



General Assembly

Amendment

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LCO No. 8790



Offered by:

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To: Senate Bill No. 811

File No. 655

Cal. No. 630

(As Amended by Senate Amendment Schedules "A" and "B")

**"AN ACT CONCERNING PARITY IN HOSPITAL SALES
OVERSIGHT."**

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

3 "Section 1. Section 38a-1084 of the general statutes is repealed and
4 the following is substituted in lieu thereof (*Effective October 1, 2015*):

5 The exchange shall:

6 (1) Administer the exchange for both qualified individuals and
7 qualified employers;

8 (2) Commission surveys of individuals, small employers and health

9 care providers on issues related to health care and health care
10 coverage;

11 (3) Implement procedures for the certification, recertification and
12 decertification, consistent with guidelines developed by the Secretary
13 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
14 of health benefit plans as qualified health plans;

15 (4) Provide for the operation of a toll-free telephone hotline to
16 respond to requests for assistance;

17 (5) Provide for enrollment periods, as provided under Section
18 1311(c)(6) of the Affordable Care Act;

19 (6) (A) Maintain an Internet web site through which enrollees and
20 prospective enrollees of qualified health plans may obtain
21 standardized comparative information on such plans including, but
22 not limited to, the enrollee satisfaction survey information under
23 Section 1311(c)(4) of the Affordable Care Act and any other
24 information or tools to assist enrollees and prospective enrollees
25 evaluate qualified health plans offered through the exchange, and (B)
26 on and after July 1, 2016, establish and maintain a consumer health
27 information Internet web site as described in section 2 of this act;

28 (7) Publish the average costs of licensing, regulatory fees and any
29 other payments required by the exchange and the administrative costs
30 of the exchange, including information on moneys lost to waste, fraud
31 and abuse, on an Internet web site to educate individuals on such
32 costs;

33 (8) On or before the open enrollment period for plan year 2017,
34 assign a rating to each qualified health plan offered through the
35 exchange in accordance with the criteria developed by the Secretary
36 under Section 1311(c)(3) of the Affordable Care Act, and determine
37 each qualified health plan's level of coverage in accordance with
38 regulations issued by the Secretary under Section 1302(d)(2)(A) of the
39 Affordable Care Act;

40 (9) Use a standardized format for presenting health benefit options
41 in the exchange, including the use of the uniform outline of coverage
42 established under Section 2715 of the Public Health Service Act, 42
43 USC 300gg-15, as amended from time to time;

44 (10) Inform individuals, in accordance with Section 1413 of the
45 Affordable Care Act, of eligibility requirements for the Medicaid
46 program under Title XIX of the Social Security Act, as amended from
47 time to time, the Children's Health Insurance Program (CHIP) under
48 Title XXI of the Social Security Act, as amended from time to time, or
49 any applicable state or local public program, and enroll an individual
50 in such program if the exchange determines, through screening of the
51 application by the exchange, that such individual is eligible for any
52 such program;

53 (11) Collaborate with the Department of Social Services, to the
54 extent possible, to allow an enrollee who loses premium tax credit
55 eligibility under Section 36B of the Internal Revenue Code and is
56 eligible for HUSKY Plan, Part A or any other state or local public
57 program, to remain enrolled in a qualified health plan;

58 (12) Establish and make available by electronic means a calculator to
59 determine the actual cost of coverage after application of any premium
60 tax credit under Section 36B of the Internal Revenue Code and any
61 cost-sharing reduction under Section 1402 of the Affordable Care Act;

62 (13) Establish a program for small employers through which
63 qualified employers may access coverage for their employees and that
64 shall enable any qualified employer to specify a level of coverage so
65 that any of its employees may enroll in any qualified health plan
66 offered through the exchange at the specified level of coverage;

67 (14) Offer enrollees and small employers the option of having the
68 exchange collect and administer premiums, including through
69 allocation of premiums among the various insurers and qualified
70 health plans chosen by individual employers;

71 (15) Grant a certification, subject to Section 1411 of the Affordable
72 Care Act, attesting that, for purposes of the individual responsibility
73 penalty under Section 5000A of the Internal Revenue Code, an
74 individual is exempt from the individual responsibility requirement or
75 from the penalty imposed by said Section 5000A because:

76 (A) There is no affordable qualified health plan available through
77 the exchange, or the individual's employer, covering the individual; or

78 (B) The individual meets the requirements for any other such
79 exemption from the individual responsibility requirement or penalty;

80 (16) Provide to the Secretary of the Treasury of the United States the
81 following:

82 (A) A list of the individuals granted a certification under
83 subdivision (15) of this section, including the name and taxpayer
84 identification number of each individual;

85 (B) The name and taxpayer identification number of each individual
86 who was an employee of an employer but who was determined to be
87 eligible for the premium tax credit under Section 36B of the Internal
88 Revenue Code because:

89 (i) The employer did not provide minimum essential health benefits
90 coverage; or

91 (ii) The employer provided the minimum essential coverage but it
92 was determined under Section 36B(c)(2)(C) of the Internal Revenue
93 Code to be unaffordable to the employee or not provide the required
94 minimum actuarial value; and

95 (C) The name and taxpayer identification number of:

96 (i) Each individual who notifies the exchange under Section
97 1411(b)(4) of the Affordable Care Act that such individual has changed
98 employers; and

99 (ii) Each individual who ceases coverage under a qualified health
100 plan during a plan year and the effective date of that cessation;

101 (17) Provide to each employer the name of each employee, as
102 described in subparagraph (B) of subdivision (16) of this section, of the
103 employer who ceases coverage under a qualified health plan during a
104 plan year and the effective date of the cessation;

105 (18) Perform duties required of, or delegated to, the exchange by the
106 Secretary or the Secretary of the Treasury of the United States related
107 to determining eligibility for premium tax credits, reduced cost-
108 sharing or individual responsibility requirement exemptions;

109 (19) Select entities qualified to serve as Navigators in accordance
110 with Section 1311(i) of the Affordable Care Act and award grants to
111 enable Navigators to:

112 (A) Conduct public education activities to raise awareness of the
113 availability of qualified health plans;

114 (B) Distribute fair and impartial information concerning enrollment
115 in qualified health plans and the availability of premium tax credits
116 under Section 36B of the Internal Revenue Code and cost-sharing
117 reductions under Section 1402 of the Affordable Care Act;

118 (C) Facilitate enrollment in qualified health plans;

