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Network Adequacy
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§§ 38a-472f-1—38a-472f-6

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Network Adequacy

Sec. 38a-472f-1. Policy Definitions

For purposes of sections 38a-472f-2 to 38a-472f-5, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Ancillary service" means a health care service that is not provided as part of an office visit, outpatient procedure or hospital admission, but for which a patient presents at a separate facility or site of service.

(2) "Primary care physician" means a participating health care provider designated by a health carrier to supervise, coordinate or provide initial health care services or continuing health care services to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services provided to the covered person.

(3)(A) "Specialist" means a health care provider who (i) focuses on a specific area of physical, mental or behavioral health or a specific group of patients, and (ii) has successfully completed required training and is recognized by this state to provide specialty care.

(B) "Specialist" includes a subspecialist who has additional training and recognition beyond that required for a specialist.

(4) "Urgent care" means a condition, other than an emergency condition, manifesting itself by acute symptoms of sufficient severity that, in the assessment of a prudent layperson possessing an average knowledge of medicine and health, could reasonably be expected to result in serious impairment of bodily functions, serious dysfunction of a bodily organ or a body part, or one's mental ability, or any other condition that would place the health or safety of the covered person in serious jeopardy in the absence of treatment within twenty-four (24) hours.

(Effective July 2, 2018)

Sec. 38a-472f-2. Health insurance carrier standards and responsibilities

Each health carrier that delivers, issues for delivery, renews, amends or continues any individual or group health insurance policy or certificate in this state that uses a provider network shall:

(1) Contract with the appropriate type and number of health care providers to ensure that each person covered by such health carrier under such a plan or certificate has reasonable access to participating providers located near such covered person's place of residence or employment. Reasonable access includes maintaining a sufficient number and appropriate types of participating providers that predominately serve, without unreasonable travel or delay:

(A) Low income individuals;

(B) Medically underserved individuals;

(C) Individuals with serious, chronic or complex illnesses; and

(D) Individuals with physical or mental disabilities.

(2) Make additional arrangements to meet the needs of persons covered by such health

carrier under such a health insurance policy or certificate if the requirements of subdivision (1) cannot be met, including the needs of:

(A) Low-income individuals;

(B) Children and adults with serious, chronic or complex conditions or physical or mental disabilities; or

(C) Individuals with limited English proficiency.

(3) Establish and maintain a process to ensure that each person covered by such health carrier under such a health insurance policy or certificate receives a covered benefit at an in-network level, including an in-network level of cost-sharing, from a nonparticipating provider, or shall make other arrangements acceptable to the commissioner, when:

(A) The health carrier has a sufficient network but does not have available:

(i) A type of participating provider to provide the covered benefit to the covered person; or

(ii) A participating provider to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay or within the standard timeframes recommended by the commissioner.

(4) Monitor, on an ongoing basis, compliance with provider contracts, and the ability, clinical capacity and legal authority of its participating providers to provide all covered benefits to its covered persons.

(5) Establish and maintain procedures by which a participating provider shall be notified, on an ongoing basis, of the specific covered health care services for which such participating provider shall be responsible, including any limitations on, or conditions of, such services.

(6) Notify participating providers of their obligations, if any:

(A) To collect applicable coinsurance, deductibles or copayments from a person covered pursuant to such a plan or certificate;

(B) To hold covered persons harmless from balance billing beyond any contractual cost-sharing amounts;

(C) Regarding surprise billing practices;

(D) To notify each covered person, prior to delivery of health care services if possible, of such covered person's financial obligations, if any, for non-covered benefits;

(E) To provide at least sixty (60) days' advance notice to such health carrier when the participating provider leaves such health carrier's provider network; and

(F) To provide to such health carrier, not later than thirty (30) days after the health carrier receives the notice of termination described in subparagraph (E) of this subdivision, a list of the participating provider's patients who are covered under a health insurance policy or certificate delivered, issued for delivery, renewed, amended or continued by such health carrier in this state.

(7) Establish and maintain procedures by which a participating provider may determine, in a timely manner, at the time benefits are provided whether an individual is a covered

person or is within a grace period during which such health carrier may hold a claim for health care services pending receipt of payment of any premium by such health carrier.

(8) Timely notify a health care provider or facility, when the health carrier has included the health care provider or facility as a participating provider for any of such health carrier's health insurance policies or certificates, of such health care provider's or facility's network participation status.

(9) Notify each participating provider of the participating provider's responsibilities with respect to such health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, hold harmless agreements, utilization review, quality assessment and improvement programs, credentialing, grievance and appeals processes, data reporting requirements, reporting requirements for timely notice of changes in practice such as discontinuance of accepting new patients, notice of termination as a network provider, confidentiality requirements, any applicable federal or state programs and obtaining necessary approval of referrals to nonparticipating providers.

(10) Establish and maintain procedures for the resolution of administrative, payment or other disputes between such health carrier and participating providers.

(11) Provide at least sixty (60) days' advance written notice to a participating provider before such health carrier removes the participating provider from such health carrier's participating provider network.

