



General Assembly

Amendment

February Session, 2016

LCO No. 5357



Offered by:
SEN. CRISCO, 17th Dist.

To: Subst. Senate Bill No. 368

File No. 440

Cal. No. 295

**"AN ACT CONCERNING LICENSURE OF SINGLE PURPOSE
DENTAL HEALTH CARE CENTERS."**

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 38a-15 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective October 1, 2016*):

5 (a) The commissioner shall, as often as the commissioner deems it
6 expedient, undertake a market conduct examination of the affairs of
7 any insurance company, health care center, third-party administrator,
8 as defined in section 38a-720, or fraternal benefit society doing
9 business in this state. Any such examination may be conducted in
10 accordance with the procedures and definitions set forth in the
11 National Association of Insurance Commissioners' Market Regulation
12 Handbook.

13 (b) To carry out the examinations under this section, the
14 commissioner may appoint, as market conduct examiners, one or more

15 competent persons, who shall not be officers of, or connected with or
16 interested in, any insurance company, health care center, third-party
17 administrator or fraternal benefit society, other than as a policyholder.
18 In conducting the examination, the commissioner, the commissioner's
19 actuary or any examiner authorized by the commissioner may
20 examine, under oath, the officers and agents of such insurance
21 company, health care center, third-party administrator or fraternal
22 benefit society and all persons deemed to have material information
23 regarding the company's, center's, administrator's or society's property
24 or business. Each such company, center, administrator or society, its
25 officers and agents, shall produce the books and papers, in its or their
26 possession, relating to its business or affairs, and any other person may
27 be required to produce any book or paper in such person's custody,
28 deemed to be relevant to the examination, for the inspection of the
29 commissioner, the commissioner's actuary or examiners, when
30 required. The officers and agents of the company, center, administrator
31 or society shall facilitate the examination and aid the examiners in
32 making the same so far as it is in their power to do so.

33 (c) Each market conduct examiner shall make a full and true report
34 of each market conduct examination made by such examiner, which
35 shall comprise only facts appearing upon the books, papers, records or
36 documents of the examined company, center, administrator or society
37 or ascertained from the sworn testimony of its officers or agents or of
38 other persons examined under oath concerning its affairs. The
39 examiner's report shall be presumptive evidence of the facts therein
40 stated in any action or proceeding in the name of the state against the
41 company, center, administrator or society, its officers or agents. The
42 commissioner shall grant a hearing to the company, center,
43 administrator or society examined before filing any such report and
44 may withhold any such report from public inspection for such time as
45 the commissioner deems proper. The commissioner may, if the
46 commissioner deems it in the public interest, publish any such report,
47 or the result of any such examination contained therein, in one or more
48 newspapers of the state.

49 (d) (1) All the expense of any examination made under the authority
50 of this section, other than examinations of domestic insurance
51 companies and domestic health care centers, shall be paid by the
52 company, center, administrator or society examined. [, and]

53 (2) No domestic insurance company or domestic health care center
54 subject to an examination under this section shall pay as costs
55 associated with the examination the salaries, fringe benefits or travel
56 and maintenance expenses of examining personnel of the Insurance
57 Department engaged in such examination if such domestic insurance
58 company or domestic health care center is otherwise liable to
59 assessment levied under section 38a-47, except that domestic insurance
60 companies and [other domestic entities] domestic health care centers
61 examined outside the state shall pay the [traveling] travel and
62 maintenance expenses of [examiners] such examining personnel.

63 (e) (1) No cause of action shall arise nor shall any liability be
64 imposed against the commissioner, the commissioner's authorized
65 representative or any examiner appointed or engaged by the
66 commissioner for any statements made or conduct performed in good
67 faith while carrying out the provisions of this section.

68 (2) No cause of action shall arise nor shall any liability be imposed
69 against any person for the act of communicating or delivering
70 information or data pursuant to an examination made under the
71 authority of this section to the commissioner, the commissioner's
72 authorized representative or an examiner if such communication or
73 delivery was performed in good faith and without fraudulent intent or
74 the intent to deceive.

75 (3) The provisions of this subsection shall not abrogate or modify
76 any common law or statutory privilege or immunity heretofore
77 enjoyed by any person identified in subdivision (1) of this subsection.

78 (f) Nothing in this section shall be construed to prevent or prohibit
79 the commissioner from disclosing at any time the content or results of
80 an examination report or a preliminary examination report or any

81 matter relating to such report, to (1) the insurance regulatory officials
82 of this state or any other state or country, (2) law enforcement officials
83 of this or any other state, or (3) any agency of this or any other state or
84 of the federal government, provided such officials or agency receiving
85 the report or matters relating to the report agrees, in writing, to hold
86 such report or matters confidential.

87 (g) All workpapers, recorded information, documents and copies
88 thereof produced by, obtained by or disclosed to the commissioner or
89 any other person in the course of an examination made under the
90 authority of this section shall be confidential, shall not be subject to
91 subpoena and shall not be made public by the commissioner or any
92 other person, except to the extent provided in subsection (f) of this
93 section. The commissioner may grant access to such workpapers,
94 recorded information, documents and copies to the National
95 Association of Insurance Commissioners, provided said association
96 agrees, in writing, to hold such workpapers, recorded information,
97 documents and copies thereof confidential.

98 Sec. 2. Subsection (a) of section 38a-16 of the general statutes is
99 repealed and the following is substituted in lieu thereof (*Effective*
100 *October 1, 2016*):

101 (a) (1) The Insurance Commissioner or the commissioner's
102 authorized representative may, as often as the commissioner deems
103 necessary, conduct investigations and hearings in aid of any
104 investigation on any matter under the provisions of this title. Pursuant
105 to any such investigation or hearing, the commissioner or the
106 commissioner's authorized representative may issue data calls,
107 subpoenas, administer oaths, compel testimony, order the production
108 of books, records, papers and documents, and examine books and
109 records. If any person refuses to allow the examination of books and
110 records, to appear, to testify or to produce any book, record, paper or
111 document when so ordered, a judge of the Superior Court, upon
112 application of the commissioner or the commissioner's authorized
113 representative, may make such order as may be appropriate to aid in

114 the enforcement of this section.

115 (2) Data provided in response to a data call under this section shall
116 not be subject to disclosure under section 1-210.

117 Sec. 3. Section 38a-175 of the 2016 supplement to the general statutes
118 is repealed and the following is substituted in lieu thereof (*Effective July*
119 *1, 2016*):

120 As used in this section and sections [38a-175] 38a-176 to 38a-194,
121 inclusive:

122 (1) "Healing arts" means the professions and occupations licensed
123 under the provisions of chapters 370, 372, 373, 375, 378, 379, 380, 381,
124 383 and 400j.

125 (2) "Carrier" means a health care center, insurer, hospital service
126 corporation, medical service corporation or other entity responsible for
127 the payment of benefits or provision of services under a group
128 contract.

129 (3) "Commissioner" means the Insurance Commissioner, except
130 when explicitly stated otherwise.

131 (4) "Evidence of coverage" means a statement of essential features
132 and services of the health care center coverage [which] that is given to
133 the subscriber by the health care center or by the group contract
134 holder.

