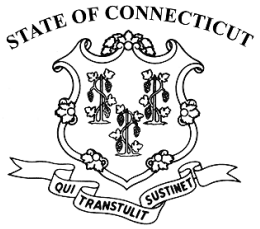

Substitute Senate Bill No. 433

Public Act No. 16-205

AN ACT CONCERNING STANDARDS AND REQUIREMENTS FOR HEALTH CARRIERS' PROVIDER NETWORKS AND CONTRACTS BETWEEN HEALTH CARRIERS AND PARTICIPATING PROVIDERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) **[**Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, and each preferred provider network, as defined in section 38a-479aa, that contracts with a health care provider, as defined in section 38a-478, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards.**]** As used in this section:

(1) "Authorized representative" means (A) an individual to whom a covered person has given express written consent to represent the covered person, (B) an individual authorized by law to provide substituted consent for a covered person, or (C) the covered person's

treating health care provider when the covered person is unable to provide consent or a family member of the covered person;

(2) "Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) "Covered person" has the same meaning as provided in section 38a-591a;

(4) "Essential community provider" means a health care provider or facility that (A) serves predominantly low-income, medically underserved individuals and includes covered entities, as defined in 42 USC 256b, as amended from time to time, or (B) is described in 42 USC 1396r-8(c)(1)(D)(i)(IV), as amended from time to time;

(5) "Facility" has the same meaning as provided in section 38a-591a;

(6) "Health benefit plan" has the same meaning as provided in section 38a-591a;

(7) "Health care provider" has the same meaning as provided in section 38a-477aa;

(8) "Health care services" has the same meaning as provided in section 38a-478;

(9) "Health carrier" has the same meaning as provided in section 38a-591a;

(10) "Intermediary" means a person, as defined in section 38a-1, authorized to negotiate and execute health care provider contracts with health carriers on behalf of health care providers or a network;

(11) "Network" means the group or groups of participating providers providing health care services under a network plan;

(12) "Network plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers or facilities that are managed, owned, under contract with or employed by the health carrier;

(13) "Participating provider" means a health care provider or a facility that, under a contract with a health carrier or such health carrier's contractor or subcontractor, has agreed to provide health care services to such health carrier's covered persons, with an expectation of receiving payment or reimbursement directly or indirectly from the health carrier, other than coinsurance, copayments or deductibles;

(14) "Primary care" means health care services for a range of common physical, mental or behavioral health conditions, provided by a health care provider;

(15) "Primary care provider" 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;

(16) "Specialist" means a health care provider who (A) focuses on a specific area of physical, mental or behavioral health or a specific group of patients, and (B) has successfully completed required training and is recognized by this state to provide specialty care. "Specialist" includes a subspecialist who has additional training and recognition beyond that required for a specialist;

(17) "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions, or those conditions that may manifest in particular ages or

subpopulations, that are provided by a specialist in coordination with a health care provider; and

(18) "Tiered network" means a network that identifies and groups some or all types of health care providers and facilities into specific groups to which different participating provider reimbursement, covered person cost-sharing or participating provider access requirements, or any combination thereof, apply for the same health care services.

(b) The provisions of this section and sections 2 and 3 of this act shall apply to all health carriers that deliver, issue for delivery, renew, amend or continue a network plan in this state.

(c) (1) (A) Each health carrier shall establish and maintain a network that includes a sufficient number and appropriate types of participating providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered benefits will be accessible to all such health carrier's covered persons without unreasonable travel or delay.

(B) Covered persons shall have access to emergency services, as defined in section 38a-477aa, twenty-four hours a day, seven days a week.

