



General Assembly

January Session, 2015

Raised Bill No. 6867

LCO No. 3529



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 Section 38a-472f of the general statutes is repealed and the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, 2016*):

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

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

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

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

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

44 (4) In assessing provider network adequacy, the commissioner and

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

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

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

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

77 health care center, managed care organization, other entity or
78 preferred provider network; and

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

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

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

90 Sec. 2. Section 38a-1041 of the general statutes is amended by adding
91 subsection (h) as follows (*Effective January 1, 2016*):

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2016</i>	38a-472f
Sec. 2	<i>January 1, 2016</i>	38a-1041

Statement of Purpose:

To require insurers, health care centers, managed care organizations or other entities and preferred provider networks to maintain adequate health care provider networks and the Insurance Commissioner, in consultation with the Healthcare Advocate, to assess such network adequacy.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]