135 (5) "Federal Health Maintenance Organization Act" means Title XIII
136 of the Public Health Service Act, 42 USC Subchapter XI, as [from time
137 to time] amended from time to time, or any successor thereto relating
138 to qualified health maintenance organizations.

139 (6) "Group contract" means a contract for health care services
140 [which] that by its terms limits eligibility to members of a specified
141 group. The group contract may include coverage for dependents.

142 (7) "Group contract holder" means the person to which a group
143 contract has been issued.

144 (8) "Health care" includes, but shall not be limited to, the following:
145 (A) Medical, surgical and dental care provided through licensed
146 practitioners, including any supporting and ancillary personnel,
147 services and supplies; (B) physical therapy service provided through
148 licensed physical therapists upon the prescription of a physician; (C)
149 psychological examinations provided by registered psychologists; (D)
150 optometric service provided by licensed optometrists; (E) hospital
151 service, both inpatient and outpatient; (F) convalescent institution care
152 and nursing home care; (G) nursing service provided by a registered
153 nurse or by a licensed practical nurse; (H) home care service of all
154 types required for the health of a person; (I) rehabilitation service
155 required or desirable for the health of a person; (J) preventive medical
156 services of all and any types; (K) furnishing necessary appliances,
157 drugs, medicines and supplies; (L) educational services for the health
158 and well-being of a person; (M) ambulance service; and (N) any other
159 care, service or treatment related to the prevention or treatment of
160 disease, the correction of defects and the maintenance of the physical
161 and mental well-being of human beings. Any diagnosis and treatment
162 of diseases of human beings required for health care as defined in this
163 section, if rendered, shall be under the supervision and control of the
164 providers.

165 (9) "Health care center" means [either: (A) A person, including a
166 profit or a nonprofit corporation organized under the laws of this
167 state] (A) any organization governed by sections 38a-175 to 38a-192,
168 inclusive, and licensed or authorized by the commissioner pursuant to
169 section 38a-41 or 38a-41a, for the purpose of carrying out the activities
170 and purposes set forth in subsection (b) of section 38a-176, at the
171 expense of the health care center, including the providing of health
172 care [, as herein defined,] to members of the community, including
173 subscribers to one or more plans under an agreement entitling such
174 subscribers to health care in consideration of a basic advance or
175 periodic charge and shall include a health maintenance organization,

176 or (B) a line of business conducted by an organization that is formed []
177 pursuant to the laws of this state for the purposes of, but not limited to,
178 carrying out the activities and purposes set forth in subsection (b) of
179 section 38a-176.

180 (10) "Individual contract" means a contract for health care services
181 issued to and covering an individual. The individual contract may
182 include dependents of the subscriber.

183 (11) "Individual practice association" means a partnership,
184 corporation, association [] or other legal entity [which] that has
185 entered into a services arrangement with health care professionals
186 licensed in this state to provide services to enrollees of a health care
187 center.

188 (12) "Insolvent" or "insolvency" means, with respect to an
189 organization, that the organization has been declared insolvent and
190 placed under an order of liquidation by a court of competent
191 jurisdiction.

192 (13) "Net worth" means the excess of total admitted assets over total
193 liabilities, but the liabilities shall not include fully subordinated debt,
194 as [defined] that term is used in section 38a-193.

195 (14) "Member" or "enrollee" means an individual who is enrolled in
196 a health care center.

197 (15) "Person" means an individual, corporation, limited liability
198 company, partnership, association, trust or any other legal entity.

199 (16) "Uncovered expenditures" means the cost of health care services
200 that are covered by a health care center, for which an enrollee would
201 also be liable in the event of the health care center's insolvency, and for
202 which no alternative arrangements have been made that are acceptable
203 to the commissioner. [Uncovered expenditures shall] "Uncovered
204 expenditures" does not include expenditures for services when a
205 provider has agreed not to bill the enrollee even though the provider is

206 not paid by the health care center or for services that are guaranteed,
207 insured or assumed by a person other than the health care center.

208 (17) "Enrolled population" means a group of persons, defined as to
209 probable age, sex and family composition, [which] that receives health
210 care from a health care center in consideration of a basic advance or
211 periodic charge.

212 (18) "Participating provider" means a provider who, under an
213 express or implied contract with the health care center or with its
214 contractor or subcontractor, has agreed to provide health care services
215 to enrollees with an expectation of receiving payment, other than
216 copayment or deductible, directly or indirectly from the health care
217 center.

218 (19) "Provider" means any licensed health care professional or
219 facility, including individual practice associations.

220 (20) "Subscriber" means an individual whose employment or other
221 status, except family dependency, is the basis for eligibility for
222 enrollment in the health care center, or in the case of an individual
223 contract, the person in whose name the contract is issued.

224 Sec. 4. Section 38a-178 of the general statutes is repealed and the
225 following is substituted in lieu thereof (*Effective July 1, 2016*):

226 Persons desiring to form a health care center may organize under
227 the general law of the state governing corporations, partnerships,
228 associations or trusts, [but] subject to the following provisions: (1) The
229 certificate of incorporation or other organizational document of each
230 such organization shall have endorsed thereon or attached thereto the
231 consent of the commissioner if [he] the commissioner finds the same to
232 be in accordance with the provisions of sections 38a-175 to 38a-192,
233 inclusive, as amended by this act; and (2) the certificate or other
234 document shall include a statement of the area in which the health care
235 center will operate and the services to be rendered by such
236 organization within this state and in other jurisdictions in which the

237 health care center may be authorized to do business.

238 Sec. 5. Section 38a-179 of the general statutes is repealed and the
239 following is substituted in lieu thereof (*Effective July 1, 2016*):

240 (a) If [the] a domestic health care center is organized as a nonprofit,
241 nonstock corporation, the care, control and disposition of the property
242 and funds of each such corporation and the general management of its
243 affairs shall be vested in a board of directors. Each such corporation
244 shall have the power to adopt bylaws for the governing of its affairs,
245 which bylaws shall prescribe the number of directors, their term of
246 office and the manner of their election, subject to the provisions of
247 sections 38a-175 to 38a-192, inclusive, as amended by this act. The
248 bylaws may be adopted and repealed or amended by the affirmative
249 vote of two-thirds of all the directors at any meeting of the board of
250 directors duly held upon at least ten days' notice, provided notice of
251 such meeting shall specify the proposed action concerning the bylaws
252 to be taken at such meeting. The bylaws of the corporation shall
253 provide that the board of directors shall include representation from
254 persons engaged in the healing arts and from persons who are eligible
255 to receive health care from the corporation, subject to the following
256 provisions: (1) One-quarter of the board of directors shall be persons
257 engaged in the different fields in the healing arts at least two of whom
258 shall be a physician and a dentist; (2) one-quarter of the board of
259 directors shall be subscribers who are eligible to receive health care
260 from the health care center, but no such representative need be seated
261 until the first annual meeting following the approval by the
262 commissioner of the initial agreement or agreements to be offered by
263 the corporation, and there shall be only one representative from any
264 group covered by a group service agreement.

265 (b) If [the] a domestic health care center is not organized as a
266 nonprofit, nonstock corporation, management of its affairs shall be in
267 accordance with other applicable laws of the state, provided [that the]
268 such health care center shall establish and maintain a mechanism to
269 afford its members an opportunity to participate in matters of policy

270 and operation such as an advisory panel, advisory referenda on major
271 policy decisions or other similar mechanisms.

