



Senate

General Assembly

File No. 287

February Session, 2014

Senate Bill No. 392

Senate, April 2, 2014

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 bill ought to pass.

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 Section 38a-472f of the general statutes is repealed and the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*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 \$	FY 16 \$
Insurance Department	IF - Cost	747,000	769,000

Municipal Impact: None

Explanation

The bill is anticipated to result in a cost of \$747,000 to the Insurance Fund (IF) beginning in FY 15 for additional staff and resources at the Insurance Department. The bill requires the Insurance Department to actuarially assess the adequacy of provider networks, examine insurers' contracting practices, and interview both enrollees and providers. These additional costs include: 1) personal services costs of \$510,000 for six full time positions (a program manager, three market conduct examiners, and two research analysts) and two part time (an actuary and an attorney); 2) fringe benefit costs of \$187,000; and \$50,000 for network data modeling software.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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)