(2) The Insurance Commissioner shall determine the sufficiency of a health carrier's network in accordance with the provisions of this subsection and may establish sufficiency by reference to any reasonable criteria, including, but not limited to, (A) the ratio of participating providers to covered persons by specialty, (B) the ratio of primary care providers to covered persons, (C) the geographic accessibility of participating providers, (D) the geographic variation and dispersion of the state's population, (E) the wait times for appointments with participating providers, (F) the hours of operation

of participating providers, (G) the ability of the network to meet the needs of covered persons that may include low-income individuals, children and adults with serious, chronic or complex conditions or physical or mental disabilities or individuals with limited English proficiency, (H) the availability of other health care delivery system options, such as centers of excellence and mobile clinics, (I) the volume of technological and specialty care services available to serve the needs of covered persons who require technologically advanced or specialty care services, (J) the extent to which participating health care providers are accepting new patients, (K) the degree to which (i) participating health care providers are authorized to admit patients to hospitals participating in the network, and (ii) hospital-based health care providers are participating providers, and (L) the regionalization of specialty care.

(d) (1) Each health carrier shall 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:

(A) The health carrier has a sufficient network but does not have (i) a type of participating provider available to provide the covered benefit to the covered person, or (ii) a participating provider available 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.

(2) Each health carrier shall disclose to a covered person the process to request a covered benefit from a nonparticipating provider, as provided under subdivision (1) of this subsection, 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.

(3) The health carrier shall deem the health care services such covered person receives from a nonparticipating provider pursuant to subdivision (2) of this subsection to be health care services provided by a participating provider, including counting the covered person's cost-sharing for such health care services toward the maximum out-of-pocket expenses limit applicable to health care services received from participating providers under the health benefit plan.

(4) The health carrier shall ensure that the processes described under subdivisions (1) and (2) of this subsection address a covered person's request to obtain a covered benefit from a nonparticipating provider in a timely fashion appropriate to the covered person's condition. The time frames for such processes shall mirror those set forth in subsections (e) and (f) of section 38a-591g for external reviews of adverse determinations and final adverse determinations.

(5) The health carrier shall document all requests from its covered persons to obtain a covered benefit from a nonparticipating provider pursuant to this subsection and shall provide such documentation to the commissioner upon request.

(6) No health carrier shall use the process described in subdivisions (1) and (2) of this subsection as a substitute for establishing and

maintaining a sufficient network as required under subsection (b) of this section. No covered person shall use such process to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this subsection shall be construed to affect any rights or remedies available to a covered person under sections 38a-591a to 38a-591g, inclusive, or federal law relating to internal or external claims grievance and appeals processes.

(e) (1) Each health carrier shall:

(A) Maintain adequate arrangements 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. In determining whether a health carrier has complied with this subparagraph, the commissioner shall give due consideration to the availability of health care providers with the requisite expertise and training in the service area under consideration;

(B) Monitor on an ongoing basis the ability, clinical capacity and legal authority of its participating providers to provide all covered benefits to its covered persons;

(C) 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;

(D) Notify participating providers of their obligations, if any, (i) to collect applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person's health benefit plan, and (ii) to notify covered persons, prior to delivery of health care services if possible, of such covered persons' financial obligations for

noncovered benefits;

(E) 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;

(F) 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;

(G) 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, utilization review, quality assessment and improvement programs, credentialing, grievance and appeals processes, date reporting requirements, reporting requirements for timely notice of changes in practice such as discontinuance of accepting new patients, confidentiality requirements, any applicable federal or state programs and obtaining necessary approval of referrals to nonparticipating providers; and

(H) Establish and maintain procedures for the resolution of administrative, payment or other disputes between the health carrier and a participating provider.

(2) No health carrier shall:

(A) Offer or provide an inducement to a participating provider that would encourage or otherwise incentivize a participating provider to provide less than medically necessary health care services to a covered

person;

(B) Prohibit a participating provider from (i) discussing any specific or all treatment options with covered persons, irrespective of such health carrier's position on such treatment options, or (ii) advocating on behalf of covered persons within the utilization review or grievance and appeals processes established by such health carrier or a person contracting with such health carrier or in accordance with any rights or remedies available to covered persons under sections 38a-591a to 38a-591g, inclusive, or federal law relating to internal or external claims grievance and appeals processes; or

(C) Penalize a participating provider because such participating provider reports in good faith to state or federal authorities any act or practice by such health carrier that jeopardizes patient health or welfare.

(f) (1) Each health carrier shall develop standards, to be used by such health carrier and its intermediaries, for selecting and tiering, as applicable, participating providers and each health care provider specialty.

