations in the state
- Handled 586 MCO-related consumer complaints
- Spoke to more than 1,800 citizens
- Participated in numerous public outreach programs
- Examined compliance for all 59 Utilization Review companies licensed during 2012 in Connecticut
- Distributed nearly 4,000 informational pamphlets
- Administered the External Review Program
- Provided oversight for 29 licensed Preferred Provider Networks

Table of Contents

I.	Structure of the Insurance Department	4
II.	External Review Process	5
III.	Consumer Report Card	6
IV.	Utilization Review	7
V.	Consumer Complaints.	8
VI.	Outreach Programs	9
VII.	Other	10
VIII.	List of Managed Care Organizations.....	11

I. Organizational Structure of the Insurance Department

The CID is composed of the following divisions:

Administration
Computer Support
Consumer Services & Business Regulation
Financial Examination
Actuarial
Legal
Life & Health
Property & Casualty

The following are the duties and responsibilities of divisions that have direct oversight of managed care:

Life and Health Division

- Reviews and approves managed care policy rates, forms, riders and applications
- Licenses utilization review companies
- Publishes managed care report card
- Provides technical support to Consumer Services & Business Regulation Division, MCOs, the Legislature and other state agencies regarding managed care issues

Consumer Services & Business Regulation

Consumer Affairs Health Insurance Unit

- Reviews managed care and UR complaints
- Oversees external review process
- Mediates claim disputes to determine whether statutory requirements and contractual obligations within Commissioner's jurisdiction have been met
- Conducts active outreach program to inform and educate consumers

Market Conduct

- Oversees UR compliance program on companies licensed by the CID to protect rights of health plan participants
- Examines data through surveys, on-site and desk audits
- Impose administrative action, including fines and remediation agreements, in cases of non-compliance

II. External Review Process

Five entities were chosen through a competitive bidding process to conduct external reviews. A Request for Proposal for external review was issued in September, 2011 and was featured on the CID's upgraded Web site under the new section "[Doing Business with CID](#)" and also shared via the CID's social media outlets – [Facebook](#) and [Twitter](#).

Nine (9) proposals were received by the CID. The **selection criteria** included:

- Specific experience in managed care utilization and/or peer review
- Reference from previous projects
- Clearly defined organization responsibilities
- Demonstration of committed staff resources
- Method used to protect patient confidentiality
- Method used to determine a reviewer's qualifications and training
- Process used for assigning cases to reviewers
- Detailed description of procedures to ensure no conflict of interest

The entities selected in 2011 to perform external appeals for the period January 1, 2012 through December 31, 2013 are:

1. IPRO, Inc.
1979 Marcus Avenue
Lake Success, NY 11042
2. MAXIMUS Federal Services, Inc.
11419 Sunset Hills Road
Reston, VA 20190
3. National Medical Reviews, Inc.
260 Knowles Avenue – Suite 330
Southampton, PA 18966
4. Permedion
350 Worthington Road, Suite H
Westerville, OH 43082
5. IMX Medical Management Services, Inc. (services terminated 12/31/12)
Two Bala Plaza – Suite 600
Bala Cynwyd, PA 19004

An [External Review Consumer Guide](#) has been published that includes the application to be used to initiate an appeal. The guide is revised annually to update federal poverty levels and to incorporate regulatory changes. The external review process has been expanded to include retrospective claim denials based on medical necessity. Information regarding this added option and an expedited external review process have been incorporated into the guide. This consumer-friendly brochure focused on four main goals:

- To inform consumers of the eligibility requirements.

- To educate consumers of the decision-making process used by managed care plans.
- To provide consumers with a “Request for External Review” form and the information necessary to properly file for an external review.
- To inform consumers as to how the external review process will work once all the necessary information to conduct the appeal is submitted.

Copies of the brochure are available by contacting the CID or by accessing the CID’s Web site. In addition, each utilization review denial letter from a utilization review company or managed care organization must inform the enrollee as to how to contact the CID in order to obtain information regarding the external review process. The final denial letter to an enrollee from the managed care organization or utilization review company must also include a copy of the external review application and brochure. In late 2012, the CID began redrafting the brochure to incorporate more consumer-friendly information, including an enhanced checklist of documentation that consumers can request from their providers to begin their appeals process. The CID intends to launch the revised and renamed brochure – “*Consumer’s Guide to Health Insurance Appeals and External Review*” – in the first quarter of 2013.

External review requests in 2012

- 303 requests for external reviews received
- 91 not accepted for full review because the enrollee did not meet eligibility requirements.
- 16 withdrawn before full review
- 196 accepted for full review
 - 52 (27%) reversed UR companies’ denials
 - 130 (69%) denials affirmed
 - 7 (4%) revised denials
 - 7 currently pending

III. Consumer Report Card

In February, 2012, the CID sent a survey to all managed care organizations (MCOs) in Connecticut, asking for information that would be included in the consumer report card. Each MCO was required to provide the requested information to the CID by May 1, 2012, with the exception of the Health Plan Employer Data and Information Set (HEDIS) data that, by statute, was not required until July 2, 2012. The Report Card was published October 1, 2012.