119 (D) Provide referrals to the Office of the Healthcare Advocate or
120 health insurance ombudsman established under Section 2793 of the
121 Public Health Service Act, 42 USC 300gg-93, as amended from time to
122 time, or any other appropriate state agency or agencies, for any
123 enrollee with a grievance, complaint or question regarding the
124 enrollee's health benefit plan, coverage or a determination under that
125 plan or coverage; and

126 (E) Provide information in a manner that is culturally and
127 linguistically appropriate to the needs of the population being served

128 by the exchange;

129 (20) Review the rate of premium growth within and outside the
130 exchange and consider such information in developing
131 recommendations on whether to continue limiting qualified employer
132 status to small employers;

133 (21) Credit the amount, in accordance with Section 10108 of the
134 Affordable Care Act, of any free choice voucher to the monthly
135 premium of the plan in which a qualified employee is enrolled and
136 collect the amount credited from the offering employer;

137 (22) Consult with stakeholders relevant to carrying out the activities
138 required under sections 38a-1080 to 38a-1090, inclusive, including, but
139 not limited to:

140 (A) Individuals who are knowledgeable about the health care
141 system, have background or experience in making informed decisions
142 regarding health, medical and scientific matters and are enrollees in
143 qualified health plans;

144 (B) Individuals and entities with experience in facilitating
145 enrollment in qualified health plans;

146 (C) Representatives of small employers and self-employed
147 individuals;

148 (D) The Department of Social Services; and

149 (E) Advocates for enrolling hard-to-reach populations;

150 (23) Meet the following financial integrity requirements:

151 (A) Keep an accurate accounting of all activities, receipts and
152 expenditures and annually submit to the Secretary, the Governor, the
153 Insurance Commissioner and the General Assembly a report
154 concerning such accountings;

155 (B) Fully cooperate with any investigation conducted by the
156 Secretary pursuant to the Secretary's authority under the Affordable
157 Care Act and allow the Secretary, in coordination with the Inspector
158 General of the United States Department of Health and Human
159 Services, to:

160 (i) Investigate the affairs of the exchange;

161 (ii) Examine the properties and records of the exchange; and

162 (iii) Require periodic reports in relation to the activities undertaken
163 by the exchange; and

164 (C) Not use any funds in carrying out its activities under sections
165 38a-1080 to 38a-1089, inclusive, and section 38a-1091 that are intended
166 for the administrative and operational expenses of the exchange, for
167 staff retreats, promotional giveaways, excessive executive
168 compensation or promotion of federal or state legislative and
169 regulatory modifications;

170 (24) Seek to include the most comprehensive health benefit plans
171 that offer high quality benefits at the most affordable price in the
172 exchange;

173 (25) Report at least annually to the General Assembly on the effect
174 of adverse selection on the operations of the exchange and make
175 legislative recommendations, if necessary, to reduce the negative
176 impact from any such adverse selection on the sustainability of the
177 exchange, including recommendations to ensure that regulation of
178 insurers and health benefit plans are similar for qualified health plans
179 offered through the exchange and health benefit plans offered outside
180 the exchange. The exchange shall evaluate whether adverse selection is
181 occurring with respect to health benefit plans that are grandfathered
182 under the Affordable Care Act, self-insured plans, plans sold through
183 the exchange and plans sold outside the exchange; and

184 (26) Seek funding for and oversee the planning, implementation and

185 development of policies and procedures for the administration of the
186 all-payer claims database program established under section 38a-1091.

187 Sec. 2. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
188 section and sections 3 to 7, inclusive, of this act:

189 (1) "Allowed amount" means the maximum reimbursement dollar
190 amount that an insured's health insurance policy allows for a specific
191 procedure or service;

192 (2) "Episode of care" means all health care services related to the
193 treatment of a condition or a service category for such treatment and,
194 for acute conditions, includes health care services and treatment
195 provided from the onset of the condition to its resolution or a service
196 category for such treatment and, for chronic conditions, includes
197 health care services and treatment provided over a given period of
198 time or a service category for such treatment;

199 (3) "Exchange" means the Connecticut Health Insurance Exchange
200 established pursuant to section 38a-1081 of the general statutes;

201 (4) "Health care provider" means any individual, corporation,
202 facility or institution licensed by this state to provide health care
203 services;

204 (5) "Health carrier" means any insurer, health care center, hospital
205 service corporation, medical service corporation, fraternal benefit
206 society or other entity delivering, issuing for delivery, renewing,
207 amending or continuing any individual or group health insurance
208 policy in this state providing coverage of the type specified in
209 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
210 statutes;

211 (6) "Hospital" has the same meaning as provided in section 19a-490
212 of the general statutes;

213 (7) "Out-of-pocket costs" means costs that are not reimbursed by a

214 health insurance policy and includes deductibles, coinsurance and
215 copayments for covered services and other costs to the consumer
216 associated with a procedure or service;

217 (8) "Outpatient surgical facility" has the same meaning as provided
218 in section 19a-493b of the general statutes; and

219 (9) "Public or private third party" means the state, the federal
220 government, employers, a health carrier, third-party administrator, as
221 defined in section 38a-720 of the general statutes, or managed care
222 organization.

223 (b) (1) On and after July 1, 2016, the exchange shall, within available
224 resources, establish and maintain a consumer health information
225 Internet web site to assist consumers in making informed decisions
226 concerning their health care and informed choices among health care
227 providers. Such Internet web site shall: (A) Contain information
228 comparing the quality, price and cost of health care services, including,
229 to the extent practicable, (i) comparative price and cost information for
230 the primary diagnoses and procedures reported pursuant to
231 subsection (c) of this section categorized by payer and listed by health
232 care provider, (ii) links to the Internet web sites for The Joint
233 Commission and Medicare hospital compare tool where consumers
234 may obtain comparative quality information, (iii) definitions of
235 common health insurance and medical terms so consumers may
236 compare health coverage and understand the terms of their coverage,
237 (iv) factors consumers should consider when choosing an insurance
238 product or provider group, including provider network, premium,
239 cost-sharing, covered services and tier information, and (v) patient
240 decision aids; (B) be designed to assist consumers and institutional
241 purchasers in making informed decisions regarding their health care
242 and informed choices among health care providers and allow
243 comparisons between prices paid by various health carriers to health
244 care providers; (C) present information in language and a format that
245 is understandable to the average consumer; and (D) be publicized to
246 the general public. All information received by the exchange pursuant

247 to the provisions of this section shall be posted on the Internet web
248 site.

249 (2) Information collected, stored and published by the exchange
250 pursuant to this section is subject to the federal Health Insurance
251 Portability and Accountability Act of 1996, P.L. 104-191, as amended
252 from time to time.

253 (3) The exchange may consider adding quality measures to the
254 Internet web site as recommended by the State Innovation Model
255 Initiative program management office.

