



**Substitute Senate Bill No. 368**

**Public Act No. 16-213**

**AN ACT CONCERNING THE INSURANCE DEPARTMENT'S MARKET CONDUCT AUTHORITY AND DATA CALL CONFIDENTIALITY, AUTHORIZING MULTISTATE HEALTH CARE CENTERS IN CONNECTICUT, ELIMINATING A HEALTH CARRIER UTILIZATION REVIEW REPORT FILING REQUIREMENT, AND CONCERNING LICENSURE OF SINGLE PURPOSE DENTAL HEALTH CARE CENTERS.**

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

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 Section 38a-15 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

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

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons, who shall not be officers of, or connected with or

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interested in, any insurance company, health care center, third-party administrator or fraternal benefit society, other than as a policyholder. In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such insurance company, health care center, third-party administrator or fraternal benefit society and all persons deemed to have material information regarding the company's, center's, administrator's or society's property or business. Each such company, center, administrator or society, its officers and agents, shall produce the books and papers, in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper in such person's custody, deemed to be relevant to the examination, for the inspection of the commissioner, the commissioner's actuary or examiners, when required. The officers and agents of the company, center, administrator or society shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so.

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

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newspapers of the state.

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

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

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

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

(3) The provisions of this subsection shall not abrogate or modify any common law or statutory privilege or immunity heretofore

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enjoyed by any person identified in subdivision (1) of this subsection.

(f) Nothing in this section shall be construed to prevent or prohibit the commissioner from disclosing at any time the content or results of an examination report or a preliminary examination report or any matter relating to such report, to (1) the insurance regulatory officials of this state or any other state or country, (2) law enforcement officials of this or any other state, or (3) any agency of this or any other state or of the federal government, provided such officials or agency receiving the report or matters relating to the report agrees, in writing, to hold such report or matters confidential.

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

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

(a) (1) The Insurance Commissioner or the commissioner's authorized representative may, as often as the commissioner deems necessary, conduct investigations and hearings in aid of any investigation on any matter under the provisions of this title. Pursuant to any such investigation or hearing, the commissioner or the commissioner's authorized representative may issue data calls,

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subpoenas, administer oaths, compel testimony, order the production of books, records, papers and documents, and examine books and records. If any person refuses to allow the examination of books and records, to appear, to testify or to produce any book, record, paper or document when so ordered, a judge of the Superior Court, upon application of the commissioner or the commissioner's authorized representative, may make such order as may be appropriate to aid in the enforcement of this section.

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

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

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

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

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

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

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

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

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

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

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

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(9) "Health care center" means [either: (A) A person, including a profit or a nonprofit corporation organized under the laws of this state] (A) any organization governed by sections 38a-175 to 38a-192, inclusive, and licensed or authorized by the commissioner pursuant to section 38a-41 or 38a-41a, for the purpose of carrying out the activities and purposes set forth in subsection (b) of section 38a-176, at the expense of the health care center, including the providing of health care [, as herein defined,] to members of the community, including subscribers to one or more plans under an agreement entitling such subscribers to health care in consideration of a basic advance or periodic charge and shall include a health maintenance organization, or (B) a line of business conducted by an organization that is formed [,] pursuant to the laws of this state for the purposes of, but not limited to, carrying out the activities and purposes set forth in subsection (b) of section 38a-176.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) If [the] a domestic health care center is organized as a nonprofit, nonstock corporation, the care, control and disposition of the property and funds of each such corporation and the general management of its affairs shall be vested in a board of directors. Each such corporation shall have the power to adopt bylaws for the governing of its affairs, which bylaws shall prescribe the number of directors, their term of office and the manner of their election, subject to the provisions of sections 38a-175 to 38a-192, inclusive, as amended by this act. The bylaws may be adopted and repealed or amended by the affirmative vote of two-thirds of all the directors at any meeting of the board of directors duly held upon at least ten days' notice, provided notice of such meeting shall specify the proposed action concerning the bylaws to be taken at such meeting. The bylaws of the corporation shall provide that the board of directors shall include representation from persons engaged in the healing arts and from persons who are eligible

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to receive health care from the corporation, subject to the following provisions: (1) One-quarter of the board of directors shall be persons engaged in the different fields in the healing arts at least two of whom shall be a physician and a dentist; (2) one-quarter of the board of directors shall be subscribers who are eligible to receive health care from the health care center, but no such representative need be seated until the first annual meeting following the approval by the commissioner of the initial agreement or agreements to be offered by the corporation, and there shall be only one representative from any group covered by a group service agreement.