Report Card Contents: The CID required each MCO to file the following:

- Number of providers, specialists, hospitals and pharmacies by county
- Percentage of primary care physicians who are board certified
- Percentage of specialists who are board certified
- Percentage of employer groups who did not renew their contracts
- Provider turnover rate

- Profit/non-profit status
- NCQA accreditation status
- Utilization review statistics
- Mental health benefit utilization measures, including:
 - Inpatient discharges and average lengths of stays;
 - Follow-up after hospitalizations for mental illness;
 - Anti-depressant medication management; and
 - Alcohol and other drug services broken down by level of care
- Customer service information
- Breast cancer screening measures
- Cervical cancer screening measures
- Colorectal cancer screening measures
- Controlling high blood pressure measures
- Cholesterol management for patients with cardiovascular disease measures
- Childhood immunizations measures
- Pre-natal and post-partum care
- Adult access to preventive care
- Eye exams for people with diabetes
- Beta blocker treatments after a heart attack
- Outpatient prescription drug utilization
- Claim denial data
- Member Satisfaction Survey results

Report Card Distribution

The CID broadly distributed the Report Card by:

- Posting a copy on our [Web site](#)
- Mailing a copy to every public library in the state
- Advising every lawmaker by letter on how to access the report on our Web site
- Distributing at consumer outreach programs
- Issuing a press release to state-wide media outlets (print, radio, TV, Internet)
- Sharing it through CID's social media sites – [Facebook](#) and [Twitter](#)
- Providing it to walk-in visitors at CID

IV. Utilization Review

The CID is responsible for the licensing of all utilization review (UR) companies in accordance §38a-591j of the Connecticut General Statutes. In addition, each utilization review license is renewed annually on October 1. As part of the CID's renewal requirements, each utilization review company is required to demonstrate compliance with all statutory requirements.

In 2011, Public Act No. 11-58 brought the state's utilization review, internal grievance and external appeal requirements into compliance with the requirements set forth in the federal Patient Protection and Affordable Care Act, Pub.L.111-148, as amended by the Health Care and

Education Reconciliation Act of 2010, Pub. L. 111-152, (“PPACA”) and corresponding regulation 26 CFR Parts 54, 29 CFR 2590 and 45 CFR147 as amended

Under the new law, the definition of “utilization review” was amended to include retrospective review. Licensing requirements were limited to those entities conducting utilization review for fully insured plans issued or delivered in Connecticut that provide coverage of the type specified in subdivisions (1), (2), (4), (10), (11), (12) and (16) of Connecticut General Statute §38a-469. As a result of that change, there were 62 utilization review companies licensed or pending license renewal in Connecticut as of December 31, 2012.

The **Market Conduct** unit of the Consumer Services and Business Regulation Division conducted examinations of utilization review companies to determine if the companies are operating in compliance with all statutory requirements, including timeliness of decisions and notification requirements, adherence to confidentiality laws, and use of appropriate medical personnel.

The unit reviews company protocols and procedures used in the decision making to determine if the protocols and procedures are clearly communicated in written form. Additionally, the unit ensures that the protocols are periodically updated to reflect changes in medicine and statute and developed with local input from appropriately licensed medical professionals. The protocols must be made available to providers upon request. The unit also verifies, through review of sample case files, that specialists in the relevant medical fields are involved in utilization review determinations.

A written report is issued at the conclusion of the examination that states any compliance exceptions noted and the actions required of the company to remedy the exceptions.

2012 Utilization Review Market Conduct Survey:

- 59 licensed (as of January 1, 2012) UR companies were surveyed for compliance with state requirements
- 7 identified for more comprehensive review
- 11 administrative actions were imposed
- The most frequent areas cited .for improvements or modifications were:
 - Failure to comply with the statutory requirements for timely notification of the outcomes of determinations and appeals;
 - Failure to maintain sufficient documentation for all denials of certification;
 - Lack of proper appeal language and
 - Erroneous reporting of utilization review information to the Insurance Commissioner.

V. Consumer Complaints and Responsive Advocacy

The CID’s Consumer Services Division (CSD) continued its strong advocacy for enrollees and policy-holders in 2012. The unit helped the CID recover and return nearly \$4.1 million owed to consumers in all insurance categories with over \$2 million recovered from health and accident claims.

The Health Insurance sub-unit of the CSD researched and responded to 586 complaints concerning managed care organizations. Of those complaints, 110 were filed by or on behalf of enrollees and 476 were filed by providers. Claim payment delays accounted for 9 percent of all complaints.

The CSD maintains a record of all complaints filed and how many of those filed are determined to be justified against the managed care organizations. A [ranking report](#) of licensed companies based on justified and questionable complaints is published annually by the CID and is available on our Web site.

VI. Outreach

Consumer awareness, education and outreach are essential for policy-holders and enrollees to understand their rights and avenues of recourse. The professional and knowledgeable staff at the CID helps consumers “demystify” their health insurance each and every day.

Consumers have numerous ways to reach the CID, including phone, fax, e-mail and online links of “Ask a Question” and “How to File a Complaint.”

