STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin HC - 54
July 9, 1997

To: All insurance companies and health care centers issuing Managed Care Plans in Connecticut

RE: Public Act 97-99, An Act Concerning Managed Care, as amended by PA 97-8 June 18 Special Session

Public Act 97-99, as amended by PA 97-8 June 18 Special Session, establishes a system for the regulation of Managed Care Organizations and Managed Care Plans. The Bill affects, among other things, Managed Care Plans **delivered, issued for delivery, renewed, or continued in Connecticut on or after October 1, 1997**.

The purpose of this Bulletin is to provide direction relative to the filing of contractual coverage documents as necessitated by the enactment of the subject legislation.

This Bulletin is not intended to be all inclusive, and there are additional requirements, set forth in the subject legislation, with which all Managed Care Organizations must comply.
In the upcoming months, this Department expects to issue further Bulletins, as necessary, to Managed Care Organizations in efforts to facilitate their compliance activities.

All Managed Care Organizations that desire to market Managed Care Plans, in the State of Connecticut, **on or after October 1, 1997**, must file and obtain approval of documents consistent with the following, **prior** to that date.

- All individual and group managed care contracts shall contain:

  1) The name and address of the Managed Care Organization;

  2) Eligibility requirements;

  3) A statement of copayments, deductibles or other out-of-pocket expenses the enrollee must pay;

  4) A statement of the nature of the health care services, benefits, or coverages to be furnished and the period during which they will be furnished and, if there are any services, benefits or coverages to be excepted, a detailed statement of such exceptions;

  5) A statement of terms and conditions upon which the contract may be canceled or otherwise terminated at the option of either party;

  6) Claims procedures;

  7) Enrollee grievance procedures;

8) Continuation of coverage;

9) Conversion;

10) Extension of benefits, if any;

11) Subrogation provisions, if any

12) Description of the service area, and out-of-area benefits and services, if any;

13) A statement of the amount the enrollee or others on his behalf must pay to the Managed Care Organization and the manner in which such amount is payable;

14) A statement that the contract includes the endorsement thereon and attached papers, if any, and contains the entire contract;

15) A statement that no statement by the enrollee in his application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; and

16) A statement of the grace period for making any payment due under the contract, which shall not be less than ten days.

- Each Managed Care Organization shall provide every enrollee with a plan description. The plan description shall be in plain language as commonly used by the enrollees and consistent with the Insurance Plain Language Act of Connecticut. The plan description shall be made available to each enrollee and potential enrollee prior to the enrollee's entering into the contract and during any open enrollment period. The plan description shall not contain provisions or statements that are inconsistent with the plan's medical protocols. The plan description shall contain:

  1) A clear summary of the provisions set forth in items 1-12, above;

  2) A written statement of the types of financial arrangements or contractual provisions that the Managed Care Organization has with hospitals, utilization review companies, physicians and any other health care providers including, but not limited to, compensation based on a fee-for- service arrangement, a risk-sharing arrangement or a capitated risk arrangement;

  3) Each plan description, issued in connection with a Managed Care Plan that requires a percentage coinsurance payment by the insured, shall explain that the Managed Care Plan will calculate the insured's coinsurance payment on the lesser of the provider's or vendor's charges for the goods or services or the amount payable by the Managed Care Organization for such goods or services, except as otherwise required by the laws of a state other than Connecticut when applicable to providers, vendors or patients in such state;

4) Each plan description shall disclose that no contract between the Managed Care Organization and any participating provider shall prohibit the provider from discussing with an enrollee any treatment options and services available in or out of network, including experimental treatments;

5) Each plan description shall disclose that no contract between the Managed Care Organization and any participating provider shall prohibit the provider from disclosing, to an enrollee who inquires, the method the Managed Care Organization uses to compensate the provider;

6) A statement disclosing that not later than March 15, 1999, and annually thereafter, the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall develop and distribute a consumer report card on all Managed Care Organizations. The Commissioner shall develop the consumer report card in a manner permitting consumer comparison across Managed Care Organizations.

7) A statement of the number of Managed Care Organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the Managed Care Organization's utilization review procedure;

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

9) Coverage of the plan, including exclusions of specific conditions, ailments or disorders;

10) The use of drug formularies or any limits on the availability of prescription drugs, and the procedure for obtaining information on the availability of specific drugs covered.

11) The number, types and specialties and geographic distribution of direct. health care providers;

12) Participating and non-participating provider reimbursement procedures;

13) Preauthorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

14) The medical loss ratio, or percentage of total premium revenue spent on medical care compared to administrative costs and plan marketing;

15) The plan's for-profit, nonprofit incorporation and ownership status;

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

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

18) The procedures for obtaining referrals to specialists or for consulting a physician other than the primary care physician;

19) The status of the National Committee of Quality Assurance accreditation;

20) Enrollee satisfaction information; and

21) Procedures for protecting the confidentiality of medical records and other patient information.

- **PA 97-99, as amended by PA 97-8 June 18 Special Session, also mandates that as of October 1, 1997, no group or individual health insurance policy may be delivered, issued for delivery, renewed, amended, continued, or substantially altered, in Connecticut**, unless such policy provides that persons covered under such policy will be eligible for expenses arising from biologically-based mental or nervous conditions that are at least equal to coverage for any other illness. All forms submitted must comply with this mandate as well as with any other applicable legislation.

This Department will review all required filings in the order in which they are received. We urge each Managed Care Organization to file the required documentation at their earliest possible convenience. To facilitate the approval process, this Department recommends that all filings be submitted as amendments to existing documents. All existing documents must also be submitted with approval dates, directing the Department to existing complying provisions. In this way, the Department will review the existing base documents in conjunction with the newly developed amendments, as a comprehensive package, for purposes of compliance with the subject legislation.

A copy of Public Act 97-99, as amended by PA 97-8 June 18 Special Session, may be obtained by contacting the Insurance Department web site at http://www.state.ct.us/cid or by calling (860) 297-3862.

If you have questions concerning the above, please do not hesitate to call the Department at the (860) 297-3862.

George M. Reider Jr.

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Insurance Commissioner