



# Senate

General Assembly

**File No. 208**

January Session, 2003

Substitute Senate Bill No. 917

*Senate, April 8, 2003*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## **AN ACT CONCERNING PREFERRED PROVIDER NETWORKS.**

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

1 Section 1. Section 38a-479aa of the general statutes is repealed and  
2 the following is substituted in lieu thereof (*Effective October 1, 2003*):

3 (a) As used in this section, sections 2 to 4, inclusive, of this act, and  
4 subsection (b) of section 20-138b:

5 (1) "Covered benefits" means health care services to which an  
6 enrollee is entitled under the terms of a managed care plan;

7 (2) "Enrollee" means an individual who is eligible to receive health  
8 care services through a preferred provider network;

9 ~~[(1)]~~ (3) "Health care services" means health care related services or  
10 products rendered or sold by a provider within the scope of the  
11 provider's license or legal authorization, and includes hospital,  
12 medical, surgical, dental, vision and pharmaceutical services or

13 products;

14 (4) "Managed care organization" means a managed care  
15 organization, as defined in section 38a-478;

16 (5) "Managed care plan" means a managed care plan, as defined in  
17 section 38a-478;

18 [(2)] (6) "Person" means an individual, agency, political subdivision,  
19 partnership, corporation, limited liability company, association or any  
20 other entity;

21 [(3)] (7) "Preferred provider network" or "network" means [an  
22 arrangement in which agreements relating to the health care services  
23 to be rendered by providers, including the amounts to be paid to the  
24 providers for such services, are entered into between such providers  
25 and a person who establishes, operates, maintains or underwrites the  
26 arrangement, in whole or in part, and includes any provider-  
27 sponsored preferred provider network or independent practice  
28 association that offers network services, but] a person, which is not a  
29 managed care organization, but which accepts financial liability for the  
30 delivery of health care services and establishes, operates or maintains  
31 an arrangement or contract with providers relating to (A) the health  
32 care services rendered by the providers, and (B) the amounts to be  
33 paid to the providers for such services. "Preferred provider network"  
34 or "network" does not include a workers' compensation preferred  
35 provider organization established pursuant to section 31-279-10 of the  
36 regulations of Connecticut state agencies; [or an arrangement relating  
37 only to health care services offered by providers to individuals covered  
38 under self-insured Employee Welfare Benefit Plans established  
39 pursuant to the federal Employee Retirement Income Security Act of  
40 1974, as from time to time amended;]

41 [(4)] (8) "Provider" means an individual or entity duly licensed or  
42 legally authorized to provide health care services; and

43 [(5)] (9) "Commissioner" means the Insurance Commissioner.

44 [(b) All preferred provider networks shall file with the  
45 commissioner prior to the start of enrollment and shall annually  
46 update such filing by July first of each year thereafter.]

47 (b) On and after May 1, 2004, no preferred provider network may  
48 conduct business in this state unless it is licensed by the commissioner.  
49 Any person seeking to obtain or renew a license shall submit an  
50 application to the commissioner, on such form as the commissioner  
51 may prescribe, and shall include the filing described in this subsection,  
52 except that a person seeking to renew a license may submit only the  
53 information necessary to update its previous filing. Applications shall  
54 be submitted by March first of each year in order to qualify for the  
55 May first license issue or renewal date. The filing required by such  
56 preferred provider network shall include the following information:  
57 (1) The identity of the preferred provider network and any company or  
58 organization controlling the operation of the preferred provider  
59 network, including the name, business address, contact person, a  
60 description of [such] the controlling company or organization and,  
61 where applicable, the following: (A) A certificate from the Secretary of  
62 the State regarding the preferred provider network's and the  
63 controlling company's or organization's good standing to do business  
64 in the state; (B) a copy of the preferred provider network's and the  
65 controlling company's or organization's [balance sheet at] financial  
66 statement completed in accordance with section 38a-54, as applicable,  
67 for the end of its most recently concluded fiscal year, along with the  
68 name and address of any public accounting firm or internal accountant  
69 which prepared or assisted in the preparation of such [balance sheet]  
70 financial statement; (C) a list of the names, official positions and  
71 occupations of members of the preferred provider network's and the  
72 controlling company's or organization's board of directors or other  
73 policy-making body and of those executive officers who are  
74 responsible for the preferred provider network and controlling  
75 company's or organization's activities with respect to the [medical  
76 care] health care services network; (D) a list of the preferred provider  
77 network's and the controlling company's or organization's principal