(2) No health carrier shall establish selection or tiering criteria in a manner that would (A) allow the health carrier to discriminate against high-risk populations by excluding or tiering participating providers because they are located in a geographic area that contains populations or participating providers that present a risk of higher-than-average claims, losses or health care services utilization, or (B) exclude participating providers because they treat or specialize in treating populations that present a risk of higher-than-average claims, losses or health care services utilization. Nothing in this subdivision shall be construed to prohibit a health carrier from declining to select a health care provider or facility for participation in such health carrier's network who fails to meet legitimate selection criteria established by

such health carrier.

(3) No health carrier shall establish selection criteria that would allow the health carrier to discriminate, with respect to participation in a network plan, against any health care provider who is acting within the scope of such health care provider's license or certification under state law. Nothing in this subdivision shall be construed to require a health carrier to contract with any health care provider or facility willing to abide by the terms and conditions for participation established by such health carrier.

(4) Each health carrier shall make the standards required under subdivision (1) of this subsection available to the commissioner for review and shall post on its Internet web site and make available to the public a plain language description of such standards.

(5) Nothing in this subsection shall require a health carrier, its intermediaries or health care provider networks with which such health carrier or intermediary contracts to (A) employ specific health care providers acting within the scope of such health care providers' license or certification under state law who meet such health carrier's selection criteria, or (B) contract with or retain more health care providers acting within the scope of such health care providers' license or certification under state law than are necessary to maintain a sufficient network.

(g) (1) (A) A health carrier and participating provider shall provide at least sixty days' written notice to each other before the health carrier removes a participating provider from the network or the participating provider leaves the network. Each participating provider that receives a notice of removal or issues a departure notice shall 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.

(B) A health carrier shall make a good faith effort to provide written notice, not later than thirty days after the health carrier receives or issues a written notice under subparagraph (A) of this subdivision, to all covered persons who are patients being treated on a regular basis by or at the participating provider being removed from or leaving the network, irrespective of whether such removal or departure is for cause.

(2) (A) For the purposes of this subdivision:

(i) "Active course of treatment" means (I) a medically necessary, ongoing course of treatment for a life-threatening condition, (II) a medically necessary, ongoing course of treatment for a serious condition, (III) medically necessary care provided during the second or third trimester of pregnancy, or (IV) a medically necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes;

(ii) "Life-threatening condition" means a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted;

(iii) "Serious condition" means a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the covered person is currently receiving; and

(iv) "Treating provider" means a covered person's treating health care provider or a facility at which a covered person is receiving treatment, that is removed from or leaves a health carrier's network pursuant to subdivision (1) of this subsection.

(B) (i) Each health carrier shall establish and maintain reasonable

procedures to transition a covered person, who is in an active course of treatment with a participating health care provider or at a participating facility that becomes a treating provider, to another participating provider in a manner that provides for continuity of care.

(ii) In addition to the notice required under subdivision (1) of this subsection, the health carrier shall provide to such covered person (I) a list of available participating providers in the same geographic area as such covered person who are of the same health care provider or facility type, and (II) the procedures for how such covered person may request continuity of care as set forth in this subparagraph.

(iii) Such procedures shall provide that:

(I) Any request for a continuity of care period shall be made by the covered person or the covered person's authorized representative;

(II) A request for a continuity of care period, made by a covered person who meets the requirements under subparagraph (B)(i) of this subdivision or such covered person's authorized representative and whose treating provider was not removed from or did not leave the network for cause, shall be reviewed by the health carrier's medical director after consultation with such treating provider; and

(III) For a covered person who is in the second or third trimester of pregnancy, the continuity of care period shall extend through the postpartum period.

(iv) The continuity of care period for a covered person who is undergoing an active course of treatment shall extend to the earliest of the following: (I) Termination of the course of treatment by the covered person or the treating provider; (II) ninety days after the date the participating provider is removed from or leaves the network, unless the health carrier's medical director determines that a longer period is necessary; (III) the date that care is successfully transitioned to another

participating provider; (IV) the date benefit limitations under the health benefit plan are met or exceeded; or (V) the date the health carrier determines care is no longer medically necessary.