256 (c) Not later than July 1, 2016, and annually thereafter, the Insurance
257 Commissioner and the Commissioner of Public Health shall, to the
258 extent the information is available, jointly report to the exchange and
259 make available to the public on the Insurance Department's and
260 Department of Public Health's Internet web sites: (1) The fifty most
261 frequently occurring inpatient primary diagnoses and procedures in
262 the state; (2) the fifty most frequently provided outpatient procedures
263 performed in the state; (3) the twenty-five most frequent surgical
264 procedures performed in the state; and (4) the twenty-five most
265 frequent imaging procedures performed in the state. Such lists
266 contained in the report may include bundled episodes of care and be
267 compiled using discharge and claims data available to said
268 departments. At the request of the exchange, such lists may be
269 expanded to include additional admissions and procedures.

270 (d) Not later than January 1, 2017, and annually thereafter, each
271 health carrier shall submit to the exchange, in a format to be decided
272 by the exchange, a report that lists by provider the (1) billed and
273 allowed amounts paid to health care providers in the health carrier's
274 network for each diagnosis and procedure included in the report
275 submitted to the exchange by the commissioners pursuant to
276 subsection (c) of this section, and (2) out-of-pocket costs for each such
277 diagnosis and procedure.

278 (e) (1) On and after January 1, 2017, each hospital shall, at the time
279 of scheduling a diagnosis or procedure for nonemergency care that is
280 included in the report submitted to the exchange by the Insurance
281 Commissioner and the Commissioner of Public Health pursuant to
282 subsection (c) of this section, notify the patient of the patient's right to
283 make a request for cost and quality information. Upon the request of a
284 patient for a diagnosis or procedure included in such report, the
285 hospital shall, not later than three business days after scheduling such
286 diagnosis or procedure, provide written notice, electronically or by
287 mail, to the patient who is the subject of the diagnosis or procedure
288 concerning: (A) If the patient is uninsured, the amount to be charged
289 for the diagnosis or procedure if all charges are paid in full without a
290 public or private third party paying any portion of the charges,
291 including the amount of any facility fee, or, if the hospital is not able to
292 provide a specific amount due to an inability to predict the specific
293 treatment or diagnostic code, the estimated maximum allowed amount
294 or charge for the admission or procedure, including the amount of any
295 facility fee; (B) the Medicare reimbursement amount; (C) if the patient
296 is insured, the allowed amount, the toll-free telephone number and the
297 Internet web site address of the patient's health carrier where the
298 patient can obtain information concerning charges and out-of-pocket
299 costs; (D) The Joint Commission's composite accountability rating and
300 the Medicare hospital compare star rating for the hospital, as
301 applicable; and (E) the Internet web site addresses for The Joint
302 Commission and the Medicare hospital compare tool where the patient
303 may obtain information concerning the hospital.

304 (2) If the patient is insured and the hospital is out-of-network under
305 the patient's health insurance policy, such written notice shall include
306 a statement that the diagnosis or procedure will likely be deemed out-
307 of-network and that any out-of-network applicable rates under such
308 policy may apply.

309 (f) For the purposes of administering the Medicaid program and to
310 the extent permitted by federal law, the Commissioner of Social

311 Services shall submit to the exchange all Medicaid data requested for
312 the all-payer claims database, established pursuant to section 38a-1091
313 of the general statutes.

314 Sec. 3. (NEW) (*Effective October 1, 2015*) (a) On and after January 1,
315 2016, each health care provider shall, prior to any scheduled
316 admission, procedure or service, for nonemergency care, determine
317 whether the patient is covered under a health insurance policy. If the
318 patient is determined not to have health insurance coverage or the
319 patient's health care provider is out-of-network, such health care
320 provider shall notify the patient, in writing, electronically or by mail,
321 (1) of the charges for the admission, procedure or service, (2) that such
322 patient may be charged, and is responsible for payment for unforeseen
323 services that may arise out of the proposed admission, procedure or
324 service, and (3) if the health care provider is out-of-network under the
325 patient's health insurance policy, that the admission, service or
326 procedure will likely be deemed out-of-network and that any out-of-
327 network applicable rates under such policy may apply. Nothing in this
328 subsection shall prevent a health care provider from charging a patient
329 for such unforeseen services.

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

334 Sec. 4. (NEW) (*Effective October 1, 2015*) On and after January 1, 2016,
335 no contract entered into or renewed between a health care provider
336 and a health carrier shall contain a provision prohibiting disclosure of
337 (1) billed or allowed amounts, reimbursement rates or out-of-pocket
338 costs, and (2) any data to the all-payer claims database program
339 established under section 38a-1091 of the general statutes for the
340 purpose of assisting consumers and institutional purchasers in making
341 informed decisions regarding their health care and informed choices
342 among health care providers and allow comparisons between prices
343 paid by various health carriers to health care providers.

344 Sec. 5. (NEW) (*Effective October 1, 2015*) (a) On and after July 1, 2016,
345 each health carrier shall maintain an Internet web site and toll-free
346 telephone number that enables consumers to request and obtain: (1)
347 Information on in-network costs for inpatient admissions, health care
348 procedures and services, including (A) the allowed amount for, at a
349 minimum, admissions and procedures reported to the exchange
350 pursuant to section 2 of this act for each health care provider in the
351 state; (B) the estimated out-of-pocket costs that a consumer would be
352 responsible for paying for any such admission or procedure that is
353 medically necessary, including any facility fee, coinsurance,
354 copayment, deductible or other out-of-pocket expense; and (C) data or
355 other information concerning (i) quality measures for the health care
356 provider, (ii) patient satisfaction, to the extent such information is
357 available, (iii) a list of in-network health care providers, (iv) whether a
358 health care provider is accepting new patients, and (v) languages
359 spoken by health care providers; and (2) information on out-of-
360 network costs for inpatient admissions, health care procedures and
361 services.

362 (b) A health carrier shall advise the consumer when providing the
363 information on out-of-pocket costs that the amounts are estimates and
364 that the consumer's actual cost may vary due to health care provider
365 contractual changes, the need for unforeseen services that arise out of
366 the proposed admission or procedure or other circumstances.

367 Sec. 6. (NEW) (*Effective October 1, 2015*) (a) Not later than thirty days
368 after the date that a health care provider stops accepting patients who
369 are enrolled in an insurance plan, such health care provider shall
370 notify, in writing, the applicable health carrier.

371 (b) Each health carrier shall update, not less than monthly, its health
372 care provider directory or directories.