78 owners; (E) in the case of an out-of-state preferred provider network,  
79 controlling company or organization, a certificate that such preferred  
80 provider network, company or organization is in good standing in its  
81 state of organization; (F) in the case of a Connecticut or out-of-state  
82 preferred provider network, controlling company or organization, a  
83 report of the details of any suspension, sanction or other disciplinary  
84 action relating to such network, or controlling company or  
85 organization in this state or in any other state; and (G) the identity,  
86 address and current relationship of any related or predecessor  
87 controlling company or organization. For purposes of this  
88 subparagraph, "related" means that a substantial number of the board  
89 or policy-making body members, executive officers or principal  
90 owners of both companies are the same; (2) a general description of the  
91 preferred provider network and participation in the preferred provider  
92 network, including: (A) The geographical service area of and the  
93 names of the hospitals included in the preferred provider network;  
94 [and] (B) the primary care physicians, the specialty physicians, any  
95 other contracting [health care] providers and the number and  
96 percentage of each group's capacity to accept new patients; (C) a list of  
97 all entities on whose behalf the preferred provider network has  
98 contracts or agreements to provide health care services; (D) a table  
99 listing all major categories of health care services provided by the  
100 preferred provider network; (E) an approximate number of total  
101 enrollees served in all of the preferred provider network's contracts or  
102 agreements; (F) a list of subcontractors of the preferred provider  
103 network, not including individual participating providers, that assume  
104 financial risk from the preferred provider network and to what extent  
105 each subcontractor assumes financial risk; (G) a contingency plan  
106 describing how contracted health care services will be provided in the  
107 event of insolvency; and (H) any other information requested by the  
108 commissioner; and (3) the name and address of the person to whom  
109 applications may be made for participation.

110 (c) Any person developing a preferred provider network, or  
111 expanding a preferred provider network into a new county, pursuant

112 to this section and subsection (b) of section 20-138b, shall publish a  
113 notice, in at least one newspaper having a substantial circulation in the  
114 service area in which the preferred provider network operates or will  
115 operate, indicating such planned development or expansion. Such  
116 notice shall include the medical specialties included in the preferred  
117 provider network, the name and address of the person to whom  
118 applications may be made for participation and a time frame for  
119 making application. The preferred provider network shall provide the  
120 applicant with written acknowledgment of receipt of the application.  
121 Each complete application shall be considered by the preferred  
122 provider network in a timely manner.

123 (d) (1) Each preferred provider network shall file with the  
124 commissioner and make available upon request from a provider [,] the  
125 general criteria for its selection or termination of providers. Disclosure  
126 shall not be required of criteria deemed by the preferred provider  
127 network to be of a proprietary or competitive nature that would hurt  
128 the preferred provider network's ability to compete or to manage  
129 health care services. For purposes of this section, [disclosure of] criteria  
130 is of a proprietary or [anticompetitive] competitive nature if it has the  
131 tendency to cause [health care] providers to alter their practice pattern  
132 in a manner that would circumvent efforts to contain health care costs  
133 and criteria is of a proprietary nature if revealing the criteria would  
134 cause the preferred provider network's competitors to obtain valuable  
135 business information.

136 (2) If a preferred provider network uses criteria that have not been  
137 filed pursuant to subdivision (1) of this subsection to judge the quality  
138 and cost-effectiveness of a provider's practice under any specific  
139 program within the preferred provider network, the preferred  
140 provider network may not reject or terminate the provider  
141 participating in that program based upon such criteria until the  
142 provider has been informed of the criteria that the provider's practice  
143 fails to meet.

144 (e) A preferred provider network [which has a limited network and

145 which does not provide any reimbursement when an enrollee obtains  
146 service outside that limited network shall inform each applicant of that  
147 fact prior to enrolling the applicant for coverage] shall permit the  
148 Insurance Commissioner to inspect its books and records.

149 (f) Each preferred provider network shall permit the commissioner  
150 to examine, under oath, any officer or agent of the preferred provider  
151 network or controlling company or organization with respect to the  
152 use of the funds of the network, company or organization, and  
153 compliance with (1) the provisions of this part and sections 2 to 4,  
154 inclusive, of this act, and (2) the terms and conditions of its contracts to  
155 provide health care services.

156 (g) Each preferred provider network shall file with the  
157 commissioner a notice of any material modification of any matter or  
158 document furnished pursuant to this part, and sections 2 to 4,  
159 inclusive, of this act, and shall include such supporting documents as  
160 are necessary to explain the modification.

161 (h) Each preferred provider network shall maintain a minimum net  
162 worth of either (A) the greater of (i) two hundred fifty thousand  
163 dollars, or (ii) an amount equal to eight per cent of its annual  
164 expenditures as reported on its most recent financial statement  
165 completed and filed with the commissioner in accordance with section  
166 38a-54, or (B) another amount determined by the commissioner.

167 (i) Each preferred provider network shall maintain or arrange for a  
168 letter of credit, bond, surety, reinsurance, or other financial security  
169 acceptable to the commissioner in an amount equal to any outstanding  
170 amounts owed by the preferred provider network to its participating  
171 providers for the exclusive use of paying any outstanding amounts  
172 owed participating providers in the event of insolvency. Such amount  
173 may be credited against the network's minimum net worth  
174 requirements set forth in subsection (h) of this section.