(12) Make a good faith effort to provide written notice, not later than thirty (30) days from receipt of the list of the participating providers' patients who are covered persons, to all covered persons who are patients being treated on a regular basis by such provider. For purposes of this subsection, "treated on a regular basis" means receiving treatment at least once during the twelve (12) months immediately prior to provision of the thirty (30) day notice described in this subdivision.

(13) Require that any subcontracted network meets the standards set forth in this section, including all network adequacy standards, and monitor compliance with those standards.

(14) Disclose to a person covered under such a policy or certificate issued by such health carrier the process to request a covered benefit from a nonparticipating provider, when:

(A) The covered person is diagnosed with a condition or disease that requires specialty care; and

(B) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(15) Make a reasonable effort to contract with centers of excellence, mobile clinics, technological and specialty care services, walk-in clinics, urgent care facilities and regionalized specialty care providers, as applicable.

(16) Establish procedures to meet network adequacy standards.

(17) Establish and document any issues of non-compliance and corrective actions.

(Effective July 2, 2018)

Sec. 38a-472f-3. Minimum Standards for Network Adequacy

(a) Each health carrier that delivers, issues for delivery, renews, amends or continues any individual or group health insurance policy or certificate in this state that uses a provider network shall:

(1) Establish and monitor the provider network to ensure that a person covered under the policy or certificate has access to health care services within the maximum time and distance standards.

(2) Ensure that the provider network has at least one primary care physician per two thousand (2,000) covered persons.

(3) Ensure that the percentage of providers participating in the network that accept new patients is at least seventy percent (70%).

(4) Establish reasonable wait times for access to primary care, urgent care, specialist care, mental health, ancillary services and any other categories of service, and monitor provider compliance with the requirements established pursuant to this subdivision.

(5) Demonstrate a good faith effort to contract with centers of excellence, mobile clinics, walk-in clinics, urgent care facilities and providers of technological or specialty care services, to the extent available.

(6) Have an adequate process in place to provide in-network levels of coverage from nonparticipating providers, without unreasonable travel or delay or unreasonable wait time for an appointment, when a participating provider is not available.

(7) Demonstrate a good faith effort to contract with hospital-based providers.

(8) Ensure that covered persons:

(A) Have access to emergency services, as defined in section 38a-477aa of the Connecticut General Statutes, twenty-four (24) hours a day, seven (7) days a week.

(B) Have reasonable access to participating providers within normal business hours.

(9) Ensure that participating providers shall have admitting rights to at least one participating hospital, where appropriate.

(b) No individual or group health insurance policy or certificate that uses a provider network shall be delivered, issued for delivery, renewed, amended or continued in this state if the provider network does not meet the required minimum standards for network adequacy set forth in subsection (a) of this section.

(Effective July 2, 2018)

Sec. 38a-472f-4. Minimum Standards for Provider Directories

Each health carrier that delivers, issues for delivery, renews, amends or continues any individual or group health insurance policy or certificate in this state that uses a provider network shall:

(1) Post an on-line provider directory in searchable format for each provider network that is made available in the state;

(2) Clearly label the provider network so it may be linked to a specific plan offered;

(3) Update the on-line provider directory no less than monthly;

(4) Make the provider directory accessible to both members and non-members;

(5) State the date the provider directory was last updated;

(6) Make a hard copy of the provider directory, that is updated no less than annually, available upon request;

(7) Provide an e-mail address and telephone number to report inaccurate information;

(8) Indicate whether each participating provider listed in the provider directory accepts new patients, and whether such health care provider is accepting new patients on an outpatient services basis;

(9) Indicate the languages spoken in each participating provider's office or facility;

(10) Indicate whether each participating provider's office or facility is handicapped accessible;

(11) Indicate the participating providers for each different tier of benefits, if applicable;

(12) Establish and maintain an audit process to ensure accuracy of provider directories;

(13) Ensure the provider directory accommodates the communication needs of individuals with disabilities or limited English proficiency and provides information on how to receive assistance;

(14) Provide by type, for participating facilities other than hospitals, the facility name, the type, the types of health care services performed at the facility and the facility's location and telephone number;

(15) Provide, for each participating facility that is a hospital, the hospital name, the type (such as acute, rehabilitation, children's or cancer), location and telephone number;

(16) Provide, for each participating health care provider, the health care provider's name, contact information, specialty (if applicable) and participating office location or locations;

(17) Indicate whether participating health care providers are authorized to admit patients to hospitals participating in the network; and

(18) Indicate whether hospital-based health care providers are participating providers and see patients on an outpatient service basis.

(Effective July 2, 2018)

Sec. 38a-472f-5. Annual Filing Requirements

Each health carrier that delivers, issues for delivery, renews, amends or continues any individual or group health insurance policy or certificate in this state that uses a provider network shall submit an annual report, in the form of a survey response, to the Commissioner regarding the adequacy of the network. Each health carrier shall submit a separate report for each provider network used by the health carrier, and each report shall be in a form prescribed by the commissioner. The commissioner shall provide at least sixty

(60) days' advance notice to a health carrier of the due date of the report required by this section.

(Effective July 2, 2018)

Sec. 38a-472f-6. Separability

If any provision of sections 38a-472f-1 to 38a-472f-5, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstances, is for any reason held to be invalid, the remainder of said sections, and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective July 2, 2018)