

**State of Connecticut
Regulation of
Insurance Department
Concerning
Network Adequacy**

The Regulations of Connecticut State Agencies are amended by adding sections 38a-472f-1 through 38a-472f-6, inclusive, as follows.

(NEW) Sec. 38a-472f-1. Policy Definitions

Except as provided hereafter, no individual or group health insurance policy or certificate delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section. For purposes of these regulations, the following definitions apply:

1. “Ancillary service” means a 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. Such services include but are not limited to radiology, clinical laboratory, or pharmacy.
2. “Primary care physician” means an advanced practice registered nurse (APRN) or a physician practicing general medicine, internal medicine, family medicine, or general pediatrics.
3. “Specialist” means a physician that is not a primary care physician.
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, 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.

(NEW) Sec. 38a-472f-2. Health Insurance Carrier Standards and Responsibilities

Each carrier that offers health insurance plans that include a network shall:

(a) Contract with appropriate type and number of providers to assure that such health carrier’s covered persons have reasonable access to participating providers located near such covered persons’ places of residence or employment. Reasonable access includes:

- (1) maintaining a sufficient number and appropriate types of participating providers that predominately serve low income individuals without unreasonable travel or delay,
- (2) maintaining a sufficient number and appropriate types of participating providers that predominately serve medically underserved individuals without unreasonable travel or delay,
- (3) maintaining a sufficient number and appropriate types of participating providers that predominately serve individuals with serious, chronic or complex illnesses without unreasonable travel or delay, and
- (4) maintaining a sufficient number and appropriate types of participating providers that predominately serve individuals with physical or mental disabilities without unreasonable travel or delay;

(b) Make additional arrangements to meet the needs of covered persons if the requirements of subsection (a) cannot be met, including the needs of:

- (1) low-income individuals,
- (2) children and adults with serious, chronic or complex conditions or physical or mental disabilities, or
- (3) individuals with limited English proficiency;
- (c) Establish and maintain a process to ensure that a covered person 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:
 - (1) The health carrier has a sufficient network but does not have:
 - (A) a type of participating provider available to provide the covered benefit to the covered person, or
 - (B) a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or
 - (2) 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.
 - (d) Monitor on an ongoing basis the compliance with provider contracts, and ability, clinical capacity, and legal authority of its participating providers to provide all covered benefits to its covered persons;
 - (e) Establish and maintain procedures by which a participating provider will be notified on an ongoing basis of the specific covered health care services for which such participating provider will be responsible, including any limitations on or conditions of such services;
 - (f) Notify participating providers of their obligations, if any:
 - (1) to collect applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person's health benefit plan,
 - (2) to hold patients harmless from balance billing beyond any contractual cost sharing amounts,
 - (3) regarding surprise billing practices,
 - (4) to notify covered persons, prior to delivery of health care services if possible, of such covered persons' financial obligations if any for non-covered benefits,
 - (5) to provide at least sixty (60) days' notice to the carrier when a participating provider leaves the network, and
 - (6) to provide to the health carrier a list of such participating provider's patients who are covered persons under a network plan of such health carrier within thirty (30) days' of the notice of termination.
 - (g) 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 for payment of premium during which such health carrier may hold a claim for health care services pending receipt of payment of premium by such health carrier;
 - (h) Timely notify a health care provider or facility, when such health carrier has included such health care provider or facility as a participating provider for any of such health carrier's health benefit plans, of such health care provider's or facility's network participation status;
 - (i) Notify participating providers 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;
 - (j) Establish and maintain procedures for the resolution of administrative, payment or other

disputes between the health carrier and a participating provider;

(k) Provide at least sixty (60) days of written notice to the provider before the carrier removes a participating provider from the network.

(l) 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 previous twelve (12) months;

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

(n) Disclose to a covered person the process to request a covered benefit from a nonparticipating provider, as provided when:

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

(2) The health carrier:

(A) 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

(B) 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.

(o) 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.

(p) Establish procedures to meet network adequacy standards.

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

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

No individual or group health insurance policy or certificate that includes network benefits shall be delivered, issued for delivery, renewed, amended or continued in this State if the network does not meet the following required minimum standards for network adequacy. The carrier shall:

(a) Establish and monitor the networks to ensure access within the maximum time and distance standards;

(b) Ensure that the network has at least one primary care physician per 2,000 covered members;

(c) Ensure that the percentage of providers that accept new patients shall be at least 70%;

(d) 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 this requirement.

(e) 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.

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

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

(h) Ensure that covered persons shall:

(1) 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.

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

(i) Ensure that participating providers shall have admitting rights to at least one participating

hospital, where appropriate.

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

Health insurance carriers that offer plans that include networks shall:

- (a) Post an on-line directory in searchable format for each network that is made available in the state;
- (b) Clearly label the network so it may be linked to a specific plan offered;
- (c) Update the on-line directory no less than monthly;
- (d) Make the directory accessible to both members and non-members;
- (e) Clearly state the date the directory was last updated;
- (f) Make a hard copy of the directory, that is updated no less than annually, available upon request;
- (g) Provide an e-mail address and telephone number to report inaccurate information;
- (h) Indicate whether a provider accepts new patients, and whether such health care provider is accepting new patients on an outpatient services basis;
- (i) Indicate the languages spoken in the provider's office or facility;
- (j) Indicate whether the provider's office or facility is handicapped accessible;
- (k) Clearly indicate the providers for each different tier of benefits if applicable;
- (l) Establish and maintain an audit process to ensure accuracy of the directories;
- (m) Ensure the directory accommodates the communication needs of individuals with disabilities or limited English proficiency. and provides information on how to receive assistance;
- (n) Provide by type, for facilities other than hospitals, the facility name, the facility type, the types of health care services performed at the facility and the participating facility location or locations and telephone number or numbers;
- (o) Provide, for hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer and the participating hospital location and telephone number;
- (p) Provide, for health care providers, the health care provider's name, contact information, specialty, if applicable and participating office location or locations;
- (q) Indicate whether participating health care providers are authorized to admit patients to hospitals participating in the network; and
- (r) Indicate whether hospital-based health care providers are participating providers and see patients on an outpatient basis.

(NEW) Sec. 38a-472f-5. Annual Filing Requirements

Insurance carriers that deliver, issue for delivery, renew, amend or continue any individual or group health insurance policy or certificate that includes network benefits, shall submit an annual report in the form of a survey response to the Commissioner regarding the adequacy of the network. A separate survey response shall be submitted for each network offered and shall be in a form prescribed by the commissioner. The commissioner will provide at least sixty (60) days of notice of the due date of the survey.

Sec. 38a-472f-6. Separability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

R-39 Rev. 02/2012

Statement of Purpose

These regulations implement CGS sections 38a-472f, 38a-477h and 38a-477g to set standards for health carrier network adequacy, provider contracts, and participating provider directories. This regulation is issued pursuant to the authority vested in the Commissioner under Sections 38a-472f, 38a-477g, and 38a-477h of the Connecticut General Statutes. This regulation shall apply to all individual and group health insurance policies and certificates with networks. The requirements contained in this regulation shall be in addition to any other applicable regulations or bulletins previously adopted and not inconsistent therewith. This regulation has no fiscal impact to the state and does not affect small businesses.