175 (j) Each preferred provider network shall pay the applicable license  
176 or renewal fee specified in section 38a-11, as amended by this act. The

177 commissioner shall use the amount of such fees solely for the purpose  
178 of regulating preferred provider networks.

179 (k) In no event, including, but not limited to, nonpayment by the  
180 managed care organization, insolvency of the managed care  
181 organization, or breach of contract between the managed care  
182 organization and the preferred provider network, shall a preferred  
183 provider network bill, charge, collect a deposit from, seek  
184 compensation, remuneration or reimbursement from, or have any  
185 recourse against an enrollee or enrollee's designee, other than the  
186 managed care organization, for covered benefits provided.

187 (l) Each contract or agreement between a preferred provider  
188 network and a participating provider shall contain a provision that if  
189 the preferred provider network fails to pay for health care services as  
190 set forth in the contract, the enrollee shall not be liable to the  
191 participating provider for any sums owed by the managed care  
192 organization or preferred provider network.

193 Sec. 2. (NEW) (*Effective May 1, 2005*) (a) On and after May 1, 2005, no  
194 managed care organization may enter into, renew, continue or  
195 maintain a contractual relationship with a preferred provider network  
196 that is not licensed in accordance with section 38a-479aa of the general  
197 statutes, as amended by this act.

198 (b) Each managed care organization that contracts with a preferred  
199 provider network shall maintain or require the preferred provider  
200 network to maintain a letter of credit, bond, surety, reinsurance or  
201 other financial security acceptable to the Insurance Commissioner in  
202 an amount equal to any outstanding amounts owed by the preferred  
203 provider network to its participating providers. In the event of  
204 insolvency such security shall be used by the preferred provider  
205 network, or other entity designated by the commissioner, solely for the  
206 purpose of paying any outstanding amounts owed participating  
207 providers.

208 (c) Each managed care organization that contracts with a preferred

209 provider network shall provide at the time the contract is entered into  
210 and annually thereafter:

211 (1) Information, as determined by the managed care organization,  
212 regarding the amount and method of remuneration to be paid to the  
213 preferred provider network;

214 (2) Information, as determined by the managed care organization, to  
215 assist the preferred provider network in being informed regarding any  
216 financial risk assumed under the contract or agreement, including, but  
217 not limited to, enrollment data, primary care provider to covered  
218 person ratios, provider to covered person ratios by specialty, a table of  
219 the services that the preferred provider network is responsible for,  
220 expected or projected utilization rates, and all factors used to adjust  
221 payments or risk-sharing targets;

222 (3) The National Associations of Insurance Commissioners annual  
223 statement for the managed care organization; and

224 (4) Any other information the commissioner may require.

225 (d) Each managed care organization shall ensure that any contract it  
226 has with a preferred provider network includes:

227 (1) A provision that requires the preferred provider network to  
228 provide to the managed care organization at the time a contract is  
229 entered into, annually, and upon request of the managed care  
230 organization, (A) the financial statement completed in accordance with  
231 section 38a-54 of the general statutes, as applicable, and section 38a-  
232 479aa of the general statutes, as amended by this act; (B)  
233 documentation that satisfies the managed care organization that the  
234 preferred provider network has sufficient ability to accept financial  
235 risk; and (C) documentation that satisfies the managed care  
236 organization that a preferred provider network has appropriate  
237 management expertise and infrastructure;

238 (2) A provision that requires the preferred provider network to  
239 provide to the managed care organization a quarterly status report that

240 includes (A) information updating the financial statement completed  
241 in accordance with section 38a-54 of the general statutes, as applicable,  
242 and section 38a-479aa of the general statutes, as amended by this act;  
243 (B) a report showing amounts paid to those providers who provide  
244 health care services on behalf of the managed care organization; (C) an  
245 estimate of payments due providers but not yet reported by providers;  
246 and (D) amounts owed to providers for that quarter;

247 (3) A provision that requires the preferred provider network to  
248 provide notice to the managed care organization not later than thirty  
249 days after (A) any change involving the ownership structure of the  
250 preferred provider network; (B) financial or operational concerns  
251 regarding the financial viability of the preferred provider network; or  
252 (C) the preferred provider network's loss of a license in this or any  
253 other state;

254 (4) A provision that if the managed care organization fails to pay for  
255 health care services as set forth in the contract, the enrollee will not be  
256 liable to the provider or preferred provider network for any sums  
257 owed by the managed care organization or preferred provider  
258 network;

259 (5) A provision that the preferred provider network shall include in  
260 all contracts between the preferred provider network and participating  
261 providers a provision that if the preferred provider network fails to  
262 pay for health care services as set forth in the contract, for any reason,  
263 the enrollee will not be liable to the participating provider or preferred  
264 provider network for any sums owed by the managed care  
265 organization or preferred provider network;

266 (6) A provision requiring the preferred provider network to provide  
267 information to the managed care organization, satisfactory to the  
268 managed care organization, regarding the preferred provider  
269 network's reserves for financial risk;