373 Sec. 7. (NEW) (*Effective January 1, 2016*) (a) Each insurer, health care
374 center, hospital service corporation, medical service corporation,
375 fraternal benefit society or other entity that delivers, issues for

376 delivery, renews, amends or continues a health insurance policy
377 providing coverage of the type specified in subdivisions (1), (2), (4),
378 (11) and (12) of section 38a-469 of the general statutes in this state,
379 shall:

380 (1) Make available to consumers, in an easily readable and
381 understandable format, the following information for each such policy:
382 (A) Any coverage exclusions; (B) any restrictions on the use or quantity
383 of a covered benefit, including on prescription drugs or drugs
384 administered in a physician's office or a clinic; (C) a specific
385 description of how prescription drugs are included or excluded from
386 any applicable deductible, including a description of other out-of-
387 pocket expenses that apply to such drugs; and (D) the specific dollar
388 amount of any copayment and the percentage of any coinsurance
389 imposed on each covered benefit, including each covered prescription
390 drug;

391 (2) Make available to consumers a way to determine accurately (A)
392 whether a specific prescription drug is available under such policy's
393 drug formulary; (B) the coinsurance, copayment, deductible or other
394 out-of-pocket expense applicable to such drug; (C) whether such drug
395 is covered when dispensed by a physician or a clinic; (D) whether such
396 drug requires preauthorization or the use of step therapy; (E) whether
397 specific types of health care specialists are in-network; and (F) whether
398 a specific health care provider or hospital is in-network.

399 (b) (1) Each insurer, health care center, hospital service corporation,
400 medical service corporation, fraternal benefit society or other entity
401 shall make the information required under subsection (a) of this
402 section available to consumers at the time of enrollment and shall post
403 such information on its Internet web site.

404 (2) The Connecticut Health Insurance Exchange, established
405 pursuant to section 38a-1081 of the general statutes, shall post links on
406 its Internet web site to such information for each qualified health plan
407 that is offered or sold through the exchange.

408 (c) The Insurance Commissioner shall post links on its Internet web
409 site to any on-line tools or calculators to help consumers compare and
410 evaluate health insurance policies and plans.

411 Sec. 8. Section 38a-591 of the general statutes is repealed and the
412 following is substituted in lieu thereof (*Effective July 1, 2016*):

413 (a) For purposes of this section, "Affordable Care Act" means the
414 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
415 from time to time, and regulations adopted thereunder.

416 (b) Each insurance company, fraternal benefit society, hospital
417 service corporation, medical service corporation and health care center
418 licensed to do business in the state shall comply with Sections 1251,
419 1252 and 1304 of the Affordable Care Act and the following Sections of
420 the Public Health Service Act, as amended by the Affordable Care Act:
421 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
422 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

423 (c) This section shall apply, on and after the effective dates specified
424 in the Affordable Care Act, to insurance companies, fraternal benefit
425 societies, hospital service corporations, medical service corporations
426 and health care centers licensed to do business in the state.

427 (d) No provision of the general statutes concerning a requirement of
428 the Affordable Care Act shall be construed to supersede a provision of
429 the general statutes that provides greater protection to an insured,
430 except to the extent the latter prevents the application of a requirement
431 of the Affordable Care Act.

432 (e) (1) The Insurance Commissioner shall, within available
433 appropriations, evaluate whether insurance companies, fraternal
434 benefit societies, hospital service corporations, medical service
435 corporations and health care centers subject to the Affordable Care Act
436 are in compliance with the requirements under said act, including, but
437 not limited to, the prohibition against discriminatory benefit designs.
438 Any such company, society, corporation or center shall submit to the

439 commissioner, upon request, the following information for a specific
440 health insurance policy or plan: (A) The benefits covered under each of
441 the categories of the essential health benefits package, as defined by
442 the Secretary of Health and Human Services; (B) any coverage
443 exclusions or restrictions on covered benefits, including under the
444 prescription drug benefit; (C) any drug formulary used, the tier
445 structure of such formulary and a list of each prescription drug on
446 such formulary and its tier placement; (D) any applicable coinsurance,
447 copayment, deductible or other out-of-pocket expenses for each
448 covered benefit; and (E) any other information the commissioner
449 deems necessary to evaluate such company, society, corporation or
450 center.

451 (2) The commissioner shall report annually, within available
452 appropriations, to the joint standing committee of the General
453 Assembly having cognizance of matters relating to insurance on any
454 insurance company, fraternal benefit society, hospital service
455 corporation, medical service corporation or health care center
456 evaluated pursuant to subdivision (1) of this section in the preceding
457 year and the findings of such evaluation.

458 [(e)] (f) The Insurance Commissioner may adopt regulations, in
459 accordance with the provisions of chapter 54, to implement the
460 provisions of this section.

461 Sec. 9. (NEW) (Effective July 1, 2016) (a) As used in this section:

462 (1) "Emergency condition" has the same meaning as "emergency
463 medical condition", as provided in section 38a-591a of the general
464 statutes;

465 (2) "Emergency services" means, with respect to an emergency
466 condition, (A) a medical screening examination as required under
467 Section 1867 of the Social Security Act, as amended from time to time,
468 that is within the capability of a hospital emergency department,
469 including ancillary services routinely available to such department to

470 evaluate such condition, and (B) such further medical examinations
471 and treatment required under said Section 1867 to stabilize such
472 individual, that are within the capability of the hospital staff and
473 facilities;

474 (3) "Health care plan" means an individual or a group health
475 insurance policy or health benefit plan that provides coverage of the
476 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
477 469 of the general statutes;

478 (4) "Health care provider" means an individual licensed to provide
479 health care services under chapters 370 to 373, inclusive, of the general
480 statutes, chapters 375 to 383b, inclusive, of the general statutes, and
481 chapters 384a to 384c, inclusive, of the general statutes;

482 (5) "Health carrier" means an insurance company, health care center,
483 hospital service corporation, medical service corporation, fraternal
484 benefit society or other entity that delivers, issues for delivery, renews,
485 amends or continues a health care plan in this state;

486 (6) (A) "Surprise bill" means a bill for health care services, other than
487 emergency services, received by an insured for services rendered by an
488 out-of-network health care provider, where such services were
489 rendered by such out-of-network provider at an in-network facility,
490 during a service or procedure performed by an in-network provider or
491 during a service or procedure previously approved or authorized by
492 the health carrier and the insured did not knowingly elect to obtain
493 such services from such out-of-network provider.

494 (B) "Surprise bill" does not include a bill for health care services
495 received by an insured when an in-network health care provider was
496 available to render such services and the insured knowingly elected to
497 obtain such services from another health care provider who was out-
498 of-network.