(v) The health carrier shall only grant a continuity of care period as provided under subparagraph (B)(iv) of this subdivision if the treating provider agrees, in writing, (I) to accept the same payment from such health carrier and abide by the same terms and conditions as provided in the contract between such health carrier and treating provider when such treating provider was a participating provider, and (II) not to seek any payment from the covered person for any amount for which such covered person would not have been responsible if the treating provider was still a participating provider.

(h) (1) (A) Beginning January 1, 2017, a health carrier shall file with the commissioner for review each existing network as of said date and an access plan for each such network.

(B) For each new network a health carrier intends to offer after January 1, 2017, such health carrier shall file with the commissioner for review, within thirty days prior to the date such health carrier will offer such new network, the new network and an access plan for such new network.

(C) A health carrier shall notify the commissioner of any material change to an existing network not later than fifteen business days after such change and shall file with the commissioner an update to such existing network not later than thirty days after such material change. For the purposes of this subparagraph, "material change" means (i) a change of twenty-five per cent or more in the participating providers in a health carrier's network or the type of participating providers available in a health carrier's network to provide health care services or specialty care to covered persons, or (ii) any change that renders a health carrier's network noncompliant with one or more network

adequacy standards, including, but not limited to, (I) a significant reduction in the number of primary care or specialty care providers available in the network, (II) a reduction in a specific type of participating provider such that a specific covered benefit is no longer available to covered persons, (III) a change to a tiered, multitiered, layered or multilevel network plan structure, (IV) a change in inclusion of a major health system, as defined in section 19a-508c, that causes a network to be significantly different from what a covered person initially purchased, or (V) after notice, any other change the commissioner deems to be a material change.

(2) Each access plan required under subdivision (1) of this subsection shall be in a form and manner prescribed by the commissioner and shall contain descriptions of at least the following:

(A) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(B) The health carrier's procedures for monitoring and assuring on an ongoing basis the sufficiency of its network to meet the health care needs of the populations that enroll in its network plans;

(C) The factors used by the health carrier to build its network, including a description of the network and the criteria used to select and tier health care providers and facilities;

(D) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic or complex conditions. Such description shall include the health carrier's efforts, when appropriate, to include various types of essential community providers in its network;

(E) The health carrier's methods for assessing the health care needs

of covered persons and covered persons' satisfaction with the health care services provided;

(F) The health carrier's method of informing covered persons of the network plan's covered benefits, including, but not limited to, (i) the network plan's grievance and appeals processes, (ii) the network plan's process for covered persons to choose or change participating providers in the network plan, (iii) the health carrier's process for updating its participating provider directories for each of its network plans, (iv) a statement of the health care services offered by the network plan, including those health care services offered through the preventive care benefit, if applicable, and (v) the network plan's procedures for covering and approving emergency, urgent and specialty care, if applicable;

(G) The health carrier's system for ensuring the coordination and continuity of care for covered persons (i) referred to specialty physicians, or (ii) using ancillary services that are covered benefits, including, but not limited to, social services and other community resources and for ensuring appropriate discharge planning for covered persons using such ancillary services;

(H) The health carrier's process for enabling covered persons to change their designation of a primary care provider, if applicable;

(I) The health carrier's proposed plan for providing continuity of care to covered persons in the event of contract termination between the health carrier and any of its participating providers or in the event of the health carrier's insolvency or other inability to continue operations. Such description shall explain how covered persons will be notified of such contract termination, insolvency or other cessation of operations and transitioned to other participating providers in a timely manner;

(J) The health carrier's process for monitoring access to specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology and laboratory services at such health carrier's participating hospitals;

(K) The health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that such health carrier has designed to include health care providers and facilities that provide high quality of care and health outcomes;

(L) The health carrier's accreditation by the National Committee for Quality Assurance that such health carrier meets said committee's network adequacy requirements or by URAC that such health carrier meets URAC's provider network access and availability standards; and

(M) Any other information required by the commissioner to determine the health carrier's compliance with this section.