270 (7) A provision that (A) the preferred provider network or managed  
271 care organization shall post and maintain a letter of credit, bond,

272 surety, reinsurance or other financial security acceptable to the  
273 commissioner in an amount equal to any outstanding amounts owed  
274 by the preferred provider network to its participating providers, (B)  
275 the managed care organization shall determine who posts the security  
276 required under subparagraph (A) of this subdivision, and (C) that in  
277 the event of insolvency, such security shall be used by the preferred  
278 provider network, or other entity designated by the commissioner,  
279 solely for the purpose of paying any outstanding amounts owed  
280 participating providers;

281 (8) A provision under which the managed care organization is  
282 permitted, at the discretion of the managed care organization, to pay  
283 participating providers directly and in lieu of the preferred provider  
284 network, in the event of insolvency or mismanagement by the  
285 preferred provider network;

286 (9) A provision transferring and assigning contracts between the  
287 preferred provider network and participating providers to the  
288 managed care organization for the provision of future services by  
289 participating providers to enrollees, at the discretion of the managed  
290 care organization, in the event the preferred provider network  
291 becomes insolvent or otherwise ceases to conduct business, as  
292 determined by the commissioner; and

293 (10) A provision that each contract or agreement between the  
294 preferred provider network and participating providers shall include a  
295 provision transferring and assigning contracts between the preferred  
296 provider network and participating providers to the managed care  
297 organization for the provision of future health care services by  
298 participating providers to enrollees, at the discretion of the managed  
299 care organization, in the event the preferred provider network  
300 becomes insolvent or otherwise ceases to conduct business, as  
301 determined by the commissioner.

302 (e) Each managed care organization that contracts with a preferred  
303 provider network shall have adequate procedures in place to notify the  
304 commissioner that a preferred provider network has experienced an

305 event that may threaten the preferred provider network's ability to  
306 materially perform under its contract with the managed care  
307 organization. The managed care organization shall provide such notice  
308 to the commissioner not later than five days after it discovers that the  
309 preferred provider network has experienced such an event.

310 (f) Each managed care organization that contracts with a preferred  
311 provider network shall monitor and maintain systems and controls for  
312 monitoring the financial health of the preferred provider networks  
313 with which it contracts.

314 (g) Each managed care organization that contracts with a preferred  
315 provider network shall provide to the commissioner, and update on an  
316 annual basis, a contingency plan, satisfactory to the commissioner,  
317 describing how health care services will be provided to enrollees if the  
318 preferred provider network becomes insolvent or is mismanaged. The  
319 contingency plan shall include a description of what contractual and  
320 financial steps have been taken to ensure continuity of care to enrollees  
321 if the preferred provider network becomes insolvent or is  
322 mismanaged.

323 (h) Notwithstanding any agreement to the contrary, each managed  
324 care organization shall retain full responsibility for providing coverage  
325 for health care services pursuant to any applicable managed care plan  
326 or any applicable state or federal law.

327 (i) Notwithstanding any agreement to the contrary, each managed  
328 care organization shall be able to demonstrate to the satisfaction of the  
329 commissioner that the managed care organization can fulfill its  
330 nontransferable obligations to provide coverage for the provision of  
331 health care services to enrollees in any event, including, but not limited  
332 to, the failure, for any reason, of a preferred provider network.

333 (j) Nothing in section 38a-479aa of the general statutes, as amended  
334 by this act, or sections 2 to 4, inclusive, of this act, shall be construed to  
335 require a preferred provider network to share proprietary information  
336 with a managed care organization concerning contracts or financial

337 arrangements with providers who are not included in that managed  
338 care organization's network, or other preferred provider networks or  
339 managed care organizations.

340 Sec. 3. (NEW) (*Effective October 1, 2003*) (a) If the Insurance  
341 Commissioner determines that a preferred provider network or  
342 managed care organization, or both, have not complied with any  
343 provision in section 38a-479aa of the general statutes, as amended by  
344 this act, or sections 2 to 4, inclusive, of this act, the commissioner may  
345 (1) order the preferred provider network or managed care  
346 organization, or both, to cease and desist all operations in violation of  
347 said sections; (2) terminate or suspend the preferred provider  
348 network's license; (3) institute a corrective action against the preferred  
349 provider network or managed care organization, or both; (4) order the  
350 payment of a civil penalty by the preferred provider network or  
351 managed care organization, or both, of not more than one thousand  
352 dollars for each and every act or violation; (5) order the payment of  
353 such reasonable expenses as may be necessary to compensate the  
354 commissioner in conjunction with any proceedings held to investigate  
355 or enforce violations of section 38a-479aa of the general statutes, as  
356 amended by this act, and sections 2 to 4, inclusive, of this act; and (6)  
357 use any of the commissioner's other enforcement powers to obtain  
358 compliance with section 38a-479aa of the general statutes, as amended  
359 by this act, and sections 2 to 4, inclusive, of this act. The commissioner  
360 may hold a hearing concerning any matter governed by section 38a-  
361 479aa of the general statutes, as amended by this act, or sections 2 to 4,  
362 inclusive, of this act, in accordance with section 38a-16 of the general  
363 statutes. Subject to the same confidentiality and liability protections set  
364 forth in subsections (c) and (k) of section 38a-14 of the general statutes,  
365 the commissioner may engage the services of attorneys, appraisers,  
366 independent actuaries, independent certified public accountants or  
367 other professionals and specialists to assist the commissioner in  
368 conducting an investigation under this section, the cost of which shall  
369 be borne by the managed care organization or preferred provider  
370 network, or both, that is the subject of the investigation.