499 (b) (1) No health carrier shall require prior authorization for
500 rendering emergency services to an insured.

501 (2) No health carrier shall impose, for emergency services rendered
502 to an insured by an out-of-network health care provider, a
503 coinsurance, copayment, deductible or other out-of-pocket expense
504 that is greater than the coinsurance, copayment, deductible or other
505 out-of-pocket expense that would be imposed if such emergency
506 services were rendered by an in-network health care provider.

507 (3) (A) If emergency services were rendered to an insured by an out-
508 of-network health care provider, such health care provider may bill the
509 health carrier directly and the health carrier shall reimburse such
510 health care provider the greatest of the following amounts: (i) The
511 amount the insured's health care plan would pay for such services if
512 rendered by an in-network health care provider; (ii) the usual,
513 customary and reasonable rate for such services, or (iii) the amount
514 Medicare would reimburse for such services. As used in this
515 subparagraph, "usual, customary and reasonable rate" means the
516 eightieth percentile of all charges for the particular health care service
517 performed by a health care provider in the same or similar specialty
518 and provided in the same geographical area, as reported in a
519 benchmarking database maintained by a nonprofit organization
520 specified by the Insurance Commissioner. Such organization shall not
521 be affiliated with any health carrier.

522 (B) Nothing in this subdivision shall be construed to prohibit such
523 health carrier and out-of-network health care provider from agreeing
524 to a greater reimbursement amount.

525 (c) With respect to a surprise bill:

526 (1) An insured shall only be required to pay the applicable
527 coinsurance, copayment, deductible or other out-of-pocket expense
528 that would be imposed for such health care services if such services
529 were rendered by an in-network health care provider; and

530 (2) A health carrier shall reimburse the out-of-network health care
531 provider or insured, as applicable, for health care services rendered at

532 the in-network rate under the insured's health care plan as payment in
533 full, unless such health carrier and health care provider agree
534 otherwise.

535 (d) If health care services were rendered to an insured by an out-of-
536 network health care provider and the health carrier failed to inform
537 such insured, if such insured was required to be informed, of the
538 network status of such health care provider pursuant to subdivision (3)
539 of subsection (d) of section 38a-591b of the general statutes, as
540 amended by this act, the health carrier shall not impose a coinsurance,
541 copayment, deductible or other out-of-pocket expense that is greater
542 than the coinsurance, copayment, deductible or other out-of-pocket
543 expense that would be imposed if such services were rendered by an
544 in-network health care provider.

545 Sec. 10. Subsection (d) of section 38a-591b of the general statutes is
546 repealed and the following is substituted in lieu thereof (*Effective July*
547 *1, 2016*):

548 (d) Each health carrier shall:

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

552 (A) Its utilization review and benefit determination procedures;

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

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

558 (i) A covered person may file a request for an external review of an
559 adverse determination or a final adverse determination with the
560 commissioner and that such review is available when the adverse

561 determination or the final adverse determination involves an issue of
562 medical necessity, appropriateness, health care setting, level of care or
563 effectiveness. Such disclosure shall include the contact information of
564 the commissioner; and

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

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

576 (E) A description of what constitutes a surprise bill, as defined in
577 subsection (a) of section 9 of this act;

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

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

592 such service or treatment;

593 ~~[(3)]~~ (4) Inform a covered person and the covered person's health
594 care professional of the health carrier's grievance procedures whenever
595 the health carrier denies certification of a benefit requested by a
596 covered person's health care professional;

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

599 ~~[(4)]~~ (6) Include in materials intended for prospective covered
600 persons a summary of its utilization review and benefit determination
601 procedures;

602 ~~[(5)]~~ (7) Print on its membership or identification cards a toll-free
603 telephone number for utilization review and benefit determinations;

604 ~~[(6)]~~ (8) Maintain records of all benefit requests, claims and notices
605 associated with utilization review and benefit determinations made in
606 accordance with section 38a-591d for not less than six years after such
607 requests, claims and notices were made. Each health carrier shall make
608 such records available for examination by the commissioner and
609 appropriate federal oversight agencies upon request; and

610 ~~[(7)]~~ (9) Maintain records in accordance with section 38a-591h of all
611 grievances received. Each health carrier shall make such records
612 available for examination by covered persons, to the extent such
613 records are permitted to be disclosed by law, the commissioner and
614 appropriate federal oversight agencies upon request.

615 Sec. 11. Section 20-7f of the general statutes is repealed and the
616 following is substituted in lieu thereof (*Effective July 1, 2016*):

617 (a) For purposes of this section:

618 (1) "Request payment" includes, but is not limited to, submitting a
619 bill for services not actually owed or submitting for such services an

620 invoice or other communication detailing the cost of the services that is
621 not clearly marked with the phrase "This is not a bill".

622 (2) "Health care provider" means a person licensed to provide health
623 care services under chapters 370 to 373, inclusive, chapters 375 to 383b,
624 inclusive, chapters 384a to 384c, inclusive, or chapter 400j.

625 (3) "Enrollee" means a person who has contracted for or who
626 participates in a [managed] health care plan for [himself or his] such
627 enrollee or such enrollee's eligible dependents.

628 [(4) "Managed care organization" means an insurer, health care
629 center, hospital or medical service corporation or other organization
630 delivering, issuing for delivery, renewing or amending any individual
631 or group health managed care plan in this state.]

632 [(5) "Copayment or deductible"] (4) "Coinsurance, copayment,
633 deductible or other out-of-pocket expense" means the portion of a
634 charge for services covered by a [managed] health care plan that,
635 under the plan's terms, it is the obligation of the enrollee to pay.

636 (5) "Health care plan" has the same meaning as provided in
637 subsection (a) of section 9 of this act.

638 (6) "Health carrier" has the same meaning as provided in subsection
639 (a) of section 9 of this act.

640 (7) "Emergency services" has the same meaning as provided in
641 subsection (a) of section 9 of this act.

642 (b) It shall be an unfair trade practice in violation of chapter 735a for
643 any health care provider to request payment from an enrollee, other
644 than a coinsurance, copayment, [or] deductible or other out-of-pocket
645 expense, for [medical] (1) health care services or a facility fee, as
646 defined in section 19a-508c, as amended by this act, covered under a
647 [managed] health care plan, (2) emergency services covered under a
648 health care plan and rendered by an out-of-network health care

649 provider, or (3) a surprise bill, as defined in section 9 of this act.

650 (c) It shall be an unfair trade practice in violation of chapter 735a for
651 any health care provider to report to a credit reporting agency an
652 enrollee's failure to pay a bill for [medical] the services, facility fee or
653 surprise bill as set forth in subsection (b) of this section, when a
654 [managed care organization] health carrier has primary responsibility
655 for payment of such services, fees or bills.