272 Sec. 6. Section 38a-186 of the general statutes is repealed and the
273 following is substituted in lieu thereof (*Effective July 1, 2016*):

274 (a) In the event of the dissolution, liquidation or termination of the
275 corporate existence of a domestic health care center [which] that is
276 organized as a nonprofit, nonstock corporation, no part of the property
277 or assets of the health care center shall inure to the benefit of any
278 director, officer, subscriber or employee of the corporation, each of
279 whom by holding such position shall be deemed to have waived and
280 relinquished all rights conferred by statute or otherwise upon
281 subscribers of a corporation without capital stock to share in such
282 assets upon dissolution, liquidation or termination. After the payment
283 of all lawful claims against the corporation, all its remaining assets
284 shall be devoted permanently and exclusively to the purposes for
285 which the corporation is formed, or paid over to an organization
286 organized and operated exclusively for charitable, educational and
287 scientific purposes, and in such amount and proportions, as the board
288 of directors in its discretion shall determine.

289 (b) No person may, with respect to a domestic health care center, (1)
290 make a tender for or a request or invitation for tenders of, or enter into
291 an agreement to exchange securities for or acquire in the open market
292 or otherwise, any voting security of [a] such health care center, (2)
293 enter into any other agreement if, after the consummation [thereof,
294 that] of such agreement, such person would, directly or indirectly, or
295 by conversion or by exercise of any right to acquire, be in control of
296 such health care center, or (3) enter into an agreement to merge or
297 consolidate with or otherwise to acquire control of [a] such health care
298 center, unless, at the time any offer, request or invitation is made or
299 any agreement is entered into, or prior to the acquisition of the
300 securities if no offer or agreement is involved, the person has [filed
301 with the Insurance Commissioner and has mailed or delivered to the
302 health care center, such information as is required by the commissioner

303 and the offer, request, invitation, agreement or acquisition has been
304 approved by the commissioner] complied with the provisions of
305 section 38a-130.

306 Sec. 7. Section 38a-188 of the 2016 supplement to the general statutes
307 is repealed and the following is substituted in lieu thereof (*Effective July*
308 *1, 2016*):

309 (a) Each health care center governed by sections 38a-175 to 38a-192,
310 inclusive, as amended by this act, shall be exempt from the provisions
311 of the general statutes relating to insurance in the conduct of its
312 operations under said sections and in such other activities as do
313 constitute the business of insurance, unless expressly included therein,
314 and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51,
315 38a-52, as amended by this act, 38a-56, 38a-57, 38a-58a, 38a-129 to 38a-
316 140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a
317 health care center shall not be deemed in violation of sections 38a-815
318 to 38a-819, inclusive, solely by virtue of such health care center
319 selectively contracting with certain providers in one or more
320 specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j,
321 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to
322 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-
323 786, 38a-790, 38a-792 and 38a-794, provided a health care center
324 organized as a nonprofit, nonstock corporation shall be exempt from
325 sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-
326 735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772
327 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health
328 care center is operated as a line of business, the foregoing provisions
329 shall, where possible, be applied only to that line of business and not
330 to the organization as a whole.

331 (b) The commissioner may adopt regulations, in accordance with
332 chapter 54, stating the circumstances under which the resources of a
333 person [which] that controls a health care center, or operates a health
334 care center as a line of business will be considered in evaluating the
335 financial condition of a health care center. Such regulations, if adopted,

336 shall require as a condition to the consideration of the resources of
337 such person that controls a health care center, or operates a health care
338 center as a line of business to provide satisfactory assurances to the
339 commissioner that such person will assume the financial obligations of
340 the health care center. During the period prior to the effective date of
341 regulations issued under this section, the commissioner shall, upon
342 request, consider the resources of a person that controls a health care
343 center, or operates a health care center as a line of business, if the
344 commissioner receives satisfactory assurances from such person that it
345 will assume the financial obligations of the health care center and
346 determines that such person meets such other requirements as the
347 commissioner determines are necessary.

348 (c) A health care center organized as a nonprofit, nonstock
349 corporation shall be exempt from the sales and use tax and all property
350 of each such corporation shall be exempt from state, district and
351 municipal taxes. Each corporation governed by sections 38a-175 to 38a-
352 192, inclusive, as amended by this act, shall be subject to the provisions
353 of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall
354 be construed to override contractual and delivery system
355 arrangements governing a health care center's provider relationships.

356 Sec. 8. Subparagraph (A) of subdivision (2) of subsection (b) of
357 section 19a-7j of the general statutes is repealed and the following is
358 substituted in lieu thereof (*Effective July 1, 2016*):

359 (2) (A) Each domestic insurer or domestic health care center doing
360 health insurance business in this state shall annually pay to the
361 Insurance Commissioner, for deposit in the Insurance Fund
362 established under section 38a-52a, a health and welfare fee assessed by
363 the Insurance Commissioner pursuant to this section.

364 Sec. 9. Subdivision (2) of subsection (b) of section 19a-7p of the 2016
365 supplement to the general statutes is repealed and the following is
366 substituted in lieu thereof (*Effective July 1, 2016*):

367 (2) Each domestic insurer or domestic health care center doing

368 health insurance business in this state shall annually pay to the
369 Insurance Commissioner, for deposit in the Insurance Fund
370 established under section 38a-52a, a public health fee assessed by the
371 Insurance Commissioner pursuant to this section.

372 Sec. 10. Subsection (h) of section 38a-14 of the 2016 supplement to
373 the general statutes is repealed and the following is substituted in lieu
374 thereof (*Effective July 1, 2016*):

375 (h) The commissioner shall, at least once in every five years, visit
376 and examine the affairs of each domestic insurance company, domestic
377 health care center, domestic fraternal benefit society, and foreign and
378 alien insurance company doing business in this state. Notwithstanding
379 subdivision (1) of subsection (c) of this section, no domestic insurance
380 company or other domestic entity subject to examination under this
381 section shall pay as costs associated with the examination the salaries,
382 fringe benefits, traveling and maintenance expenses of examining
383 personnel of the Insurance Department engaged in such examination if
384 such domestic company or domestic entity is otherwise liable to
385 assessment levied under section 38a-47, except that a domestic
386 insurance company or other domestic entity shall pay the traveling
387 and maintenance expenses of examining personnel of the Insurance
388 Department when such company or entity is examined outside the
389 state.

390 Sec. 11. Section 38a-43 of the general statutes is repealed and the
391 following is substituted in lieu thereof (*Effective July 1, 2016*):

392 Whenever it appears to the commissioner that permission to
393 transact business within any state of the United States or within any
394 foreign country has been refused to any domestic insurance company
395 or domestic health care center after (1) a certificate of the solvency and
396 good management of such company or health care center has been
397 issued to it by the commissioner, and [after] (2) such company or
398 health care center has complied with any reasonable laws of such state
399 or foreign country requiring deposits of money or securities with the

400 government of such state or country, the commissioner may
401 immediately cancel the authority of each company or health care
402 center organized under the laws of such state or foreign government
403 and licensed to do business in this state and may refuse a certificate of
404 authority to each such company or health care center thereafter
405 applying for authority to do business in this state, until the
406 commissioner's certificate has been recognized by the government of
407 such state or country.