371 (b) If a preferred provider network fails to comply with any  
372 provision of section 38a-479aa of the general statutes, as amended by  
373 this act, or sections 2 to 4, inclusive, of this act, the commissioner may  
374 assign or require the preferred provider network to assign its rights  
375 and obligations under any contract with participating providers in  
376 order to ensure that covered benefits are provided.

377 (c) The commissioner shall receive and investigate any grievance  
378 filed against a preferred provider network or managed care  
379 organization, or both, by an enrollee or an enrollee's designee  
380 concerning matters governed by section 38a-479aa of the general  
381 statutes, as amended by this act, or sections 2 to 4, inclusive, of this act.  
382 The commissioner shall code, track and review such grievances. The  
383 preferred provider network or managed care organization, or both,  
384 shall provide the commissioner with all information necessary for the  
385 commissioner to investigate such grievances. The information  
386 collected by the commissioner pursuant to this section shall be  
387 maintained as confidential and shall not be disclosed to any person  
388 except to the extent necessary to carry out the purposes of section 38a-  
389 479aa of the general statutes, as amended by this act, and sections 2  
390 and 3 of this act, and as allowed under title 38a of the general statutes.

391 Sec. 4. (NEW) (*Effective October 1, 2003*) The Insurance  
392 Commissioner may adopt regulations, in accordance with chapter 54  
393 of the general statutes, to implement the provisions of section 38a-  
394 479aa of the general statutes, as amended by this act, and sections 2  
395 and 3 of this act.

396 Sec. 5. Subsection (a) of section 38a-11 of the general statutes is  
397 repealed and the following is substituted in lieu thereof (*Effective*  
398 *October 1, 2003*):

399 (a) The commissioner shall demand and receive the following fees:  
400 (1) For the annual fee for each license issued to a domestic insurance  
401 company, one hundred dollars; (2) for receiving and filing annual  
402 reports of domestic insurance companies, twenty-five dollars; (3) for  
403 filing all documents prerequisite to the issuance of a license to an

404 insurance company, one hundred seventy-five dollars, except that the  
405 fee for such filings by any health care center, as defined in section 38a-  
406 175, shall be one thousand one hundred dollars; (4) for filing any  
407 additional paper required by law, fifteen dollars; (5) for each certificate  
408 of valuation, organization, reciprocity or compliance, twenty dollars;  
409 (6) for each certified copy of a license to a company, twenty dollars; (7)  
410 for each certified copy of a report or certificate of condition of a  
411 company to be filed in any other state, twenty dollars; (8) for  
412 amending a certificate of authority, one hundred dollars; (9) for each  
413 license issued to a rating organization, one hundred dollars. In  
414 addition, insurance companies shall pay any fees imposed under  
415 section 12-211; (10) a filing fee of twenty-five dollars for each initial  
416 application for a license made pursuant to section 38a-769; (11) with  
417 respect to insurance agents appointments: (A) A filing fee of twenty-  
418 five dollars for each request for any agent appointment; (B) a fee of  
419 forty dollars for each appointment issued to an agent of a domestic  
420 insurance company or for each appointment continued; and (C) a fee  
421 of twenty dollars for each appointment issued to an agent of any other  
422 insurance company or for each appointment continued, except that no  
423 fee shall be payable for an appointment issued to an agent of an  
424 insurance company domiciled in a state or foreign country which does  
425 not require any fee for an appointment issued to an agent of a  
426 Connecticut insurance company; (12) with respect to insurance  
427 producers: (A) An examination fee of seven dollars for each  
428 examination taken, except when a testing service is used, the testing  
429 service shall pay a fee of seven dollars to the commissioner for each  
430 examination taken by an applicant; (B) a fee of forty dollars for each  
431 license issued; and (C) a fee of forty dollars for each license renewed;  
432 (13) with respect to public adjusters: (A) An examination fee of seven  
433 dollars for each examination taken, except when a testing service is  
434 used, the testing service shall pay a fee of seven dollars to the  
435 commissioner for each examination taken by an applicant; and (B) a fee  
436 of one hundred twenty-five dollars for each license issued or renewed;  
437 (14) with respect to casualty adjusters: (A) An examination fee of ten  
438 dollars for each examination taken, except when a testing service is

