



General Assembly

**Raised Bill No. 392**

February Session, 2014

LCO No. 1677



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

**AN ACT CONCERNING HEALTH CARE PROVIDER NETWORK ADEQUACY.**

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

1 Section 1. Section 38a-472f of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective January 1, 2015*):

3 (a) Each insurer, health care center, managed care organization or  
4 other entity that delivers, issues for delivery, renews, amends or  
5 continues an individual or group health insurance policy or medical  
6 benefits plan, and each preferred provider network, as defined in  
7 section 38a-479aa, that contracts with a health care provider, as defined  
8 in section 38a-478, for the purposes of providing covered health care  
9 services to its enrollees, shall: [maintain a]

10 (1) Maintain an adequate network of such providers [that is  
11 consistent with the National Committee for Quality Assurance's  
12 network adequacy requirements or URAC's provider network access  
13 and availability standards.] in accordance with the provisions of this  
14 section; and

15     (2) Report annually to the commissioner for each of its policies or  
16 plans the number of enrollees and the number of participating in-  
17 network health care providers.

18     (b) (1) The commissioner, in consultation with the Healthcare  
19 Advocate, shall assess through actuarial analysis the provider network  
20 adequacy of each such insurer, health care center, managed care  
21 organization, other entity or preferred provider network. Such  
22 assessment shall be done annually at the time of license renewal or at  
23 the time of initial licensure and annually thereafter.

24     (2) No insurer, health care center, managed care organization, other  
25 entity or preferred provider network shall exclude from its provider  
26 network any appropriately licensed type of health care provider as a  
27 class.

28     (3) Each provider network shall be adequate to meet the  
29 comprehensive needs of the enrollees of the insurer, health care center,  
30 managed care organization or other entity and provide an appropriate  
31 choice of health care providers sufficient to provide the services  
32 covered under the policies or plans of such insurer, health care center,  
33 managed care organization or other entity. The actuarial analysis  
34 required under subdivision (1) of this subsection shall determine (A)  
35 whether a network includes a sufficient number of geographically  
36 accessible participating health care providers for the number of  
37 enrollees in a given region, (B) whether enrollees have the opportunity  
38 to select from at least five primary care health care providers within  
39 reasonable travel time and distance, taking into account the conditions  
40 for provider access in rural areas, (C) whether a network includes  
41 sufficient health care providers in each area of specialty practice to  
42 meet the needs of the enrollee population, and (D) that such network  
43 does not exclude health care providers as set forth in subdivision (2) of  
44 this subsection.

45     (4) In assessing provider network adequacy, the commissioner and  
46 the Healthcare Advocate shall consider (A) the availability and

47 accessibility of appropriate and timely care provided to disabled  
48 enrollees in accordance with the Americans with Disabilities Act of  
49 1990, 42 USC 12101 et seq., as amended from time to time, (B) the  
50 network's capability to provide culturally and linguistically competent  
51 care to meet the needs of the enrollee population, and (C) the number  
52 of grievances filed pursuant to sections 38a-591c to 38a-591g, inclusive,  
53 related to waiting times for appointments, appropriateness of referrals  
54 and other indicators of limited network capacity.

55 (c) (1) If the commissioner believes a provider network is not  
56 adequate or that other indicators of limited network capacity exist, the  
57 commissioner shall:

58 (A) Require the insurer, health care center, managed care  
59 organization, other entity or preferred provider network to conduct a  
60 statistically valid survey of (i) a random sample of in-network health  
61 care providers to determine each participating provider's full-time  
62 equivalency for a given health plan's enrollees, and (ii) a random  
63 sample of enrollees, including new enrollees, who have received  
64 services within the three months immediately preceding to determine  
65 whether and to what extent such enrollees have had or are having  
66 difficulty obtaining timely appointments with in-network health care  
67 providers;

68 (B) Examine the contracting practices of such insurer, health care  
69 center, managed care organization, other entity or preferred provider  
70 network, including, but not limited to, the willingness of such insurer,  
71 health care center, managed care organization, other entity or  
72 preferred provider network to enter into good faith negotiations with  
73 nonparticipating health care providers. To determine good faith, the  
74 commissioner shall interview representatives of such insurer, health  
75 care center, managed care organization, other entity or preferred  
76 provider network, participating in-network health care providers and  
77 health care providers who chose not to contract with such insurer,  
78 health care center, managed care organization, other entity or  
79 preferred provider network; and

80 (C) Interview enrollees, including new enrollees, of such insurer,  
81 health care center, managed care organization or other entity about  
82 such enrollees' experiences in obtaining an appointment with an in-  
83 network health care provider.

84 (2) The commissioner shall approve the methodology used for any  
85 survey conducted pursuant to subparagraph (A) of subdivision (1) of  
86 this subsection.

87 (d) The commissioner may conduct or undertake any other activities  
88 the commissioner determines are reasonably necessary to assess  
89 provider network adequacy of an insurer, health care center, managed  
90 care organization, other entity or preferred provider network.

91 Sec. 2. Section 38a-1041 of the general statutes is amended by adding  
92 subsection (g) as follows (*Effective January 1, 2015*):

93 (NEW) (g) The Healthcare Advocate shall consult with the  
94 Insurance Commissioner as set forth in section 38a-472f, as amended  
95 by this act, to assess and ensure health care provider network  
96 adequacy.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2015</i>	38a-472f
Sec. 2	<i>January 1, 2015</i>	38a-1041

**INS**      *Joint Favorable*