408 Sec. 12. Section 38a-52 of the general statutes is repealed and the
409 following is substituted in lieu thereof (*Effective July 1, 2016*):

410 Any (1) domestic insurance company or other domestic entity
411 aggrieved because of any assessment levied under section 38a-48, (2)
412 fraternal benefit society or foreign or alien insurance company or other
413 entity aggrieved because of any assessment levied under the
414 provisions of sections 38a-49 to 38a-51, inclusive, or (3) domestic
415 insurer, domestic health care center, third-party administrator licensed
416 pursuant to section 38a-720a or exempt insurer, as defined in
417 subdivision (1) of subsection (b) of section 19a-7j, aggrieved because of
418 any assessment levied under said section 19a-7j, may, within one
419 month from the time provided for the payment of such assessment,
420 appeal therefrom to the superior court for the judicial district of New
421 Britain, which appeal shall be accompanied by a citation to the
422 commissioner to appear before said court. Such citation shall be signed
423 by the same authority, and such appeal shall be returnable at the same
424 time and served and returned in the same manner, as is required in
425 case of a summons in a civil action. The authority issuing the citation
426 shall take from the appellant a bond or recognizance to the state, with
427 surety to prosecute the appeal to effect and to comply with the orders
428 and decrees of the court in the premises. Such appeals shall be
429 preferred cases, to be heard, unless cause appears to the contrary, at
430 the first session, by the court or by a committee appointed by the court.
431 Said court may grant such relief as may be equitable, and, if such
432 assessment has been paid prior to the granting of such relief, may
433 order the Treasurer to pay the amount of such relief, with interest at

434 the rate of six per cent per annum, to the aggrieved company. If the
435 appeal has been taken without probable cause, the court may tax
436 double or triple costs, as the case demands; and, upon all such appeals
437 which may be denied, costs may be taxed against the appellant at the
438 discretion of the court, but no costs shall be taxed against the state.

439 Sec. 13. Section 38a-53 of the 2016 supplement to the general statutes
440 is repealed and the following is substituted in lieu thereof (*Effective July*
441 *1, 2016*):

442 (a) (1) Each domestic insurance company or domestic health care
443 center shall, annually, on or before the first day of March, submit to the
444 commissioner, and electronically to the National Association of
445 Insurance Commissioners, a true and complete report, signed and
446 sworn to by its president or a vice president, and secretary or an
447 assistant secretary, of its financial condition on the thirty-first day of
448 December next preceding, prepared in accordance with the National
449 Association of Insurance Commissioners annual statement instructions
450 handbook and following those accounting procedures and practices
451 prescribed by the National Association of Insurance Commissioners
452 accounting practices and procedures manual, subject to any deviations
453 in form and detail as may be prescribed by the commissioner. An
454 electronically filed report in accordance with section 38a-53a that is
455 timely submitted to the National Association of Insurance
456 Commissioners shall not exempt a domestic insurance company or
457 domestic health care center from timely filing a true and complete
458 paper copy with the commissioner.

459 (2) Each accredited reinsurer, as defined in subdivision (1) of
460 subsection (c) of section 38a-85, and assuming insurance company, as
461 provided in section 38a-85, shall file an annual report in accordance
462 with the provisions of section 38a-85.

463 (b) Each foreign insurance company or foreign health care center
464 doing business in this state shall, annually, on or before the first day of
465 March, submit to the commissioner, by electronically filing with the

466 National Association of Insurance Commissioners, a true and complete
467 report, signed and sworn to by its president or a vice president, and
468 secretary or an assistant secretary, of its financial condition on the
469 thirty-first day of December next preceding, prepared in accordance
470 with the National Association of Insurance Commissioners annual
471 statement instructions handbook and following those accounting
472 procedures and practices prescribed by the National Association of
473 Insurance Commissioners accounting practices and procedures
474 manual, subject to any deviations in form and detail as may be
475 prescribed by the commissioner. An electronically filed report in
476 accordance with section 38a-53a that is timely submitted to the
477 National Association of Commissioners shall be deemed to have been
478 submitted to the commissioner in accordance with this section.

479 (c) In addition to such annual report, the commissioner, when the
480 commissioner deems it necessary, may require any insurance company
481 or health care center doing business in this state to file financial
482 statements on a quarterly basis. An electronically filed true and
483 complete report filed in accordance with section 38a-53a that is timely
484 filed with the National Association of Insurance Commissioners shall
485 be deemed to have been submitted to the commissioner in accordance
486 with the provisions of this section.

487 (d) In addition to such annual report and the quarterly report
488 required under subsection (c) of this section, the commissioner,
489 whenever the commissioner determines that more frequent reports are
490 required because of certain factors or trends affecting companies
491 writing a particular class or classes of business or because of changes
492 in the company's management or financial or operating condition, may
493 require any insurance company or health care center doing business in
494 this state to file financial statements on other than an annual or
495 quarterly basis.

496 (e) Any insurance company or health care center doing business in
497 this state that fails to file any report or statement required under this
498 section shall pay a late filing fee of one hundred seventy-five dollars

499 per day for each day from the due date of such report or statement to
500 the date of filing. The commissioner may extend the due date of any
501 report or statement required under this section (1) if the insurance
502 company or health care center cannot file such report or statement
503 because the governor of such company's or center's state of domicile
504 has proclaimed a state of emergency in such state and such state of
505 emergency impairs the company's or center's ability to file the report
506 or statement, (2) if the insurance regulatory official of the state of
507 domicile of a foreign insurance company has permitted such company
508 to file such report or statement late, or (3) for a domestic insurance
509 company or a domestic health care center, for good cause shown.

510 (f) Each insurance company or health care center doing business in
511 this state shall include in all reports required to be filed with the
512 commissioner under this section a certification by an actuary or reserve
513 specialist of all reserve liabilities prepared in accordance with
514 regulations that shall be adopted by the commissioner in accordance
515 with chapter 54. The regulations shall: (1) Specify the contents and
516 scope of the certification; (2) provide for the availability to the
517 commissioner of the workpapers of the actuary or loss reserve
518 specialist; and (3) provide for granting companies or centers
519 exemptions from compliance with the requirements of this subsection.
520 The commissioner shall maintain, as confidential, all workpapers of
521 the actuary or loss reserve specialist and the actuarial report and
522 actuarial opinion summary provided in support of the certification.
523 Such workpapers, reports and summaries shall not be subject to
524 subpoena or disclosure under the Freedom of Information Act, as
525 defined in section 1-200.

526 Sec. 14. Subsections (a) and (b) of section 38a-54 of the general
527 statutes are repealed and the following is substituted in lieu thereof
528 (*Effective July 1, 2016*):

529 (a) Each domestic insurance company, domestic health care center
530 or domestic fraternal benefit society doing business in this state shall
531 have an annual audit conducted by an independent certified public

532 accountant and shall annually file an audited financial report with the
533 commissioner, and electronically to the National Association of
534 Insurance Commissioners on or before the first day of June for the year
535 ending the preceding December thirty-first. An electronically filed true
536 and complete report timely submitted to the National Association of
537 Insurance Commissioners does not exempt a domestic insurance
538 company or a domestic health care center from timely filing a true and
539 complete paper copy to the commissioner.