656 Sec. 12. Subdivision (3) of subsection (c) of section 38a-193 of the
657 general statutes is repealed and the following is substituted in lieu
658 thereof (*Effective July 1, 2016*):

659 (3) No participating provider, or agent, trustee or assignee thereof,
660 may: (A) Maintain any action at law against a subscriber or enrollee to
661 collect sums owed by the health care center; [or] (B) request payment
662 from a subscriber or enrollee for such sums; (C) request payment from
663 a subscriber or enrollee for covered emergency services that are
664 provided by an out-of-network provider; or (D) request payment from
665 a subscriber or enrollee for a surprise bill, as defined in section 9 of this
666 act. For purposes of this subdivision "request payment" includes, but is
667 not limited to, submitting a bill for services not actually owed or
668 submitting for such services an invoice or other communication
669 detailing the cost of the services that is not clearly marked with the
670 phrase "THIS IS NOT A BILL". The contract between a health care
671 center and a participating provider shall inform the participating
672 provider that pursuant to section 20-7f, as amended by this act, it is an
673 unfair trade practice in violation of chapter 735a for any health care
674 provider to request payment from a subscriber or an enrollee, other
675 than a coinsurance, copayment, [or] deductible or other out-of-pocket
676 expense, for covered medical or emergency services or facility fees, as
677 defined in section 19a-508c, as amended by this act, or surprise bills, or
678 to report to a credit reporting agency an enrollee's failure to pay a bill
679 for [medical] such services when a health care center has primary
680 responsibility for payment of such services, fees or bills.

681 Sec. 13. Section 19a-508c of the general statutes is repealed and the
682 following is substituted in lieu thereof (*Effective October 1, 2015*):

683 (a) As used in this section:

684 (1) "Affiliated provider" means a provider that is: (A) Employed by
685 a hospital or health system, (B) under a professional services
686 agreement with a hospital or health system that permits such hospital
687 or health system to bill on behalf of such provider, or (C) a clinical
688 faculty member of a medical school, as defined in section 33-182aa,
689 that is affiliated with a hospital or health system in a manner that
690 permits such hospital or health system to bill on behalf of such clinical
691 faculty member;

692 (2) "Campus" means: (A) The physical area immediately adjacent to
693 a hospital's main buildings and other areas and structures that are not
694 strictly contiguous to the main buildings but are located within two
695 hundred fifty yards of the main buildings, or (B) any other area that
696 has been determined on an individual case basis by the Centers for
697 Medicare and Medicaid Services to be part of a hospital's campus;

698 (3) "Facility fee" means any fee charged or billed by a hospital or
699 health system for outpatient hospital services provided in a hospital-
700 based facility that is: (A) Intended to compensate the hospital or health
701 system for the operational expenses of the hospital or health system,
702 and (B) separate and distinct from a professional fee;

703 (4) "Health system" means: (A) A parent corporation of one or more
704 hospitals and any entity affiliated with such parent corporation
705 through ownership, governance, membership or other means, or (B) a
706 hospital and any entity affiliated with such hospital through
707 ownership, governance, membership or other means;

708 (5) "Hospital" has the same meaning as provided in section 19a-490;

709 (6) "Hospital-based facility" means a facility that is owned or
710 operated, in whole or in part, by a hospital or health system where

711 hospital or professional medical services are provided;

712 (7) "Professional fee" means any fee charged or billed by a provider
713 for professional medical services provided in a hospital-based facility;
714 and

715 (8) "Provider" means an individual, entity, corporation or health
716 care provider, whether for profit or nonprofit, whose primary purpose
717 is to provide professional medical services.

718 (b) If a hospital or health system charges a facility fee utilizing a
719 current procedural terminology evaluation and management (CPT
720 E/M) code for outpatient services provided at a hospital-based facility
721 where a professional fee is also expected to be charged, the hospital or
722 health system shall provide the patient with a written notice that
723 includes the following information:

724 (1) That the hospital-based facility is part of a hospital or health
725 system and that the hospital or health system charges a facility fee that
726 is in addition to and separate from the professional fee charged by the
727 provider;

728 (2) (A) The amount of the patient's potential financial liability,
729 including any facility fee likely to be charged, and, where professional
730 medical services are provided by an affiliated provider, any
731 professional fee likely to be charged, or, if the exact type and extent of
732 the professional medical services needed are not known or the terms of
733 a patient's health insurance coverage are not known with reasonable
734 certainty, an estimate of the patient's financial liability based on typical
735 or average charges for visits to the hospital-based facility, including
736 the facility fee, (B) a statement that the patient's actual financial
737 liability will depend on the professional medical services actually
738 provided to the patient, and (C) an explanation that the patient may
739 incur financial liability that is greater than the patient would incur if
740 the professional medical services were not provided by a hospital-
741 based facility; and

742 (3) That a patient covered by a health insurance policy should
743 contact the health insurer for additional information regarding the
744 hospital's or health system's charges and fees, including the patient's
745 potential financial liability, if any, for such charges and fees.

746 (c) If a hospital or health system charges a facility fee without
747 utilizing a current procedural terminology evaluation and
748 management (CPT E/M) code for outpatient services provided at a
749 hospital-based facility, located outside the hospital campus, the
750 hospital or health system shall provide the patient with a written
751 notice that includes the following information:

752 (1) That the hospital-based facility is part of a hospital or health
753 system and that the hospital or health system charges a facility fee that
754 may be in addition to and separate from the professional fee charged
755 by a provider;

756 (2) (A) A statement that the patient's actual financial liability will
757 depend on the professional medical services actually provided to the
758 patient, and (B) an explanation that the patient may incur financial
759 liability that is greater than the patient would incur if the hospital-
760 based facility was not hospital-based; and

761 (3) That a patient covered by a health insurance policy should
762 contact the health insurer for additional information regarding the
763 hospital's or health system's charges and fees, including the patient's
764 potential financial liability, if any, for such charges and fees.

765 (d) On and after January 1, 2016, each billing statement that includes
766 a facility fee shall: (1) Clearly identify the fee as a facility fee that is
767 billed in addition to, or separately from, any professional fee billed by
768 the provider; (2) provide the Medicare facility fee reimbursement rate
769 for the same service as a comparison; (3) include a statement that the
770 facility fee is intended to cover the hospital's or health system's
771 operational expenses; (4) inform the patient that the patient's financial
772 liability may have been less if the services had been provided at a

773 facility not owned or operated by the hospital or health system; and (5)
774 include written notice of the patient's right to request a reduction in
775 the facility fee or any other portion of the bill and a telephone number
776 that the patient may use to request such a reduction.