The CID continues to improve its access to the public through ongoing updates of our Web site well as through other social media such as Facebook and Twitter.

In 2011, the CID launched a dedicated “Rate Filings” section allowing full transparency of rate filing between carriers and the CID. The section features a public comment section and all correspondence between CID actuaries and the carrier. Additionally, the CID entered into an agreement with the Office of the HealthCare Advocate that provides for four public hearings a year on rate filings in excess of 15 percent at the OHA’s request.

Off-site, the CID participated in numerous outreach activities throughout 2012 in an effort to educate both the public and private sectors. Our outreach programs focus on urban families, senior groups, Hispanic groups, small business owners and health fairs.

2012 Consumer Outreach Activity

- Outreach representatives spoke to more than 1,810 Connecticut residents
- Distributed more than 3,700 pamphlets
- Responded to more than 148 requests for informational brochures
- Consumers were reached via newspapers, radio, cable access, network television, radio programs and social media outlets.
- The CID co-produced a series of outreach videos with the Capital Community College communication students, including topics on consumer resources and federal health care reform. The videos are located on the [Department YouTube channel](#).
- The CID partnered with Consumer Reports magazine to print more than 1,000 copies a federal health care reform guide. This publication is free to consumers and also can be downloaded from the CID’s Web site.

VII. Other

Connecticut General Statute §38a-479aa requires Preferred Provider Networks (PPNs) to be licensed with CID. A PPN is defined as an entity other than a managed care organization that accepts financial risk, pays claims (in the form of provider reimbursements) and contracts with providers for service. As of December 31, 2012, twenty nine (29) PPN entities were licensed.

Connecticut General Statutes §38a-479qq - §38a-479rr require Medical Discount Plan (MDP) Organizations to be licensed with the CID. A MDP organization is defined as a person that: (A) establishes a medical discount plan, (B) contracts with providers, provider networks, or other MDP organization to provide health care services at a discount, and (C) determines the fees charged to members for the plan. Specifically excluded from licensing requirements are health insurers, health care centers, hospital service corporations, medical service corporations, or fraternal benefit society licensed in this state or any affiliate of such health insurer or center. Also excluded from licensing are MDPs that issue discount cards that consumers can buy for less than twenty-five dollars (\$25) annually, irrespective of the amount of the discounts. As of December 31, 2012, seventeen (17) MDP Organizations were licensed.

Each managed care organization is required to file a report on its quality assurance plan, including prior authorization statistics and information required by the National Committee for Quality Assurance (NCQA) for the HEDIS. If a managed care organization did not submit HEDIS information to NCQA, the Commissioner deemed that the information required for the CID report card survey would be considered equivalent data. Much of the information received has been summarized and included in the “Consumer Report Card on Health Insurance Carriers in Connecticut” published by the CID in October, 2012.

Pharmacy Benefit Managers (PBMs) are required to obtain a certificate of registration from the CID. As of December 31, 2012, twenty-two (22) PBMs were registered.

All contracts, applications, and related forms to be delivered in this state by a managed care organization must receive approval by the CID prior to use. The review of these forms includes compliance with all applicable statutes and regulations. All MCOs have filed with the CID copies of their template contracts that they use with their providers.

During 2012, the CID updated information regarding managed care on its Web site. The postings include:

- Health insurance rate filings and long term care rate filings with public comment section
- A [“Health Care Reform”](#) page with FAQs, fact sheets and videos on PPACA
- List of all MCOs doing business in Connecticut
- Downloadable consumer brochure
- Downloadable copy of “Consumer Report Card on Health Insurance Carriers in Connecticut”
- Applications for
 - Utilization review license
 - Preferred provider network
 - Medical discount plan licenses

VIII. List of Managed Care Organizations as of December 31, 2012

Aetna Health, Inc.*

www.aetna.com

Aetna Life Insurance Company

www.aetna.com

American Republic Insurance Company

www.aric.com

Anthem Blue Cross & Blue Shield of Connecticut, Inc. *

www.anthem.com

Celtic Insurance Company

www.celtic-net.com

CIGNA HealthCare of Connecticut, Inc.*

www.cigna.com

CIGNA Health & Life Insurance Company

www.cigna.com

ConnectiCare, Inc.*

www.connecticare.com

ConnectiCare Insurance Company, Inc.

www.connecticare.com

Connecticut General Life Insurance Company

www.cigna.com

Golden Rule Insurance Company

www.goldenrule.com

Guardian Life Insurance Company

www.guardianlife.com

John Alden Life Insurance Company

www.assuranthealthc.om

Oxford Health Insurance, Inc.

www.oxhp.com

Oxford Health Plans (CT), Inc.*
www.oxhp.com

Time Insurance Company
www.assuranthealthc.om

Trustmark Insurance Company
www.trustmarkinsurance.com

Trustmark Life Insurance Company
www.trustmarkinsurance.com

Union Security Insurance Company
www.trustmarkinsurance.com

United HealthCare Insurance Company
www.uhc.com

* Health Maintenance Organization (HMO)