
**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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**Insurance Commissioner**
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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 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 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 patient in life-threatening situations. The Department'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 more than 600 MCO-related consumer complaints
- Spoke to more than 2,900 citizens
- Participated in numerous public outreach programs
- Examined compliance for all 113 Utilization Review companies licensed during 2011 in Connecticut
- Distributed nearly 8,000 informational pamphlets
- Published an External Appeal Consumer Guide
- Participated in the selection of five external review companies
- Provided oversight for 28 licensed Preferred Provider Networks

## *Table of Contents*

## I. Organizational Structure of the Insurance Department

The Insurance Department 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 appeals 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 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. A Request for Proposal for external appeals was issued in September, 2011 and was featured on the Department's upgraded Web site under the new section "Doing Business with CID" and also shared via the Department's social media outlets – Facebook and Twitter.

Nine (9) proposals were received by the Department. 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
   Southhampton, PA 18966

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

5. IMX Medical Management Services, Inc.
   Two Bala Plaza – Suite 600
   Bala Cynwyd, PA 19004

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 2011**

- 274 requests for external reviews received
- 101 not accepted for full review because the enrollee did not meet eligibility requirements.
- 13 withdrawn before full review
- 160 accepted for full review
  - 38 (24%) reversed UR companies' denial
  - 107 (69%) denials affirmed
  - 7 (4%) revised denial
  - 8 currently pending

## III. Consumer Report Card

In February, 2011, 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 2, 2011, with the exception of the Health Plan Employer Data and Information Set (HEDIS) data that, by statute, was not required until July 1, 2011. The Report Card was published October 1, 2011.

**Report Card Contents:** The Department 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
- 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 Department 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 Department's social media sites – Facebook and Twitter
- Providing it to walk-in visitors at Department

## IV. Utilization Review

The Insurance Department is responsible for the licensing of all utilization review (UR) companies in accordance with §38a-226 et al section 63 of Public Act No. 11-58 which replaced the former authority pursuant to Conn.Gen Stat. §38a-226. 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.

In 2001, 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, 2011.

In addition, statutory time frames for making determinations, filing and responding to internal appeals and external appeals as well as notification processes were modified to comply with PPACA. Currently licensed utilization review companies subject to these changes were required to modify denial letters to enrollees and providers as well as internal procedures. All modifications were filed with the Department within 30 days of the effective date. Utilization review companies no longer subject to licensure were required to evaluate and modify any correspondence sent to enrollees and providers that contained incorrect information as of July 1, 2011 as current state law requirements were no longer be effective.

The consumer has the absolute right to appeal or challenge the decision of a UR company when benefits have been denied. In 2011 more than 45 percent of those denials that were appealed were reversed in favor of the consumer

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.

**2011 Utilization Review Market Conduct Survey:**

- 113 licensed (as of January 1, 2011) UR companies were surveyed for compliance with state requirements
- 12 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 Department's Consumer Services Division (CSD) continued its strong advocacy for enrollees and policy-holders in 2011. The unit helped the Department recover and return nearly $4.3 million owed to consumers in all insurance categories with over $1 million recovered from health and accident claims.

The Health Insurance sub-unit of the CSD researched and responded to 638 complaints concerning managed care organizations. Of those complaints, 163 were filed by or on behalf of enrollees and 475 were filed by providers. Claim payment delays accounted for 4 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 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 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 well as through other social media such as Facebook and Twitter.

In 2011, the Department launched a dedicated "Rate Filings" section allowing full transparency of rate filing between carriers and the Department. The section features a public comment section and all correspondence between CID actuaries and the carrier. Additionally, the Department entered into a compromise 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.

The Off-site, the Department participated in numerous outreach activities throughout 2011 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.

**2011 Consumer Outreach Activity**

- Outreach representatives spoke to more than 2,925 Connecticut residents
- Distributed more than 8,050 pamphlets
- Responded to more than 196 requests for informational brochures
- Consumers were reached via newspapers, radio, cable access, network television, radio programs and social media outlets.

## VII. 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 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, 2011, 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 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, 2011, eighteen (18) 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 "Consumer Report Card on Health Insurance Carriers in Connecticut" published by the Department in October, 2011.

Pharmacy Benefit Managers (PBMs) are required to obtain a certificate of registration from the Insurance Department. As of December 31, 2011, sixteen (16) 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 Department prior to use. The review of these forms includes compliance with all applicable statutes and regulations. All MCOs have filed with the Department copies of their template contracts that they use with their providers.

During 2011, the Insurance Department updated information regarding managed care on its Web site. The postings include:

- Health insurance rate filing 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

**Managed Care Organizations**
**December 31, 2011**

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

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)