777 [(d)] (e) The written notice described in subsections (b) [and (c)] to
778 (d), inclusive, and (h) to (j), inclusive, of this section shall be in plain
779 language and in a form that may be reasonably understood by a
780 patient who does not possess special knowledge regarding hospital or
781 health system facility fee charges.

782 [(e)] (f) (1) For nonemergency care, if a patient's appointment is
783 scheduled to occur ten or more days after the appointment is made,
784 such written notice shall be sent to the patient by first class mail,
785 encrypted electronic mail or a secure patient Internet portal not less
786 than three days after the appointment is made. If an appointment is
787 scheduled to occur less than ten days after the appointment is made or
788 if the patient arrives without an appointment, such notice shall be
789 hand-delivered to the patient when the patient arrives at the hospital-
790 based facility.

791 (2) For emergency care, such written notice shall be provided to the
792 patient as soon as practicable after the patient is stabilized in
793 accordance with the federal Emergency Medical Treatment and Active
794 Labor Act, 42 USC 1395dd, as amended from time to time, or is
795 determined not to have an emergency medical condition and before
796 the patient leaves the hospital-based facility. If the patient is
797 unconscious, under great duress or for any other reason unable to read
798 the notice and understand and act on his or her rights, the notice shall
799 be provided to the patient's representative as soon as practicable.

800 [(f)] (g) Subsections (b) to [(e)] (f), inclusive, of this section shall not
801 apply if a patient is insured by Medicare or Medicaid or is receiving
802 services under a workers' compensation plan established to provide
803 medical services pursuant to chapter 568.

804 [(g)] (h) A hospital-based facility shall prominently display written
805 notice in locations that are readily accessible to and visible by patients,
806 including patient waiting areas, stating that: (1) The hospital-based
807 facility is part of a hospital or health system, and (2) if the hospital-
808 based facility charges a facility fee, the patient may incur a financial
809 liability greater than the patient would incur if the hospital-based
810 facility was not hospital-based.

811 [(h)] (i) A hospital-based facility shall clearly hold itself out to the
812 public and payers as being hospital-based, including, at a minimum,
813 by stating the name of the hospital or health system in its signage,
814 marketing materials, Internet web sites and stationery.

815 (j) (1) On and after January 1, 2016, if any transaction, as described
816 in subsection (c) of section 19a-486i, as amended by this act, results in
817 the establishment of a hospital-based facility at which facility fees will
818 likely be billed, the hospital or health system, that is the purchaser in
819 such transaction shall, not later than thirty days after such transaction,
820 provide written notice, by first class mail, of the transaction to each
821 patient served within the previous three years by the health care
822 facility that has been purchased as part of such transaction.

823 (2) Such notice shall include the following information:

824 (A) A statement that the health care facility is now a hospital-based
825 facility and is part of a hospital or health system;

826 (B) The name, business address and phone number of the hospital
827 or health system that is the purchaser of the health care facility;

828 (C) A statement that the hospital-based facility bills, or is likely to
829 bill, patients a facility fee that may be in addition to, and separate
830 from, any professional fee billed by a health care provider at the
831 hospital-based facility;

832 (D) (i) A statement that the patient's actual financial liability will
833 depend on the professional medical services actually provided to the

834 patient, and (ii) an explanation that the patient may incur financial
835 liability that is greater than the patient would incur if the hospital-
836 based facility were not a hospital-based facility;

837 (E) The estimated amount or range of amounts the hospital-based
838 facility may bill for a facility fee or an example of the average facility
839 fee billed at such hospital-based facility for the most common services
840 provided at such hospital-based facility; and

841 (F) A statement that, prior to seeking services at such hospital-based
842 facility, a patient covered by a health insurance policy should contact
843 the patient's health insurer for additional information regarding the
844 hospital-based facility fees, including the patient's potential financial
845 liability, if any, for such fees.

846 (3) A copy of the written notice provided to patients in accordance
847 with this subsection shall be filed with the Office of Health Care
848 Access. Said office shall post a link to such notice on its Internet web
849 site.

850 (4) A hospital, health system or hospital-based facility shall not
851 collect a facility fee for services provided at a hospital-based facility
852 that is subject to the provisions of this subsection from the date of the
853 transaction until at least thirty days after the written notice required
854 pursuant to this subsection is mailed to the patient or a copy of such
855 notice is filed with the Office of Health Care Access, whichever is later.
856 A violation of this subsection shall be considered an unfair trade
857 practice pursuant to section 42-110b.

858 (k) Notwithstanding the provisions of this section, on and after
859 January 1, 2017, no hospital, health system or hospital-based facility
860 shall collect a facility fee for (1) outpatient health care services that use
861 a current procedural terminology evaluation and management code
862 and are provided at a hospital-based facility, other than a hospital
863 emergency department, located off-site from a hospital campus, or (2)
864 outpatient health care services, other than those provided in an

865 emergency department located off-site from a hospital campus,
866 received by a patient who is uninsured of more than the Medicare rate.
867 Notwithstanding the provisions of this subsection, in circumstances
868 when an insurance contract that is in effect on July 1, 2016, provides
869 reimbursement for facility fees prohibited under the provisions of this
870 section, a hospital or health system may continue to collect
871 reimbursement from the health insurer for such facility fees until the
872 date of expiration of such contract. A violation of this subsection shall
873 be considered an unfair trade practice pursuant to chapter 735a.

874 (l) (1) Each hospital and health system shall report not later than
875 July 1, 2016, and annually thereafter to the Commissioner of Public
876 Health concerning facility fees charged or billed during the preceding
877 calendar year. Such report shall include (A) the name and location of
878 each facility owned or operated by the hospital or health system that
879 provides services for which a facility fee is charged or billed, (B) the
880 number of patient visits at each such facility for which a facility fee
881 was charged or billed, (C) the number, total amount and range of
882 allowable facility fees paid at each such facility by Medicare, Medicaid
883 or under private insurance policies, (D) for each facility, the total
884 amount of revenue received by the hospital or health system derived
885 from facility fees, (E) the total amount of revenue received by the
886 hospital or health system from all facilities derived from facility fees,
887 (F) a description of the ten procedures or services that generated the
888 greatest amount of facility fee revenue and, for each such procedure or
889 service, the total amount of revenue received by the hospital or health
890 system derived from facility fees, and (G) the top ten procedures for
891 which facility fees are charged based on patient volume. For purposes
892 of this subsection, "facility" means a hospital-based facility that is
893 located outside a hospital campus.