540 (b) Each foreign insurance company, foreign health care center or
541 foreign fraternal benefit society doing business in this state shall have
542 an annual audit conducted by an independent certified public
543 accountant and shall annually file an audited financial report with the
544 commissioner, and electronically to the National Association of
545 Insurance Commissioners, on or before June first for the year ending
546 the preceding December thirty-first. An electronically filed true and
547 complete report timely submitted to the National Association of
548 Insurance Commissioners shall be deemed to have been submitted to
549 the commissioner in accordance with the provisions of this section.

550 Sec. 15. Section 38a-55 of the general statutes is repealed and the
551 following is substituted in lieu thereof (*Effective July 1, 2016*):

552 (a) No domestic insurer, domestic health care center or domestic
553 fraternal benefit society may pledge, hypothecate or otherwise
554 encumber its assets to secure the debt, guaranty or obligations of any
555 other person without the prior written consent of the Insurance
556 Commissioner. This prohibition shall not apply to obligations of the
557 insurer under surety bonds or insurance contracts issued in the regular
558 course of business.

559 (b) (1) No domestic insurer, domestic health care center or domestic
560 fraternal benefit society may, without the prior written consent of the
561 Insurance Commissioner, pledge, hypothecate or otherwise encumber
562 its assets to secure its own debt, guaranty or obligations if the amount
563 of the assets pledged, hypothecated or otherwise encumbered, when

564 the pledge, hypothecation or encumbrance is made, together with the
565 aggregate amount of assets pledged, hypothecated or encumbered to
566 secure all such debts, guarantees and obligations, exceeds the lesser of
567 five per cent of admitted assets or twenty-five per cent of surplus as
568 regards policyholders as reported in its last financial statement filed
569 with the commissioner pursuant to section 38a-53, as amended by this
570 act, or 38a-614.

571 (2) Nothing in this subsection shall be construed as prohibiting a
572 domestic insurer, domestic health care center or domestic fraternal
573 benefit society from pledging, hypothecating or encumbering any
574 assets in connection with: (A) Transactions in the ordinary course of
575 business, including, but not limited to: (i) Complying with any
576 statutory requirement, (ii) reinsurance transactions otherwise in
577 compliance with applicable statutory requirements, or (iii) investments
578 or investment practices otherwise in compliance with applicable
579 statutory requirements, including, but not limited to, securities
580 lending, repurchase transactions, reverse repurchase transactions,
581 swap, futures and options transactions, and any other transactions
582 which are not prohibited by the investment law and regulations of this
583 state; (B) transactions subject to the provisions of sections 38a-129 to
584 38a-140, inclusive; or (C) any other transaction deemed excluded by
585 the Insurance Commissioner. Assets pledged, hypothecated or
586 encumbered pursuant to subparagraph (A), (B) or (C) of this
587 subdivision shall not be charged against the limits set forth in
588 subdivision (1) of this subsection.

589 (3) In the case of a domestic life insurance company, the provisions
590 of this subsection shall apply to a separate account only to the extent
591 that reserves for guarantees with respect to (A) benefits guaranteed as
592 to dollar amount and duration or (B) funds guaranteed as to principal
593 amount or stated rate of interest are held in a separate account in
594 accordance with subdivision (3) of subsection (a) of section 38a-433.

595 Sec. 16. Section 38a-59 of the general statutes is repealed and the
596 following is substituted in lieu thereof (*Effective July 1, 2016*):

597 An amendment to the certificate of incorporation of a domestic
598 insurance company or a domestic health care center with capital stock
599 that changes the name of the company or health care center shall not
600 become effective until approved by the Insurance Commissioner after
601 reasonable notice and a public hearing, if such notice and hearing are
602 deemed by the commissioner to be in the public interest. A certificate
603 of amendment conforming to the requirements of section 33-800 shall
604 be filed in the office of the Insurance Commissioner before any
605 amendment to the certificate of incorporation of a domestic insurance
606 company or a domestic health care center with capital stock becomes
607 effective.

608 Sec. 17. Section 38a-591b of the 2016 supplement to the general
609 statutes, as amended by section 10 of public act 15-146, is repealed and
610 the following is substituted in lieu thereof (*Effective July 1, 2016*):

611 (a) Sections 38a-591a to 38a-591n, inclusive, shall apply to (1) any
612 health carrier offering a health benefit plan and that provides or
613 performs utilization review including prospective, concurrent or
614 retrospective review benefit determinations, and (2) any utilization
615 review company or designee of a health carrier that performs
616 utilization review on the health carrier's behalf, including prospective,
617 concurrent or retrospective review benefit determinations.

618 (b) Each health carrier shall be responsible for monitoring all
619 utilization review program activities carried out by or on behalf of
620 such health carrier. Such health carrier shall comply with the
621 provisions of sections 38a-591a to 38a-591n, inclusive, and any
622 regulations adopted thereunder, and shall be responsible for ensuring
623 that any utilization review company or other entity such health carrier
624 contracts with to perform utilization review complies with said
625 sections and regulations. Each health carrier shall ensure that
626 appropriate personnel have operational responsibility for the activities
627 of the health carrier's utilization review program.

628 (c) (1) A health carrier that requires utilization review of a benefit

629 request under a health benefit plan shall implement a utilization
630 review program and develop a written document that describes all
631 utilization review activities and procedures, whether or not delegated,
632 for (A) the filing of benefit requests, (B) the notification to covered
633 persons of utilization review and benefit determinations, and (C) the
634 review of adverse determinations and grievances in accordance with
635 sections 38a-591e, as amended by this act, and 38a-591f.

636 (2) Such document shall describe the following:

637 (A) Procedures to evaluate the medical necessity, appropriateness,
638 health care setting, level of care or effectiveness of health care services;

639 (B) Data sources and clinical review criteria used in making
640 determinations;

641 (C) Procedures to ensure consistent application of clinical review
642 criteria and compatible determinations;

643 (D) Data collection processes and analytical methods used to assess
644 utilization of health care services;

645 (E) Provisions to ensure the confidentiality of clinical, proprietary
646 and protected health information;

647 (F) The health carrier's organizational mechanism, such as a
648 utilization review committee or quality assurance or other committee,
649 that periodically assesses the health carrier's utilization review
650 program and reports to the health carrier's governing body; and

651 (G) The health carrier's staff position that is responsible for the day-
652 to-day management of the utilization review program.