439 used, the testing service shall pay a fee of ten dollars to the  
440 commissioner for each examination taken by an applicant; (B) a fee of  
441 forty dollars for each license issued or renewed; and (C) the expense of  
442 any examination administered outside the state shall be the  
443 responsibility of the entity making the request and such entity shall  
444 pay to the commissioner one hundred dollars for such examination  
445 and the actual traveling expenses of the examination administrator to  
446 administer such examination; (15) with respect to motor vehicle  
447 physical damage appraisers: (A) An examination fee of forty dollars  
448 for each examination taken, except when a testing service is used, the  
449 testing service shall pay a fee of forty dollars to the commissioner for  
450 each examination taken by an applicant; (B) a fee of forty dollars for  
451 each license issued or renewed; and (C) the expense of any  
452 examination administered outside the state shall be the responsibility  
453 of the entity making the request and such entity shall pay to the  
454 commissioner one hundred dollars for such examination and the  
455 actual traveling expenses of the examination administrator to  
456 administer such examination; (16) with respect to certified insurance  
457 consultants: (A) An examination fee of thirteen dollars for each  
458 examination taken, except when a testing service is used, the testing  
459 service shall pay a fee of thirteen dollars to the commissioner for each  
460 examination taken by an applicant; (B) a fee of two hundred dollars for  
461 each license issued; and (C) a fee of one hundred twenty-five dollars  
462 for each license renewed; (17) with respect to surplus lines brokers: (A)  
463 An examination fee of ten dollars for each examination taken, except  
464 when a testing service is used, the testing service shall pay a fee of ten  
465 dollars to the commissioner for each examination taken by an  
466 applicant; and (B) a fee of five hundred dollars for each license issued  
467 or renewed; (18) with respect to fraternal agents, a fee of forty dollars  
468 for each license issued or renewed; (19) a fee of thirteen dollars for  
469 each license certificate requested, whether or not a license has been  
470 issued; (20) with respect to domestic and foreign benefit societies shall  
471 pay: (A) For service of process, twenty-five dollars for each person or  
472 insurer to be served; (B) for filing a certified copy of its charter or  
473 articles of association, five dollars; (C) for filing the annual report, ten

474 dollars; and (D) for filing any additional paper required by law, three  
 475 dollars; (21) with respect to foreign benefit societies: (A) For each  
 476 certificate of organization or compliance, four dollars; (B) for each  
 477 certified copy of permit, two dollars; and (C) for each copy of a report  
 478 or certificate of condition of a society to be filed in any other state, four  
 479 dollars; (22) with respect to reinsurance intermediaries: A fee of five  
 480 hundred dollars for each license issued or renewed; (23) with respect  
 481 to viatical settlement providers: (A) A filing fee of thirteen dollars for  
 482 each initial application for a license made pursuant to section 38a-465a;  
 483 and (B) a fee of twenty dollars for each license issued or renewed; (24)  
 484 with respect to viatical settlement brokers: (A) A filing fee of thirteen  
 485 dollars for each initial application for a license made pursuant to  
 486 section 38a-465a; and (B) a fee of twenty dollars for each license issued  
 487 or renewed; (25) with respect to preferred provider networks, a fee of  
 488 two thousand five hundred dollars for each license issued or renewed;  
 489 (26) with respect to rental companies, as defined in section 38a-799, a  
 490 fee of forty dollars for each permit issued or renewed; and [(26)] (27)  
 491 with respect to each duplicate license issued a fee of twenty-five  
 492 dollars for each license issued.

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>May 1, 2005</i>
Sec. 3	<i>October 1, 2003</i>
Sec. 4	<i>October 1, 2003</i>
Sec. 5	<i>October 1, 2003</i>

**INS**      *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Type	FY 04 \$	FY 05 \$
Insurance Dept.	New Revolving Fund - Net Revenue Gain	125,000	104,000

**Municipal Impact:** None

**Explanation**

The bill results in a net revenue gain to the state. The bill requires preferred provider networks (PPNs) to pay a \$2,500 licensing fee to the Department of Insurance (DOI). Based upon the current number of PPNs in the state (75), the bill would generate \$187,500 per year. The bill specifies that the revenue from the fees can only be used to regulate PPNs.

It is anticipated that DOI could incur \$63,000 in the first year and \$84,000 in the second year (annualized) in order to comply with the requirements of the bill. These costs include the need for an additional associate examiner position (salary of \$57,546, fringe benefits of \$23,139,<sup>1</sup> and \$2,900 in expenses). The agency may also require additional resources for enforcement of the regulations and appeals, the extent of which is unknown at this time but which would not exceed the annual revenue generated by the licensing fee.

<sup>1</sup> Since the Department of Insurance is a special fund agency, the cost of fringe benefits is contained directly in the agency’s budget.