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

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

(a) In the event of the dissolution, liquidation or termination of the corporate existence of a domestic health care center [which] that is organized as a nonprofit, nonstock corporation, no part of the property or assets of the health care center shall inure to the benefit of any director, officer, subscriber or employee of the corporation, each of whom by holding such position shall be deemed to have waived and relinquished all rights conferred by statute or otherwise upon subscribers of a corporation without capital stock to share in such assets upon dissolution, liquidation or termination. After the payment of all lawful claims against the corporation, all its remaining assets shall be devoted permanently and exclusively to the purposes for which the corporation is formed, or paid over to an organization

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organized and operated exclusively for charitable, educational and scientific purposes, and in such amount and proportions, as the board of directors in its discretion shall determine.

(b) No person may, with respect to a domestic health care center, (1) make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of [a] such health care center, (2) enter into any other agreement if, after the consummation [thereof, that] of such agreement, such person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of such health care center, or (3) enter into an agreement to merge or consolidate with or otherwise to acquire control of [a] such health care center, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has [filed with the Insurance Commissioner and has mailed or delivered to the health care center, such information as is required by the commissioner and the offer, request, invitation, agreement or acquisition has been approved by the commissioner] complied with the provisions of section 38a-130.

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

(a) Each health care center governed by sections 38a-175 to 38a-192, inclusive, as amended by this act, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51, 38a-52, as amended by this act, 38a-56, 38a-57, 38a-58a, 38a-129 to 38a-140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a

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health care center shall not be deemed in violation of sections 38a-815 to 38a-819, inclusive, solely by virtue of such health care center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole.

(b) The commissioner may adopt regulations, in accordance with chapter 54, stating the circumstances under which the resources of a person [which] that controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted, shall require as a condition to the consideration of the resources of such person that controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person that controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary.

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

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

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

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

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

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

(h) The commissioner shall, at least once in every five years, visit and examine the affairs of each domestic insurance company, domestic

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health care center, domestic fraternal benefit society, and foreign and alien insurance company doing business in this state. Notwithstanding subdivision (1) of subsection (c) of this section, no domestic insurance company or other domestic entity subject to examination under this section shall pay as costs associated with the examination the salaries, fringe benefits, traveling and maintenance expenses of examining personnel of the Insurance Department engaged in such examination if such domestic company or domestic entity is otherwise liable to assessment levied under section 38a-47, except that a domestic insurance company or other domestic entity shall pay the traveling and maintenance expenses of examining personnel of the Insurance Department when such company or entity is examined outside the state.

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

Whenever it appears to the commissioner that permission to transact business within any state of the United States or within any foreign country has been refused to any domestic insurance company or domestic health care center after (1) a certificate of the solvency and good management of such company or health care center has been issued to it by the commissioner, and [after] (2) such company or health care center has complied with any reasonable laws of such state or foreign country requiring deposits of money or securities with the government of such state or country, the commissioner may immediately cancel the authority of each company or health care center organized under the laws of such state or foreign government and licensed to do business in this state and may refuse a certificate of authority to each such company or health care center thereafter applying for authority to do business in this state, until the commissioner's certificate has been recognized by the government of such state or country.

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

Any (1) domestic insurance company or other domestic entity aggrieved because of any assessment levied under section 38a-48, (2) fraternal benefit society or foreign or alien insurance company or other entity aggrieved because of any assessment levied under the provisions of sections 38a-49 to 38a-51, inclusive, or (3) domestic insurer, domestic health care center, third-party administrator licensed pursuant to section 38a-720a or exempt insurer, as defined in subdivision (1) of subsection (b) of section 19a-7j, aggrieved because of any assessment levied under said section 19a-7j, may, within one month from the time provided for the payment of such assessment, appeal therefrom to the superior court for the judicial district of New Britain, which appeal shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority, and such appeal shall be returnable at the same time and served and returned in the same manner, as is required in case of a summons in a civil action. The authority issuing the citation shall take from the appellant a bond or recognizance to the state, with surety to prosecute the appeal to effect and to comply with the orders and decrees of the court in the premises. Such appeals shall be preferred cases, to be heard, unless cause appears to the contrary, at the first session, by the court or by a committee appointed by the court. Said court may grant such relief as may be equitable, and, if such assessment has been paid prior to the granting of such relief, may order the Treasurer to pay the amount of such relief, with interest at the rate of six per cent per annum, to the aggrieved company. If the appeal has been taken without probable cause, the court may tax double or triple costs, as the case demands; and, upon all such appeals which may be denied, costs may be taxed against the appellant at the discretion of the court, but no costs shall be taxed against the state.

