Report to

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

Concerning the
Regulation of Managed Care

By:
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Executive Summary

Each year the Connecticut Insurance Department 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 Public Act 97-99. 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.

One of the most essential components arising from the legislation and this report is the annual Consumer Report Card, "Comparison of Managed Care Organizations In Connecticut." The Report Card is available on the Insurance Department Web site, at every public library in the state, as well as other outlets. The Report Card allows consumers to compare MCOs based upon such benchmarks as levels of service, coverage plans, scope of network, and customer satisfaction. These are all important variables in helping consumers make an informed choice on where to spend their health care dollars.

The information in this attached Managed Care Report is a broad-based overview of the Insurance Department's regulation and enforcement activity of MCOs. The report addresses everything from adjudicating consumer complaints to the details of an expedited approval process that doctors use when treating a hospital patient in life-threatening situations.

Some of the highlights include the fact that CID personnel:

- Handled over 1,000 MCO-related consumer complaints
- Spoke to more than 2,800 citizens
- Examined compliance for all 113 Utilization Review companies currently licensed in Connecticut
- Distributed nearly 8,000 informational pamphlets
- Published an External Appeal Consumer Guide
- Participated in the selection of five external underwriting review companies, and
- Provided oversight for 28 licensed Preferred Provider Networks,

In addition, the attached report includes an overview of:

- Compliance data
- Enforcement action
- Consumer outreach programs
- Utilization review activity, including approvals of treatment and appeals of denials
- An overview of customer complaints
- A list of managed care organizations and their Web sites
- The mediators chosen to conduct external reviews of benefit denials through 2011 as well as the criteria used for selecting those mediators, and
- A brief description of the organizational structure of the CID and its regulatory and consumer advocacy functions as they relate to this report.

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.

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I. Structure of the Insurance Department

The Insurance Department is organized in the following components:
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, approves all managed care policy rates, forms, riders and applications
- Oversees expedited review process for inpatient utilization reviews (UR) requests
- 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

- Receives, reviews, responds to consumer complaints
- Mediates claim disputes to determine whether statutory requirements and contractual obligations within Commissioner's jurisdiction have been met
- Health insurance sub-unit
    - Reviews managed care and UR complaints
    - Oversees external appeals process
- Conducts active outreach program to inform and educate consumers

Market Conduct

- Oversees UR compliance program on companies licensed by 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 Appeals Process

Five entities were chosen through a competitive bidding process to conduct external reviews. Request for Proposal for external appeals was issued in May 2009. Seven (7) proposals were received by the Department. A committee comprising representatives of the Insurance Department, Department of Public Health and the Department of Social Services evaluated the proposals and selected five entities to conduct the external reviews. 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 2009 to perform external appeals for the period January 1, 2010 through December 31, 2011 are:

1. Empire State Medical, Scientific & Educational Foundation, Inc.
   100 Weatheridge Drive
   Camillus, NY 13031

2. Island Peer Review Organization
   1979 Marcus Avenue
   Lake Success, NY 11042

3. MAXIMUS Federal Services, Inc.
   50 Square Drive, Suite 210
   Victor, NY 14564

4. National Medical Reviews, Inc.
   8 Neshaminy Interplex
   Suite 207
   Trevose, PA 19053

5. Permedion
   350 Worthington Road, Suite H
   Westerville, OH 43082

An External Appeal 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 appeals process has been expanded to include retrospective claim denials based on medical necessity. In addition, an expedited external appeals process was established by statute in 2009 and

information regarding this added option has 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 Appeal" form and the information necessary to properly file for an external appeal.
- To inform consumers as to how the external appeal process will work once all the necessary information to conduct the appeal is submitted.

Copies of the brochure are available by contacting the Department or by accessing the Department'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 Insurance Department in order to obtain information regarding the external appeals 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 appeals application and brochure.

External review requests in 2010

- 293 requests for external reviews received
- 85 not accepted for full review because the enrollee did not meet eligibility requirements.
- 8 withdrawn before full review
- 200 accepted for full review
    - 68 (35 percent) reversed UR companies denial
    - 119 (61 percent) denials affirmed
    - 9 (5 percent) revised denial
    - 4 currently pending

III. Consumer Report Card

In March, 2010, the Department 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 Department by May 1, 2010, with the exception of the Health Plan Employer Data and Information Set (HEDIS) data that, by statute, was not required until July 1, 2010. The information solicited by the Department included:

- 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
- 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
- Member Satisfaction Survey results

A copy of the "Comparison of Managed Care Organizations in Connecticut" was published in October, 2010. A copy of the guide was mailed to all public libraries in Connecticut. In addition, each member was advised by letter as to how to access the guide on our Web site. The guide is made available at consumer outreach programs conducted by the Department, by contacting the Department directly or by accessing our Web site – www.ct.gov/cid - and click "Reports" link.

IV. Patients' Rights – The Expedited Review Process

Life-saving decisions that doctors need to make each and every day in hospitals must never be bogged down in red tape. In Connecticut, there are insurance laws to expedite approval for treatment if a doctor determines that his or her patient's life is endangered if the patient is discharged or if treatment is delayed. One such law is §38a-478p, C.G.S. which requires the establishment of an expedited review process for situations when an enrollee is admitted to an acute care hospital. If the attending physician transmits a request to a utilization review company for an expedited review and does not receive a response within three (3) hours from when he or she sent in the request, the request is deemed approved. Each utilization review company must have review staff available between 8:00 a.m. - 9:00 p.m. to process these requests.