**OLR Bill Analysis**

sSB 917

**AN ACT CONCERNING PREFERRED PROVIDER NETWORKS****SUMMARY:**

This bill revises the law regulating preferred provider networks (networks) to require formal licensing by the insurance commissioner instead of an annual informational filing. Under the bill, a network is an organization that accepts financial liability for the delivery of health care services and establishes, operates, or maintains an arrangement or contract to (1) deliver such services by participating providers and (2) pay those providers for the delivery of services to covered enrollees. Networks are not managed care organizations (MCOs) or health care services covered under a self-insured employee welfare benefit plan established under the Employee Retirement Income Security Act.

The bill establishes licensing procedures, expands the information networks must file with their license application, and subjects networks to examination by the commissioner. It establishes (1) minimum net worth and financial solvency requirements for networks, (2) mandatory provisions in contracts between networks and MCOs, (3) certain legal obligations MCOs must satisfy in arrangements they may have with networks, and (4) procedures for covered enrollees to lodge a complaint against a network.

The bill also (1) prohibits networks and their providers from seeking compensation from, or having recourse against, network enrollees for the payment of benefits; (2) requires MCOs under contract with networks to file certain financial information with the commissioner, and (3) specifies that MCOs under contract with networks are responsible for health care services.

Finally, the bill authorizes the commissioner to adopt certain regulations.

EFFECTIVE DATE: October 1, 2003 except for the provisions on (1) posting financial security and financial information filing, (2) contractual provisions between networks and MCOs, (3) enrollee hold

harmless, (4) insolvency, and (5) MCO monitoring of network financial stability and management expertise, which are effective May 1, 2005

### **LICENSING REQUIREMENTS (§ 1(B), 2(A), AND 5(A))**

Beginning May 1, 2004, the bill requires licensing by the commissioner for networks conducting business in the state, and prohibits, on or after May 1, 2005, any MCO from entering into, renewing, continuing, or maintaining a contractual relationship with an unlicensed network. To obtain or renew a license, the bill requires the networks to submit an application to the commissioner on a form she prescribes and pay a new or renewal license fee of \$2,500. Applications must be submitted by March 1 annually to meet the May 1 issuance or renewal date. The application must include most of the same information networks must currently file with the commissioner; which is:

1. the identity of the network and the name and business address of a contact person;
2. a description of any Connecticut controlling company and a certificate of good standing from the secretary of the state for the network and the controlling company;
3. a copy of the network and controlling company's audited financial statement for their most recent fiscal year, and the names, official positions, and occupations of their members, board of directors, or other policymaking body, executive officers responsible for the medical care service network and owners;
4. a report of any suspension, sanction, or other disciplinary action relating to an in-or out-of-state network or controlling company;
5. the identity, address and current relationship of any related or predecessor controlling company where a substantial number of the board or policymaking body members, executive officers, or principal owners of both companies are the same;
6. a list of all entities on whose behalf the network has contracts or agreements to provide health care services and a table listing all major categories of health care services the networks provides;

7. the approximate number of total enrollees served in all of the network's contracts or agreements, a list of the network's subcontractors that assume financial risk and the extent each assumes financial risk, not including individual providers;
8. a contingency plan describing how contracted health care services will be provided in the event of insolvency;
9. a certificate showing that any out-of-state network and controlling company is in good standing in its state of organization;
10. the geographic area and the names of the hospitals included in the network's plan of operation; and
11. the number of primary care and specialty care doctors, and other contracting providers, the percentage of each group's capacity to accept new patients, and any other information the commissioner requests.

#### **EXAMINATION (§ 1(F) AND (G))**

The bill requires networks to permit the commissioner to inspect their books and records and to examine, under oath, any officer or agent of the network or controlling company about the use of network or controlling company funds and compliance with (1) the financial accountability provisions of the bill and (2) its contract to provide health care services. Networks must notify the commissioner of any material modification of any matter or document furnished or filed under the bill and include any supporting or necessary document to explain the modification.

#### **NET WORTH AND FINANCIAL SOLVENCY REQUIREMENTS (§ 1(H), (I)) AND 2(B) AND(C))**

The bill requires networks to maintain a minimum net worth of either (1) the greater of (a) \$250,000, or (b) an amount equal to 8% of its annual expenditures as reported on its most recent financial statement completed and filed with the commissioner or (2) another amount the commissioner determines.

The bill requires networks or MCOs to maintain or arrange for a letter of credit, bond, surety, reinsurance, or other financial security

acceptable to the commissioner in an amount equal to any outstanding debt owed the network's participating providers and to use it to pay such debt in the event of insolvency. The amount may be credited against the network's minimum net worth requirement. The MCO must determine who posts the security.

The bill also requires MCOs at the time they enter into a contract with a network and annually thereafter to provide the commissioner with information (1) about the amount and method of compensating a network, as determined by the MCO; (2) to assist a network in being informed about financial risk assumed under the contract, including enrollment data, primary-care-provider-to-covered person ratios, provider-to-covered-person ratios by specialty, services the network is responsible for, expected or projected utilization rates, and factors used to adjust payments or risk-sharing targets; (3) included in the National Association of Insurance Commissioners' annual statement for MCOs; and (4) the commissioner may require.