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

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

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

(b) Each foreign insurance company or foreign health care center doing business in this state shall, annually, on or before the first day of March, submit to the commissioner, by electronically filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance

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with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Commissioners shall be deemed to have been submitted to the commissioner in accordance with this section.

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

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

(e) Any insurance company or health care center doing business in this state that fails to file any report or statement required under this section shall pay a late filing fee of one hundred seventy-five dollars per day for each day from the due date of such report or statement to the date of filing. The commissioner may extend the due date of any

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report or statement required under this section (1) if the insurance company or health care center cannot file such report or statement because the governor of such company's or center's state of domicile has proclaimed a state of emergency in such state and such state of emergency impairs the company's or center's ability to file the report or statement, (2) if the insurance regulatory official of the state of domicile of a foreign insurance company has permitted such company to file such report or statement late, or (3) for a domestic insurance company or a domestic health care center, for good cause shown.

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

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

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

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

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

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

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

(b) (1) No domestic insurer, domestic health care center or domestic fraternal benefit society may, without the prior written consent of the Insurance Commissioner, pledge, hypothecate or otherwise encumber

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

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

(3) In the case of a domestic life insurance company, the provisions of this subsection shall apply to a separate account only to the extent that reserves for guarantees with respect to (A) benefits guaranteed as to dollar amount and duration or (B) funds guaranteed as to principal

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amount or stated rate of interest are held in a separate account in accordance with subdivision (3) of subsection (a) of section 38a-433.

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

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

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

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

(b) Each health carrier shall be responsible for monitoring all utilization review program activities carried out by or on behalf of such health carrier. Such health carrier shall comply with the provisions of sections 38a-591a to 38a-591n, inclusive, and any

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regulations adopted thereunder, and shall be responsible for ensuring that any utilization review company or other entity such health carrier contracts with to perform utilization review complies with said sections and regulations. Each health carrier shall ensure that appropriate personnel have operational responsibility for the activities of the health carrier's utilization review program.

(c) (1) A health carrier that requires utilization review of a benefit request under a health benefit plan shall implement a utilization review program and develop a written document that describes all utilization review activities and procedures, whether or not delegated, for (A) the filing of benefit requests, (B) the notification to covered persons of utilization review and benefit determinations, and (C) the review of adverse determinations and grievances in accordance with sections 38a-591e, as amended by this act, and 38a-591f.

(2) Such document shall describe the following:

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

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

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

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

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

(F) The health carrier's organizational mechanism, such as a utilization review committee or quality assurance or other committee,

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that periodically assesses the health carrier's utilization review program and reports to the health carrier's governing body; and

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

(d) Each health carrier shall:

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

(A) Its utilization review and benefit determination procedures;

(B) Its grievance procedures, including the grievance procedures for requesting a review of an adverse determination;

(C) A description of the external review procedures set forth in section 38a-591g, in a format prescribed by the commissioner and including a statement that discloses that:

(i) A covered person may file a request for an external review of an adverse determination or a final adverse determination with the commissioner and that such review is available when the adverse determination or the final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. Such disclosure shall include the contact information of the commissioner; and

(ii) When filing a request for an external review of an adverse determination or a final adverse determination, the covered person shall be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request;

(D) A statement of the rights and responsibilities of covered persons

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with respect to each of the procedures under subparagraphs (A) to (C), inclusive, of this subdivision. Such statement shall include a disclosure that a covered person has the right to contact the commissioner's office or the Office of Healthcare Advocate at any time for assistance and shall include the contact information for said offices;

(E) A description of what constitutes a surprise bill, as defined in subsection (a) of section 38a-477aa;

(2) Inform its covered persons, at the time of initial enrollment and at least annually thereafter, of its grievance procedures. This requirement may be fulfilled by including such procedures in an enrollment agreement or update to such agreement;

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

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

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

(6) Include in materials intended for prospective covered persons a

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summary of its utilization review and benefit determination procedures;

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

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

(9) Maintain records in accordance with section 38a-591h of all grievances received. Each health carrier shall make such records available for examination by covered persons, to the extent such records are permitted to be disclosed by law, the commissioner and appropriate federal oversight agencies upon request.