653 (d) Each health carrier shall:

654 (1) Include in the insurance policy, certificate of coverage or
655 handbook provided to covered persons a clear and comprehensive
656 description of:

- 657 (A) Its utilization review and benefit determination procedures;
- 658 (B) Its grievance procedures, including the grievance procedures for
659 requesting a review of an adverse determination;
- 660 (C) A description of the external review procedures set forth in
661 section 38a-591g, in a format prescribed by the commissioner and
662 including a statement that discloses that:
- 663 (i) A covered person may file a request for an external review of an
664 adverse determination or a final adverse determination with the
665 commissioner and that such review is available when the adverse
666 determination or the final adverse determination involves an issue of
667 medical necessity, appropriateness, health care setting, level of care or
668 effectiveness. Such disclosure shall include the contact information of
669 the commissioner; and
- 670 (ii) When filing a request for an external review of an adverse
671 determination or a final adverse determination, the covered person
672 shall be required to authorize the release of any medical records that
673 may be required to be reviewed for the purpose of making a decision
674 on such request;
- 675 (D) A statement of the rights and responsibilities of covered persons
676 with respect to each of the procedures under subparagraphs (A) to (C),
677 inclusive, of this subdivision. Such statement shall include a disclosure
678 that a covered person has the right to contact the commissioner's office
679 or the Office of Healthcare Advocate at any time for assistance and
680 shall include the contact information for said offices;
- 681 (E) A description of what constitutes a surprise bill, as defined in
682 subsection (a) of section 38a-477aa;
- 683 (2) Inform its covered persons, at the time of initial enrollment and
684 at least annually thereafter, of its grievance procedures. This
685 requirement may be fulfilled by including such procedures in an
686 enrollment agreement or update to such agreement;

687 (3) Inform a covered person or the covered person's health care
688 professional, as applicable, at the time the covered person or the
689 covered person's health care professional requests a prospective or
690 concurrent review: (A) The network status under such covered
691 person's health benefit plan of the health care professional who will be
692 providing the health care service or course of treatment; (B) an
693 estimate of the amount the health carrier will reimburse such health
694 care professional for such service or treatment; and (C) how such
695 amount compares to the usual, customary and reasonable charge, as
696 determined by the Centers for Medicare and Medicaid Services, for
697 such service or treatment;

698 (4) Inform a covered person and the covered person's health care
699 professional of the health carrier's grievance procedures whenever the
700 health carrier denies certification of a benefit requested by a covered
701 person's health care professional;

702 (5) Prominently post on its Internet web site the description
703 required under subparagraph (E) of subdivision (1) of this subsection;

704 (6) Include in materials intended for prospective covered persons a
705 summary of its utilization review and benefit determination
706 procedures;

707 (7) Print on its membership or identification cards a toll-free
708 telephone number for utilization review and benefit determinations;

709 (8) Maintain records of all benefit requests, claims and notices
710 associated with utilization review and benefit determinations made in
711 accordance with section 38a-591d for not less than six years after such
712 requests, claims and notices were made. Each health carrier shall make
713 such records available for examination by the commissioner and
714 appropriate federal oversight agencies upon request; and

715 (9) Maintain records in accordance with section 38a-591h of all
716 grievances received. Each health carrier shall make such records
717 available for examination by covered persons, to the extent such

718 records are permitted to be disclosed by law, the commissioner and
719 appropriate federal oversight agencies upon request.

720 [(e) (1) On or before March first annually, each health carrier shall
721 file with the commissioner:

722 (A) A summary report of its utilization review program activities in
723 the calendar year immediately preceding; and

724 (B) A report that includes for each type of health benefit plan
725 offered by the health carrier:

726 (i) A certificate of compliance certifying that the utilization review
727 program of the health carrier or its designee complies with all
728 applicable state and federal laws concerning confidentiality and
729 reporting requirements;

730 (ii) The number of covered lives;

731 (iii) The total number of grievances received;

732 (iv) The number of grievances resolved at each level, if applicable,
733 and their resolution;

734 (v) The number of grievances appealed to the commissioner of
735 which the health carrier has been informed;

736 (vi) The number of grievances referred to alternative dispute
737 resolution procedures or resulting in litigation; and

738 (vii) A synopsis of actions being taken to correct any problems
739 identified.

740 (2) The commissioner shall adopt regulations, in accordance with
741 chapter 54, to establish the form and content of the reports specified in
742 subdivision (1) of this subsection.]

743 Sec. 18. Subdivision (3) of subsection (a) of section 38a-591e of the
744 general statutes is repealed and the following is substituted in lieu

745 thereof (*Effective July 1, 2016*):

746 (3) In addition to a copy of such procedures, each health carrier shall
747 file annually with the commissioner, [as part of its annual report
748 required under subsection (e) of section 38a-591b] in a form prescribed
749 by the commissioner, a certificate of compliance stating that the health
750 carrier has established and maintains grievance procedures for each of
751 its health benefit plans that are fully compliant with the provisions of
752 sections 38a-591a to 38a-591n, inclusive.

753 Sec. 19. Section 38a-591h of the general statutes is repealed and the
754 following is substituted in lieu thereof (*Effective July 1, 2016*):

755 (a) (1) Each health carrier shall maintain written records to
756 document all grievances of adverse determinations it receives,
757 including the notices and claims associated with such grievances,
758 during a calendar year.

759 (2) (A) Each health carrier shall maintain such records for not less
760 than six years after the notice of an adverse determination that is the
761 subject of a grievance was provided to a covered person or the covered
762 person's authorized representative, as applicable, under section 38a-
763 591d.

764 (B) The health carrier shall make such records available for
765 examination by covered persons, to the extent such records are
766 permitted to be disclosed by law, the commissioner and appropriate
767 federal oversight agencies upon request. Such records shall be
768 maintained in a manner that is reasonably clear and accessible to the
769 commissioner.

770 (b) For each grievance the record shall contain, at a minimum, the
771 following information: (1) A general description of the reason for the
772 grievance; (2) the date the health carrier received the grievance; (3) the
773 date of each review or, if applicable, review meeting of the grievance;
774 (4) the resolution at each level of the grievance, if applicable; (5) the
775 date of resolution at each such level, if applicable; and (6) the name of

776 the covered person for whom the grievance was filed.

777 [(c) Each health carrier shall submit a report annually to the
778 commissioner, in accordance with section 38a-591b, of the grievances it
779 received.]

780 [(d)] (c) (1) Each health carrier shall maintain written records of all
781 requests for external reviews, whether such requests are for standard
782 or expedited external reviews, that such health carrier receives notice
783 of from the commissioner in a calendar year. The health carrier shall
784 maintain such records in the aggregate by state where the covered
785 person requesting such review resides and by each type of health
786 benefit plan offered by the health carrier, and shall submit a report to
787 the commissioner upon request, in a format prescribed by the
788 commissioner.

789 (2) Such report shall include, in the aggregate by state where the
790 covered person requesting such review resides and by each type of
791 health benefit plan:

792 (A) The total number of requests for an external review, whether
793 such requests were for a standard or expedited external review;

794 (B) From the total number of such requests reported under
795 subparagraph (A) of this subdivision, the number of requests
796 determined eligible for a full external review, whether such requests
797 were for a standard or expedited external review; and

798 (C) Any other information the commissioner may request or
799 require.

800 (3) The health carrier shall retain the written records required
801 pursuant to subdivision (1) of this subsection for not less than six years
802 after the request for an external review or an expedited external review
803 was received.

804 Sec. 20. Section 38a-175 of the 2016 supplement to the general
805 statutes, as amended by section 3 of this act, is repealed and the

806 following is substituted in lieu thereof (*Effective July 1, 2017*):

807 As used in this section and sections 38a-176 to 38a-194, inclusive, as
808 amended by this act:

809 (1) "Healing arts" means the professions and occupations licensed
810 under the provisions of chapters 370, 372, 373, 375, 378, 379, 379a, 380,
811 381, 383 and 400j.

812 (2) "Carrier" means a health care center, insurer, hospital service
813 corporation, medical service corporation or other entity responsible for
814 the payment of benefits or provision of services under a group
815 contract.