This process requires that each utilization review company provide to the Department two (2) methods of communication for the attending physician to use to contact the company. The first method must be by telephone. The second method may be either a telephone system with voice messaging (for recording purposes) or a facsimile (with a confirmation system) and can be used when the attending physician cannot get through the initial contact number.

In accordance with the statute, this process was developed by a committee of representatives from the Insurance Department, Connecticut State Medical Society, Connecticut Hospital Association, Connecticut HMO Association and Anthem Blue Cross and Blue Shield. The process was implemented on November 1, 1997.

The Insurance Department maintains the directory of the two methods of communication and distributes it to all acute care hospitals in Connecticut on a monthly basis.

V. Utilization Review

The Insurance Department is responsible for the licensing of all utilization review (UR) companies in accordance with §38a-226 et al of the Connecticut General Statutes. In addition, each utilization review license is renewed annually on October 1. As part of the Department's renewal requirements, each utilization review company is required to demonstrate compliance with any new statutory requirements.

The consumer has the absolute right to appeal or challenge the decision of a UR company when benefits have been denied. In 2010, more than 45 percent of those denials that were appealed were reversed in favor of the consumer

As of December 31, 2010, there were 113 utilization review companies licensed in Connecticut. The activities for 2010 regarding utilization review in Connecticut, as reported to the Department to date, are as follows:

	# of UR requests	**# of UR denials**	**% of UR denials**	**# of appeals**	**# of denials reversed on appeal**	**% of denials reversed on appeal**
Connecticut only	858,982	109,791	12.78%	12,353	5,565	45.05%

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 determined 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.

2010 Utilization Review Market Conduct Survey:

- 113 licensed UR companies were surveyed for compliance with state requirements
- 14 identified for more comprehensive review
- 5 administrative actions (five) 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 documentation evidencing that all denials of certification were issued in writing;
    - Erroneous reporting of utilization review information to the Insurance Commissioner; and
    - Lack of proper appeal language.

VI. Consumer Complaints and Responsive Advocacy

The Department's Consumer Services division continued its strong advocacy for patients and policy-holders in 2010. The unit helped the Department return recovery nearly $3.4 million owed to consumers in all insurance categories with nearly $2 million recovered over health and accident claims.

The Health Insurance sub-unit of the CAU and responded to 1,025 complaints concerning managed care organizations. Of those complaints, 823 were filed by or on behalf of enrollees and 202 were filed by providers. Claim payment delays accounted for 11 percent of all complaints.

The Consumer Services Division 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 Insurance Department.

VII. Outreach

Consumer awareness, education and outreach are essential for policy-holders and patients to understand their rights and avenues of recourse. The professional and knowledgeable staff at the Department helps consumers "demystify" their health insurance each and every day. Consumers have numerous ways to reach the department, including phone, fax, e-mail and online links of "Ask a Question" and "How to File a Complaint." The Department continues to improve its access to the public through ongoing updates of our Web site.

Off-site, the Department participated in numerous outreach activities throughout 2010 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.

2010 Consumer Outreach Activity

- Outreach representatives spoke to more than 2,842 Connecticut residents
- Distributed more than 7,850 pamphlets
- Responded to more than 211 request for informational brochures
- Consumers were reached via newspapers, radio and cable access and radio programs.

VIII. Other

Connecticut General Statute §38a-479aa requires Preferred Provider Networks (PPNs) to be licensed with the Insurance Department. A PPN is defined as an entity that accepts financial risk, pays claims (in the form of provider reimbursements) and contracts with providers for service. It specifically excludes Managed Care Organizations, Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), Workers Compensation networks, and Private Clinical Laboratories from licensing requirements. As of December 31, 2010, twenty eight (28) Preferred Provider Network (PPN) entities were licensed.

Connecticut General Statutes §38a-479qq - §38a-479rr requires Medical Discount Plan (MDP) Organizations to be licensed with the Insurance Department. 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 MDP cards that cost less than twenty-five dollars ($25) annually. As of December 31, 2010, seventeen (17) Medical Discount Plan 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 Department report card survey would be considered equivalent data. Much of the information received has been summarized and included in the “Comparison of Managed Care Organizations in Connecticut” guide published by the Department in October, 2010.

As of January 1, 2008, Pharmacy Benefit Managers (PBMs) are required to obtain a certificate of registration from the Insurance Department. As of December 31, 2010, eighteen (18) PBMs were registered.

As of May 1, 2010, current model provider contracts were filed by all managed care organizations with the Department.

All contracts, applications, and related forms to be delivered in this state by a managed care organization must receive approval by the Department prior to use. The review of these forms includes compliance with all applicable statutes and regulations.

During 2010, the Insurance Department updated information regarding managed care on its internet web site. This information includes information regarding the federal Patient Protection and Affordable Care Act, health insurance rate filings, COBRA updates, a listing of managed care organizations doing business in Connecticut, information concerning the external appeals process, a copy of a consumer brochure and application form, a copy of “A Comparison of Managed Care Organizations in Connecticut”, the application for a utilization review license and the application forms for preferred provider network and medical discount plan licenses.

Managed Care Organizations
December 31, 2010

Aetna Health, Inc.*
www.aetna.com

Aetna Life Insurance Company
www.aetna.com

Alta Health & Life Insurance Company
www.altahealthplans.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

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

Health Net Insurance of Connecticut, Inc.
www.healthnet.com

Health Net of Connecticut, Inc.*
www.healthnet.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)