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

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

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

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

(ii) The number of covered lives;

(iii) The total number of grievances received;

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

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

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

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

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

Sec. 18. Subdivision (3) of subsection (a) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

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

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

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

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

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

(b) For each grievance the record shall contain, at a minimum, the following information: (1) A general description of the reason for the grievance; (2) the date the health carrier received the grievance; (3) the date of each review or, if applicable, review meeting of the grievance; (4) the resolution at each level of the grievance, if applicable; (5) the date of resolution at each such level, if applicable; and (6) the name of the covered person for whom the grievance was filed.

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

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

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

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

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

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

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

Sec. 20. Section 38a-175 of the 2016 supplement to the general statutes, as amended by section 3 of this act, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

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

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

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

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

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

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

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

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

(8) "Health care" includes, but shall not be limited to, the following:

(A) For a health care center that provides medical and surgical services other than or in addition to dental services, (i) medical, surgical and dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies; [(B)] (ii) physical therapy service provided through licensed physical therapists upon the prescription of a physician; [(C)] (iii) psychological examinations provided by registered psychologists; [(D)] (iv) optometric service provided by licensed optometrists; [(E)] (v) hospital service, both inpatient and outpatient; [(F)] (vi) convalescent institution care and nursing home care; [(G)] (vii) nursing service provided by a registered nurse or by a licensed practical nurse; [(H)] (viii) home care service of all types required for the health of a person; [(I)] (ix) rehabilitation service required or desirable for the health of a person; [(J)] (x) preventive medical services

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of all and any types; [(K)] (xi) furnishing necessary appliances, drugs, medicines and supplies; [(L)] (xii) educational services for the health and well-being of a person; [(M)] (xiii) ambulance service; and [(N)] (xiv) any other care, service or treatment related to the prevention or treatment of disease, the correction of defects and the maintenance of the physical and mental well-being of human beings. Any diagnosis and treatment of diseases of human beings required for health care as defined in this section, if rendered, shall be under the supervision and control of the providers; and (B) for a health care center that provides only dental services, dental care provided through licensed practitioners, including any supporting and ancillary personnel, services and supplies.

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

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

(11) "Individual practice association" means a partnership, corporation, association or other legal entity that has entered into a

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services arrangement with health care professionals licensed in this state to provide services to enrollees of a health care center.

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

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

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

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

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

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

(18) "Participating provider" means a provider who, under an express or implied contract with the health care center or with its

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contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health care center.

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

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

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

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

(b) (1) The nature of the activities to be conducted and the purposes to be carried out by a health care center include, but are not limited to: [(1)] (A) Establishing, maintaining and operating facilities whereby health care [, as hereinbefore defined,] may be provided at the expense of the health care center; [(2)] and (B) providing health care (i) directly by its health care center employees who, when required by law, shall be duly licensed to render such service, or (ii) by agreement or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation, medical group clinic or person qualified and licensed to render any health care service, or (iii) by both methods [; (3) entering] set forth in subparagraphs (B)(i) and (B)(ii) of this subdivision.

(2) For a health care center that provides medical and surgical

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

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

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

[Health care may be provided (a)] A health care center may provide health care (1) directly [by a health care center] or by its employees or contractors licensed by this state to render such services, or by contract or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation or person qualified and licensed to render any health care service or by both methods; and [(b)] (2) by other methods to the extent permitted under the Federal Health

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Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner by regulation. A health care center may also enter into agreements with hospitals or individuals approved by their respective state regulating board, licensed to practice any of the healing arts, for the training of personnel under the direction of persons licensed to practice the profession or healing art. A health care center may also maintain a clinic or clinics for the prevention, study, diagnosis and treatment of human ailments and injuries by licensed persons and to promote medical, surgical, dental [and] or scientific research and learning.

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

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

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

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

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

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

(b) Any person licensed to practice any of the healing arts or occupations employed by a health care center governed by sections 38a-175 to 38a-192, inclusive, as amended by this act, shall not be subject to reprimand or discipline because [he] such person is an

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employee of the health care center or because such health care center may be engaged in rendering health care or related care through its own employees, [provided] except such person shall otherwise remain subject to reprimand or discipline by the state regulating board governing such profession or occupation as provided by law for [his] such person's act or acts for unlawful, unprofessional or immoral conduct. [by the state regulating board governing such profession or occupation as provided by law.]

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

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

Approved June 10, 2016