816 (3) "Commissioner" means the Insurance Commissioner, except
817 when explicitly stated otherwise.

818 (4) "Evidence of coverage" means a statement of essential features
819 and services of the health care center coverage that is given to the
820 subscriber by the health care center or by the group contract holder.

821 (5) "Federal Health Maintenance Organization Act" means Title XIII
822 of the Public Health Service Act, 42 USC Subchapter XI, as amended
823 from time to time, or any successor thereto relating to qualified health
824 maintenance organizations.

825 (6) "Group contract" means a contract for health care services that by
826 its terms limits eligibility to members of a specified group. The group
827 contract may include coverage for dependents.

828 (7) "Group contract holder" means the person to which a group
829 contract has been issued.

830 (8) "Health care" includes, but shall not be limited to, the following:
831 (A) [Medical] For a health care center that provides medical and
832 surgical services other than or in addition to dental services, (i)
833 medical, surgical and dental care provided through licensed
834 practitioners, including any supporting and ancillary personnel,

835 services and supplies; [(B)] (ii) physical therapy service provided
836 through licensed physical therapists upon the prescription of a
837 physician; [(C)] (iii) psychological examinations provided by registered
838 psychologists; [(D)] (iv) optometric service provided by licensed
839 optometrists; [(E)] (v) hospital service, both inpatient and outpatient;
840 [(F)] (vi) convalescent institution care and nursing home care; [(G)]
841 (vii) nursing service provided by a registered nurse or by a licensed
842 practical nurse; [(H)] (viii) home care service of all types required for
843 the health of a person; [(I)] (ix) rehabilitation service required or
844 desirable for the health of a person; [(J)] (x) preventive medical services
845 of all and any types; [(K)] (xi) furnishing necessary appliances, drugs,
846 medicines and supplies; [(L)] (xii) educational services for the health
847 and well-being of a person; [(M)] (xiii) ambulance service; and [(N)]
848 (xiv) any other care, service or treatment related to the prevention or
849 treatment of disease, the correction of defects and the maintenance of
850 the physical and mental well-being of human beings. Any diagnosis
851 and treatment of diseases of human beings required for health care as
852 defined in this section, if rendered, shall be under the supervision and
853 control of the providers; and (B) for a health care center that provides
854 only dental services, dental care provided through licensed
855 practitioners, including any supporting and ancillary personnel,
856 services and supplies.

857 (9) "Health care center" means (A) any organization governed by
858 sections 38a-175 to 38a-192, inclusive, and licensed or authorized by
859 the commissioner pursuant to section 38a-41 or 38a-41a, for the
860 purpose of carrying out the activities and purposes set forth in
861 subsection (b) of section 38a-176, as amended by this act, at the
862 expense of the health care center, including the providing of health
863 care to members of the community, including subscribers to one or
864 more plans under an agreement entitling such subscribers to health
865 care in consideration of a basic advance or periodic charge and shall
866 include a health maintenance organization, or (B) a line of business
867 conducted by an organization that is formed pursuant to the laws of
868 this state for the purposes of, but not limited to, carrying out the

869 activities and purposes set forth in subsection (b) of section 38a-176, as
870 amended by this act.

871 (10) "Individual contract" means a contract for health care services
872 issued to and covering an individual. The individual contract may
873 include dependents of the subscriber.

874 (11) "Individual practice association" means a partnership,
875 corporation, association or other legal entity that has entered into a
876 services arrangement with health care professionals licensed in this
877 state to provide services to enrollees of a health care center.

878 (12) "Insolvent" or "insolvency" means, with respect to an
879 organization, that the organization has been declared insolvent and
880 placed under an order of liquidation by a court of competent
881 jurisdiction.

882 (13) "Net worth" means the excess of total admitted assets over total
883 liabilities, but the liabilities shall not include fully subordinated debt,
884 as that term is used in section 38a-193.

885 (14) "Member" or "enrollee" means an individual who is enrolled in
886 a health care center.

887 (15) "Person" means an individual, corporation, limited liability
888 company, partnership, association, trust or any other legal entity.

889 (16) "Uncovered expenditures" means the cost of health care services
890 that are covered by a health care center, for which an enrollee would
891 also be liable in the event of the health care center's insolvency, and for
892 which no alternative arrangements have been made that are acceptable
893 to the commissioner. "Uncovered expenditures" does not include
894 expenditures for services when a provider has agreed not to bill the
895 enrollee even though the provider is not paid by the health care center
896 or for services that are guaranteed, insured or assumed by a person
897 other than the health care center.

898 (17) "Enrolled population" means a group of persons, defined as to

899 probable age, sex and family composition, that receives health care
900 from a health care center in consideration of a basic advance or
901 periodic charge.

902 (18) "Participating provider" means a provider who, under an
903 express or implied contract with the health care center or with its
904 contractor or subcontractor, has agreed to provide health care services
905 to enrollees with an expectation of receiving payment, other than
906 copayment or deductible, directly or indirectly from the health care
907 center.

908 (19) "Provider" means any licensed health care professional or
909 facility, including individual practice associations.

910 (20) "Subscriber" means an individual whose employment or other
911 status, except family dependency, is the basis for eligibility for
912 enrollment in the health care center, or in the case of an individual
913 contract, the person in whose name the contract is issued.

914 Sec. 21. Section 38a-176 of the general statutes is repealed and the
915 following is substituted in lieu thereof (*Effective July 1, 2017*):

916 (a) Each [such] health care center shall be governed by sections 38a-
917 175 to [38a-192] ~~38a-194~~, inclusive, as amended by this act, and by the
918 other applicable laws of the state to the extent not inconsistent with the
919 provisions of said sections.

920 (b) (1) The nature of the activities to be conducted and the purposes
921 to be carried out by a health care center include, but are not limited to:
922 [(1)] (A) Establishing, maintaining and operating facilities whereby
923 health care [, as hereinbefore defined,] may be provided at the expense
924 of the health care center; [(2)] and (B) providing health care (i) directly
925 by its health care center employees who, when required by law, shall
926 be duly licensed to render such service, or (ii) by agreement or by
927 indemnity arrangement with any hospital, hospital service
928 corporation, medical service corporation, medical group clinic or
929 person qualified and licensed to render any health care service, or (iii)

930 by both methods [~~(3) entering~~] set forth in subparagraphs (B)(i) and
931 (B)(ii) of this subdivision.

932 (2) For a health care center that provides medical and surgical
933 services other than or in addition to dental services, the nature of the
934 activities to be conducted and the purposes to be carried out by such
935 health care center, in addition to those set forth in subdivision (1) of
936 this subsection, include, but are not limited to: (A) Entering into
937 agreements with any governmental agency, or any provider for the
938 training of personnel under the direction of persons licensed to
939 practice any healing art; [(4)] (B) establishing, operating and
940 maintaining a medical service center, clinic or any such other facility as
941 shall be necessary for the prevention, study, diagnosis and treatment
942 of human ailments and injuries and to promote medical, surgical,
943 dental and general health education, scientific education, research and
944 learning; [(5)] (C) marketing, enrolling and administering a health care
945 plan; [(6)] (D) contracting with insurers licensed in this state, including
946 hospital service corporations and medical service corporations; [(7)] (E)
947 offering, in addition to health services, benefits covering out-of-area or
948 emergency services; [(8)] (F) providing health services not included in
949 the health care plan on a fee-for-service basis; and [(9)] (G) entering
950 into contracts in furtherance of the purposes of sections 38a-175 to 38a-
951 192, inclusive, as amended by this act.

