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**OLR Bill Analysis****SB 392*****AN ACT CONCERNING HEALTH CARE PROVIDER NETWORK ADEQUACY.*****SUMMARY:**

This bill requires insurers and related entities to maintain adequate health care provider networks in compliance with standards the bill sets, rather than standards set by either of two nonprofit organizations, the National Committee for Quality Assurance (NCQA) or URAC, previously known as the Utilization Review Accreditation Commission. NCQA and URAC accredit and certify a wide range of health care organizations. Their network adequacy standards address a number of the areas covered by the standards the bill sets, including the number and geographic distribution of health care providers based on the ability of plan enrollees to receive needed care.

The bill applies to insurers, health care centers (HMOs), managed care organizations (MCOs), or other similar entities and preferred provider networks (PPNs). It requires these entities to annually report to the insurance commissioner the number of enrollees and participating in-network providers for each of their policies or plans. (It does not specify when these annual reports are due.) It requires the insurance commissioner, in consultation with the healthcare advocate, to assess the adequacy of each network through an actuarial analysis done at the time of initial licensure and annually at license renewal. It requires the commissioner to take certain steps if a network is inadequate.

The bill also prohibits insurers or the other entities from excluding from their networks any class of appropriately licensed health care provider.

EFFECTIVE DATE: January 1, 2015

## **ADEQUATE NETWORKS**

Under the bill, provider networks must be adequate to (1) meet the comprehensive needs of policy or plan enrollees and (2) provide an appropriate choice of providers sufficient to provide covered services.

### ***Actuarial Analysis***

The commissioner's actuarial analysis of a network, done in consultation with the healthcare advocate, must determine if:

1. the network includes a sufficient number of geographically accessible participating providers for the number of enrollees in a given region,
2. enrollees can choose from at least five primary care providers within a reasonable travel time and distance,
3. a network includes sufficient providers in each area of specialty practice to meet enrollees' needs, and
4. the network improperly excludes any class of appropriately licensed providers.

In assessing a network's adequacy, the commissioner and healthcare advocate must consider the:

1. availability and accessibility of appropriate and timely care provided to disabled enrollees, in accordance with the federal Americans with Disabilities Act;
2. network's ability to provide culturally and linguistically competent care to meet enrollees' needs; and
3. number of grievances enrollees filed related to waiting times for appointments, appropriateness of referrals, and other things indicating limited network capacity.

The bill allows the commissioner to conduct or undertake any activity he determines reasonably necessary to assess a network's adequacy.

***Requirements if a Network is Inadequate***

Under the bill, if the commissioner determines a network is inadequate, or otherwise finds limited network capacity, he must require the insurer, HMO, MCO, other entity, or PPN to conduct a statistically valid survey of a random sample of (1) in-network providers to determine each provider's full-time equivalency for a given health plan's enrollees and (2) enrollees who have received services within the last three months to determine whether, and to what extent, they have had or are having difficulty getting timely appointments with in-network providers. The commissioner must approve the survey methodology.

Additionally, if the commissioner determines a network is inadequate, or otherwise finds limited network capacity, he must:

1. examine the insurer's, HMO's, MCO's, entity's, or PPN's contracting practices, including its willingness to enter into good faith negotiations with nonparticipating providers, by interviewing (a) representatives of the insurer, HMO, MCO, entity, or PPN; (b) participating in-network providers; and (c) nonparticipating providers and
2. interview enrollees, including new enrollees, of the insurer, HMO, MCO, or entity about their experiences in getting appointments with an in-network provider.

**BACKGROUND**

***Related Federal Law***

The federal Patient Protection and Affordable Care Act (P.L. 111-148) requires all carriers issuing qualified health plans through a health insurance exchange to meet certain network adequacy requirements (45 CFR 155.1050 and 156.230). The act sets a minimum, and allows states to develop more stringent requirements.

Under the act, carriers must:

1. have a network for each plan with a sufficient number, geographic distribution, and types of providers, including those

that specialize in mental health and substance abuse services, to ensure all services are accessible without unreasonable delay;

2. include in networks a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved people; and
3. make its provider directory available to the exchange for publication online and to potential enrollees in hard copy upon request.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 10    Nay 9    (03/20/2014)