#### **MANDATORY CONTRACT PROVISIONS (§ 1(D))**

The bill requires MCOs to ensure that any contract they have with a network include the following provisions:

1. At the time a contract is entered into, and annually thereafter the network must provide the MCO, at the MCO's request, with (a) a complete and audited financial statement; (b) documentation, satisfactory to the MCO, that the network has sufficient ability to accept financial risk; and (c) documentation, satisfactory to the MCO, that the network has appropriate management expertise and infrastructure.
2. The network must provide quarterly status reports to the MCO that include (a) updated financial statement information; (b) a report showing the amount paid to providers who render health care services on behalf of the MCO; (c) an estimate of payments due providers but not yet reported; and (d) amounts owed providers for that quarter.
3. The network must notify the MCO no later than 30 days after (a) a change in the network's ownership structure; (b) concerns about its financial or operational viability; or (c) the loss of its' license in this or another state.

4. If the MCO fails to pay for health care services, that health plan enrollees will not be liable to providers or the network for any sums owed by either the MCO or network.
5. The networks must include in all contracts between it and providers a provision that if the network fails for any reason, to pay for health care services, the enrollee will not be liable to the providers or the network for any sums owed by either the network or MCO.
6. The network must provide information, satisfactory to the MCO, about its reserves for financial risk.
7. The MCO must maintain or require the network to maintain a letter of credit, bond, surety, reinsurance, or other financial security acceptable to the commissioner, in an amount equal to its outstanding debt owed to providers and use it exclusively to pay them in the event of insolvency.
8. At its discretion, MCO may pay providers directly in the event of insolvency or mismanagement by the network.
9. At its discretion, in the event of a network's insolvency, MCO may transfer or assign contracts between the network and providers to the MCO for future services.
10. At MCO's discretion, contracts between the network and providers must include provision transferring and assigning contracts between the network and providers to the MCO for future health care services in the event of the network's insolvency.

The bill specifies that a network is not required to share proprietary information with a MCO about its contractual arrangement with providers who are not part of the networks and other networks and MCOs.

#### **MCO'S OBLIGATION (§ 1(E)-(J))**

The bill requires MCOs that contract with networks to (1) have adequate procedures in place to notify the commissioner, no later than five days after discovery, that a network has experienced an event that

may threaten its ability to materially perform its contractual obligations; (2) monitor and maintain systems and controls for monitoring the financial health of a network with which it contracts, and (3) provide the commissioner with an annually updated contingency plan describing how health care services will be provided to enrollees in the event of the network's insolvency or mismanagement, including a description of what contractual and financial steps have been taken to ensure continuity of care in the event of the network's insolvency or mismanagement.

The bill specifies that MCOs must demonstrate to the commissioner's satisfaction that they can fulfill their obligation to provide health care services to enrollees in any event, including the failure of a network. The bill makes MCOs responsible for providing coverage for health care services under the managed care plan or applicable state or federal law.

### **COMPLAINT PROCEDURE (§ 3(C))**

The bill requires the commissioner to receive and investigate any grievance filed by an enrollee against a network, MCO, or both relating to the bill's provisions. She must code, track, and review each grievance, and the network, MCO, or both must provide her with all relevant information necessary for the investigation. The commissioner must maintain as confidential, information she collects in the course of her investigation and may not disclose it except to the extent necessary to ensure compliance with the bill's provisions or bring an enforcement action under Connecticut's insurance laws.

### **ENFORCEMENT AUTHORITY (§ 3(A) AND (B))**

The bill specifies that, if the commissioner determines that a network, MCO, or both has failed to comply with its provisions, she may take the following enforcement actions against the network, MCO, or both: (1) issue an cease and desist operations order; (2) terminate or suspend a license; (3) institute a corrective action; (4) order the payment of a civil penalty of not more than \$1,000 for each act or violation; (5) order the payment of reasonable expenses necessary to compensate the commissioner for the cost of the investigation or enforce action; (6) assign, or require the network to assign, its rights and obligations to providers; and (7) use any of the her existing enforcement authority to obtain compliance with the bill's requirements.

**HEARING AND PROFESSIONAL SERVICES**

The bill authorizes the commissioner to hold hearings on any matter governed by the bill and hire attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists to assist her in conducting investigations. The network, MCO, or both, that are the subject of an investigation must bear the cost of hired professionals.

**REGULATIONS (§ 4)**

The bill authorizes the commissioner to adopt implementing regulations, including those to implement provisions requiring (1) networks to prove financial stability, (2) certain contract provisions, (3) enrollee hold-harmless, (4) MCO responsibilities, (5) enforcement authority, and (6) complaint procedures.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 16    Nay 1