(3) A health carrier shall post each access plan on its Internet web site and make such access plan available at the health carrier's business premises in this state and to any person upon request, except that such health carrier may exclude from such posting or publicly available access plan any information such health carrier deems to be proprietary information that, if disclosed, would cause the health carrier's competitors to obtain valuable business information. A health carrier may request the commissioner not to disclose such information under section 1-210.

(i) (1) If the commissioner determines that (A) a health carrier has not contracted with a sufficient number of participating providers to assure that its covered persons have accessible health care services in a geographic area, (B) a health carrier's access plan does not assure reasonable access to covered benefits, (C) a health carrier has entered

into a contract that does not conform to the requirements of this section or section 2 of this act, or (D) a health carrier has not complied with a provision of this section or section 2 or 3 of this act, the health carrier shall modify its access plan or implement a corrective action plan, as appropriate, and as directed by the commissioner. The commissioner may take any other action authorized under this title to bring a health carrier into compliance with this section and sections 2 and 3 of this act.

(2) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section and sections 2 and 3 of this act.

Sec. 2. (NEW) (*Effective January 1, 2017*) (a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a of the general statutes, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa of the general statutes, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f of the general statutes, as amended by this act.

(b) (1) Each contract entered into, renewed or amended on or after January 1, 2017, between a health carrier and a participating provider shall include:

(A) A hold harmless provision that specifies protections for covered persons. Such provision shall include the following statement or a substantially similar statement: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other

than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.";

(B) A provision that in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in subdivision (2) of subsection (g) of section 38a-472f of the general statutes, as amended by this act, or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled;

(C) (i) A provision that requires the participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons, and (ii) a statement that such participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records; and

(D) Definitions of what is considered timely notice and a material change for the purposes of subdivision (2) of subsection (c) of this section.

(2) The contract terms set forth in subparagraphs (A) and (B) of subdivision (1) of this subsection shall (A) be construed in favor of the covered person, (B) survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health carrier, and (C) supersede any oral or written agreement between a health care provider and a covered person or a covered person's authorized representative that is contrary to or inconsistent with the requirements set forth in subdivision (1) of this subsection.

(3) No contract subject to this subsection shall include any provision that conflicts with the provisions contained in the network plan or required under this section, section 38a-472f of the general statutes, as amended by this act, or section 3 of this act.

(4) No health carrier or participating provider that is a party to a contract under this subsection shall assign or delegate any right or responsibility required under such contract without the prior written consent of the other party.

(c) (1) At the time a contract subject to subsection (b) of this section is signed, the health carrier or such health carrier's intermediary shall

disclose to a participating provider all provisions and other documents incorporated by reference in such contract.

(2) While such contract is in force, the health carrier shall timely notify a participating provider of any change to such provisions or other documents specified under subdivision (1) of this subsection that will result in a material change to such contract.

(d) (1) (A) Each contract between a health carrier and an intermediary entered into, renewed or amended on or after January 1, 2017, shall satisfy the requirements of this subsection.

(B) Each intermediary and participating providers with whom such intermediary contracts shall comply with the applicable requirements of this subsection.

(2) No health carrier shall assign or delegate to an intermediary such health carrier's responsibilities to monitor the offering of covered benefits to covered persons. To the extent a health carrier assigns or delegates to an intermediary other responsibilities, such health carrier shall retain full responsibility for such intermediary's compliance with the requirements of this section.

(3) A health carrier shall have the right to approve or disapprove the participation status of a health care provider or facility in such health carrier's own or a contracted network that is subcontracted for the purpose of providing covered benefits to the health carrier's covered persons.

(4) A health carrier shall maintain at its principal place of business in this state copies of all intermediary subcontracts or ensure that such health carrier has access to all such subcontracts. Such health carrier shall have the right, upon twenty days' prior written notice, to make copies of any intermediary subcontracts to facilitate regulatory review.