952 (3) A health care center that provides only dental services shall not
953 be required to conduct activities set forth in subdivision (2) of this
954 subsection.

955 Sec. 22. Section 38a-177 of the general statutes is repealed and the
956 following is substituted in lieu thereof (*Effective July 1, 2017*):

957 [Health care may be provided (a)] A health care center may provide
958 health care (1) directly [by a health care center] or by its employees or
959 contractors licensed by this state to render such services, or by contract
960 or by indemnity arrangement with any hospital, hospital service
961 corporation, medical service corporation or person qualified and

962 licensed to render any health care service or by both methods; and [(b)]
963 (2) by other methods to the extent permitted under the Federal Health
964 Maintenance Organization Act and the regulations adopted
965 thereunder from time to time unless otherwise determined by the
966 commissioner by regulation. A health care center may also enter into
967 agreements with hospitals or individuals approved by their respective
968 state regulating board, licensed to practice any of the healing arts, for
969 the training of personnel under the direction of persons licensed to
970 practice the profession or healing art. A health care center may also
971 maintain a clinic or clinics for the prevention, study, diagnosis and
972 treatment of human ailments and injuries by licensed persons and to
973 promote medical, surgical, dental [and] or scientific research and
974 learning.

975 Sec. 23. Section 38a-179 of the general statutes, as amended by
976 section 5 of this act, is repealed and the following is substituted in lieu
977 thereof (*Effective July 1, 2017*):

978 (a) If a domestic health care center is organized as a nonprofit,
979 nonstock corporation, the care, control and disposition of the property
980 and funds of each such corporation and the general management of its
981 affairs shall be vested in a board of directors. Each such corporation
982 shall have the power to adopt bylaws for the governing of its affairs,
983 which bylaws shall prescribe the number of directors, their term of
984 office and the manner of their election, subject to the provisions of
985 sections 38a-175 to 38a-192, inclusive, as amended by this act. The
986 bylaws may be adopted and repealed or amended by the affirmative
987 vote of two-thirds of all the directors at any meeting of the board of
988 directors duly held upon at least ten days' notice, provided notice of
989 such meeting shall specify the proposed action concerning the bylaws
990 to be taken at such meeting. The bylaws of the corporation shall
991 provide that the board of directors shall include representation from
992 persons engaged in the healing arts and from persons who are eligible
993 to receive health care from the corporation, subject to the following
994 provisions: (1) One-quarter of the board of directors shall be persons
995 engaged in the different fields in the healing arts at least two of whom

1996 shall be a physician and a dentist, [;] except for a health care center that
1997 provides only dental services, one-quarter of the board of directors
1998 shall be persons engaged in the dental or related fields; and (2) one-
1999 quarter of the board of directors shall be subscribers who are eligible to
1000 receive health care from the health care center, but no such
1001 representative need be seated until the first annual meeting following
1002 the approval by the commissioner of the initial agreement or
1003 agreements to be offered by the corporation, and there shall be only
1004 one representative from any group covered by a group service
1005 agreement.

1006 (b) If a domestic health care center is not organized as a nonprofit,
1007 nonstock corporation, management of its affairs shall be in accordance
1008 with other applicable laws of the state, provided such health care
1009 center shall establish and maintain a mechanism to afford its members
1010 an opportunity to participate in matters of policy and operation such
1011 as an advisory panel, advisory referenda on major policy decisions or
1012 other similar mechanisms.

1013 Sec. 24. Section 38a-180 of the general statutes is repealed and the
1014 following is substituted in lieu thereof (*Effective July 1, 2017*):

1015 (a) Any clinic established [hereunder] under sections 38a-175 to 38a-
1016 192, inclusive, as amended by this act, including a clinic [which] that is
1017 a part of a medical service center or other facility, shall be subject to
1018 approval as a clinic by the Commissioner of Public Health pursuant to
1019 the standards established by [him] said commissioner for approved
1020 clinics.

1021 (b) Any person licensed to practice any of the healing arts or
1022 occupations employed by a health care center governed by sections
1023 38a-175 to 38a-192, inclusive, as amended by this act, shall not be
1024 subject to reprimand or discipline because [he] such person is an
1025 employee of the health care center or because such health care center
1026 may be engaged in rendering health care or related care through its
1027 own employees, [provided] except such person shall otherwise remain

1028 subject to reprimand or discipline by the state regulating board
 1029 governing such profession or occupation as provided by law for [his]
 1030 such person's act or acts for unlawful, unprofessional or immoral
 1031 conduct. [by the state regulating board governing such profession or
 1032 occupation as provided by law.]

1033 (c) (1) No health care center [which] that provides medical and
 1034 surgical services other than or in addition to dental services that
 1035 contracts with an individual practice association may prohibit any
 1036 practitioner of the healing arts from participating in such health care
 1037 center solely on the basis of [his] such practitioner's profession. No
 1038 person may interfere with the exercise by any other person of his or
 1039 her free choice in the selection of a practitioner [in] of the healing arts
 1040 who is participating in the health care center.

1041 (2) No health care center that provides only dental services that
 1042 contracts with an individual practice association may prohibit any
 1043 practitioner of the healing arts from participating in such health care
 1044 center solely on the basis of such practitioner's profession if such
 1045 practitioner is licensed to perform services offered by such health care
 1046 center. No person may interfere with the exercise by any other person
 1047 of his or her free choice in the selection of a practitioner of the healing
 1048 arts who is participating in the health care center."

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2016	38a-15
Sec. 2	October 1, 2016	38a-16(a)
Sec. 3	July 1, 2016	38a-175
Sec. 4	July 1, 2016	38a-178
Sec. 5	July 1, 2016	38a-179
Sec. 6	July 1, 2016	38a-186
Sec. 7	July 1, 2016	38a-188
Sec. 8	July 1, 2016	19a-7j(b)(2)(A)
Sec. 9	July 1, 2016	19a-7p(b)(2)
Sec. 10	July 1, 2016	38a-14(h)
Sec. 11	July 1, 2016	38a-43

Sec. 12	<i>July 1, 2016</i>	38a-52
Sec. 13	<i>July 1, 2016</i>	38a-53
Sec. 14	<i>July 1, 2016</i>	38a-54(a) and (b)
Sec. 15	<i>July 1, 2016</i>	38a-55
Sec. 16	<i>July 1, 2016</i>	38a-59
Sec. 17	<i>July 1, 2016</i>	38a-591b
Sec. 18	<i>July 1, 2016</i>	38a-591e(a)(3)
Sec. 19	<i>July 1, 2016</i>	38a-591h
Sec. 20	<i>July 1, 2017</i>	38a-175
Sec. 21	<i>July 1, 2017</i>	38a-176
Sec. 22	<i>July 1, 2017</i>	38a-177
Sec. 23	<i>July 1, 2017</i>	38a-179
Sec. 24	<i>July 1, 2017</i>	38a-180