(5) (A) Each intermediary shall, if applicable, (i) transmit to the health carrier documentation of health care services utilization and claims paid, and (ii) maintain at its principal place of business in this state, for a period of time prescribed by the commissioner, the books, records, financial information and documentation of health care services received by covered persons, in a manner that facilitates regulatory review, and shall allow the commissioner access to such books, records, financial information and documentation as necessary for the commissioner to determine compliance with this section and section 38a-472f of the general statutes, as amended by this act.

(B) Each health carrier shall monitor the timeliness and appropriateness of payments made by its intermediary to participating providers and of health care services received by covered persons.

(6) In the event of the intermediary's insolvency, a health carrier shall have the right to require the assignment to the health carrier of the provisions of a participating provider's contract that address such participating provider's obligation to provide covered benefits. If a health carrier requires such assignment, such health carrier shall remain obligated to pay the participating provider for providing covered benefits under the same terms and conditions as the intermediary prior to the insolvency.

(e) The commissioner shall not act to arbitrate, mediate or settle (1) disputes regarding a health carrier's decision not to include a health care provider or facility in such health carrier's network or network plan, or (2) any other dispute between a health carrier, such health carrier's intermediary or one or more participating providers, that arises under or by reason of a participating provider contract or the termination of such contract.

Sec. 3. (NEW) (*Effective January 1, 2017*) (a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same

meanings as provided in section 38a-591a of the general statutes, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa of the general statutes, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f of the general statutes, as amended by this act.

(b) (1) Each health carrier shall post on its Internet web site a current and accurate participating provider directory, updated at least monthly, for each of its network plans. The health carrier shall ensure that consumers are able to view all of the current participating providers for a network plan through a clearly identifiable link or tab on such health carrier's Internet web site, without being required to create or access an account or enter a policy or contract number.

(2) Each health carrier shall provide, upon request from a covered person or a covered person's representative, a print copy of such directory or of requested information from such directory.

(c) (1) A health carrier shall include in each such electronic or print directory the following information in plain language: (A) A description of the criteria the health carrier used to build its network; (B) if applicable, a description of the criteria the health carrier used to tier its participating providers; (C) if applicable, a description of how the health carrier designates the different participating provider tiers or levels in the network and identifies, for each specific participating provider, in which tier each is placed, such as by name, symbols or grouping, to allow a consumer to be able to identify the participating provider tiers; and (D) if applicable, a statement that authorization or referral may be required to access some participating providers.

(2) Each such directory shall also include a customer service electronic mail address and telephone number or an Internet web site address that covered persons or consumers may use to notify the

health carrier of any inaccurate participating provider information in such directory.

(3) Each health carrier shall make it clear for each such electronic or print directory which directory applies to which network plan, such as by including the specific name of the network plan as marketed and issued in this state.

(4) Each such electronic or print directory shall accommodate the communication needs of individuals with disabilities and include an Internet web site address or information regarding available assistance for individuals with limited English proficiency.

(d) (1) The health carrier shall make available through an electronic participating provider directory, for each of its network plans, the following information in a searchable format:

(A) For health care providers, (i) the health care provider's name, gender, participating office location or locations, specialty, if applicable, medical group affiliations, if any, facility affiliations, if applicable, participating facility affiliations, if applicable, (ii) any languages other than English spoken by such health care provider, and (iii) whether such health care provider is accepting new patients;

(B) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer, the participating hospital location and the hospital's accreditation status; and

(C) For facilities other than hospitals, by type, 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.

(2) In addition to the information required under subdivision (1) of this subsection, the health carrier shall make available through the

electronic directory specified under subdivision (1) of this subsection, for each of its network plans, the following information:

(A) For health care providers, the health care provider's contact information, board certification and any languages other than English spoken by clinical staff, if applicable;

(B) For hospitals, the hospital's telephone number; and

(C) For facilities other than hospitals, the facility's telephone number.

(3) (A) Each health carrier shall make available in print, upon request, the following participating provider directory information for the applicable network plan:

(i) For health care providers, (I) the health care provider's name, contact information, specialty, if applicable and participating office location or locations, (II) any languages other than English spoken by such health care provider, and (III) whether such health care provider is accepting new patients;

(ii) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer and the participating hospital location and telephone number; and

(iii) For facilities other than hospitals, by type, 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.

(B) Each health carrier shall include with the print directory information under subparagraph (A) of this subdivision and in the print participating provider directory under subdivision (2) of subsection (a) of this section a statement that the information provided

or included is accurate as of the date of printing, that covered persons or prospective covered persons should consult the health carrier's electronic participating provider directory on such health carrier's Internet web site and that covered persons may call the telephone number on such covered person's insurance card for more information.

(4) For the information required to be included in a participating provider directory pursuant to subdivisions (1) and (2) of this subsection, each health carrier shall make available through such directory the sources of such information and any limitations on such information, if applicable.

(e) Each health carrier shall periodically audit at least a reasonable sample size of its participating provider directories for accuracy and retain documentation of such audit to be made available to the commissioner upon request.

Sec. 4. Section 19a-904a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) On and after January 1, 2016, each health care provider shall, prior to any scheduled admission, procedure or service, for nonemergency care, determine whether the patient is covered under a health insurance policy. If the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, such health care provider shall notify the patient, in writing, electronically or by mail, (1) of the charges for the admission, procedure or service, (2) that such patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission, procedure or service, and (3) if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such

policy may apply. Nothing in this subsection shall prevent a health care provider from charging a patient for such unforeseen services.

(b) Each health care provider and health carrier shall ensure that any notice, billing statement or explanation of benefits submitted to a patient or insured is written in language that is understandable to an average reader.

(c) No health care provider shall collect or attempt to collect from an insured patient any money owed to such health care provider by such patient's health carrier.

Sec. 5. Subsection (a) of section 38a-477e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) On and after July 1, 2016, each health carrier, as defined in section 38a-1084a, shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the exchange pursuant to section 38a-1084a for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) **[**a list of in-network health care providers, (iv) whether a health care provider is accepting new patients, and (v) languages spoken by health care providers**]** a directory of participating providers, as defined in section 38a-472f, as amended by this act, in accordance with the provisions of section 38a-472f, as amended by this act; and (2)

information on out-of-network costs for inpatient admissions, health care procedures and services.

Sec. 6. Section 38a-478d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

For any contract delivered, issued for delivery, renewed, amended or continued in this state, each managed care organization shall:

(1) **[**Provide at least annually to each enrollee a listing of all providers available under the provisions of the enrollee's enrollment agreement, in writing or through the Internet at the option of the enrollee;

(2) Include**]** Provide at least annually to each enrollee a provider directory that conforms to the requirements of section 3 of this act. Such directory shall include, under a separate category or heading, participating advanced practice registered nurses; **[**in the listing of providers specified under subdivision (1) of this section;**]** and

[(3)**]** (2) For a managed care plan that requires the selection of a primary care provider:

(A) Allow an enrollee to designate a participating, in-network physician or a participating, in-network advanced practice registered nurse as such enrollee's primary care provider; and

(B) Provide notification **[**, as soon as possible**]** in accordance with subsection (g) of section 38a-472f, as amended by this act, to each such enrollee upon the termination or withdrawal of the enrollee's primary care provider.

Sec. 7. Section 38a-478h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) Each contract delivered, issued for delivery, renewed, amended

or continued in this state between a managed care organization and a participating provider shall **[**require the provider to give at least sixty days' advance written notice to the managed care organization and shall require the managed care organization to give at least sixty days' advance written notice to the provider in order to withdraw from or terminate the agreement**]** conform to the requirements of section 2 of this act and shall include notice provisions for the removal or departure of such provider in accordance with subsection (g) of section 38a-472f, as amended by this act.

[(b) The provisions of this section shall not apply: (1) When lack of such notice is necessary for the health or safety of the enrollees; (2) when a provider has entered into a contract with a managed care organization that is found to be based on fraud or material misrepresentation; or (3) when a provider engages in any fraudulent activity related to the terms of his contract with the managed care organization.**]**

[(c)**]** (b) No managed care organization shall take or threaten to take any action against any provider in retaliation for such provider's assistance to an enrollee under the provisions of section 38a-591g.

Approved June 7, 2016