894 (2) The commissioner shall publish the information reported
895 pursuant to subdivision (1) of this subsection, or post a link to such
896 information, on the Internet web site of the Office of Health Care
897 Access.

898 Sec. 14. (NEW) (*Effective October 1, 2015*) (a) As used in this section,
899 "campus", "facility fee", "health system", "hospital" and "hospital-based
900 facility" have the same meanings as provided in section 19a-508c of the
901 general statutes, as amended by this act.

902 (b) (1) Each health insurer, health care center or other entity that
903 delivers, issues for delivery, renews, amends or continues, on or after
904 January 1, 2016, an individual or a group health insurance policy or
905 health benefit plan providing coverage of the type specified in
906 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
907 statutes in this state, and includes in a contract entered into, renewed
908 or amended on or after October 1, 2015, with a hospital, a health
909 system or a hospital-based facility, reimbursement to such hospital,
910 health system or hospital-based facility for a facility fee for outpatient
911 health care services that are provided at a hospital-based facility
912 located off-site from a hospital campus, shall not impose any separate
913 copayment for such fee.

914 (2) With respect to an insured covered under such policy or plan,
915 who has not satisfied the deductible applicable to such policy or plan
916 at the time of the provision of the applicable health care service, no
917 such hospital, health system or hospital-based facility may collect from
918 such insured for any applicable facility fee more than the facility fee
919 reimbursement rate agreed to by such insurer, center or other entity
920 pursuant to such contract.

921 Sec. 15. (NEW) (*Effective October 1, 2015*) Each health care provider
922 that refers a patient to another health care provider who is not a
923 member of the same partnership, professional corporation or limited
924 liability company formed to render professional services but is
925 affiliated with the referring health care provider shall notify the
926 patient, in writing, that the health care providers are affiliated. Such
927 notice shall also (1) inform the patient that the patient is not required
928 to see the provider to whom he or she is referred and that the patient
929 has a right to seek care from the health care provider chosen by the
930 patient, and (2) provide the patient with the Internet web site and toll-

931 free telephone number of the patient's health carrier to obtain
932 information regarding in-network health care providers and estimated
933 out-of-pocket costs for the referred service. A health care provider is
934 not required to provide notice to a patient pursuant to this section if
935 the health care provider otherwise provides substantially similar
936 notice to patients pursuant to federal law. For purposes of this section,
937 "affiliated" means a relationship between two or more health care
938 providers that permits the health care providers to negotiate jointly or
939 as a member of the same group of health care providers with third
940 parties over rates for professional medical services.

941 Sec. 16. Section 38a-1084 of the general statutes is repealed and the
942 following is substituted in lieu thereof (*Effective October 1, 2015*):

943 The exchange shall:

944 (1) Administer the exchange for both qualified individuals and
945 qualified employers;

946 (2) Commission surveys of individuals, small employers and health
947 care providers on issues related to health care and health care
948 coverage;

949 (3) Implement procedures for the certification, recertification and
950 decertification, consistent with guidelines developed by the Secretary
951 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
952 of health benefit plans as qualified health plans;

953 (4) Provide for the operation of a toll-free telephone hotline to
954 respond to requests for assistance;

955 (5) Provide for enrollment periods, as provided under Section
956 1311(c)(6) of the Affordable Care Act;

957 (6) Maintain an Internet web site through which enrollees and
958 prospective enrollees of qualified health plans may obtain
959 standardized comparative information on such plans including, but

960 not limited to, the enrollee satisfaction survey information under
961 Section 1311(c)(4) of the Affordable Care Act and any other
962 information or tools to assist enrollees and prospective enrollees
963 evaluate qualified health plans offered through the exchange;

964 (7) Publish the average costs of licensing, regulatory fees and any
965 other payments required by the exchange and the administrative costs
966 of the exchange, including information on moneys lost to waste, fraud
967 and abuse, on an Internet web site to educate individuals on such
968 costs;

969 (8) On or before the open enrollment period for plan year 2017,
970 assign a rating to each qualified health plan offered through the
971 exchange in accordance with the criteria developed by the Secretary
972 under Section 1311(c)(3) of the Affordable Care Act, and determine
973 each qualified health plan's level of coverage in accordance with
974 regulations issued by the Secretary under Section 1302(d)(2)(A) of the
975 Affordable Care Act;

976 (9) Use a standardized format for presenting health benefit options
977 in the exchange, including the use of the uniform outline of coverage
978 established under Section 2715 of the Public Health Service Act, 42
979 USC 300gg-15, as amended from time to time;

980 (10) Inform individuals, in accordance with Section 1413 of the
981 Affordable Care Act, of eligibility requirements for the Medicaid
982 program under Title XIX of the Social Security Act, as amended from
983 time to time, the Children's Health Insurance Program (CHIP) under
984 Title XXI of the Social Security Act, as amended from time to time, or
985 any applicable state or local public program, and enroll an individual
986 in such program if the exchange determines, through screening of the
987 application by the exchange, that such individual is eligible for any
988 such program;

989 (11) Collaborate with the Department of Social Services, to the
990 extent possible, to allow an enrollee who loses premium tax credit

991 eligibility under Section 36B of the Internal Revenue Code and is
992 eligible for HUSKY Plan, Part A or any other state or local public
993 program, to remain enrolled in a qualified health plan;

994 (12) Establish and make available by electronic means a calculator to
995 determine the actual cost of coverage after application of any premium
996 tax credit under Section 36B of the Internal Revenue Code and any
997 cost-sharing reduction under Section 1402 of the Affordable Care Act;

998 (13) Establish a program for small employers through which
999 qualified employers may access coverage for their employees and that
1000 shall enable any qualified employer to specify a level of coverage so
1001 that any of its employees may enroll in any qualified health plan
1002 offered through the exchange at the specified level of coverage;

1003 (14) Offer enrollees and small employers the option of having the
1004 exchange collect and administer premiums, including through
1005 allocation of premiums among the various insurers and qualified
1006 health plans chosen by individual employers;

1007 (15) Grant a certification, subject to Section 1411 of the Affordable
1008 Care Act, attesting that, for purposes of the individual responsibility
1009 penalty under Section 5000A of the Internal Revenue Code, an
1010 individual is exempt from the individual responsibility requirement or
1011 from the penalty imposed by said Section 5000A because:

1012 (A) There is no affordable qualified health plan available through
1013 the exchange, or the individual's employer, covering the individual; or

1014 (B) The individual meets the requirements for any other such
1015 exemption from the individual responsibility requirement or penalty;

1016 (16) Provide to the Secretary of the Treasury of the United States the
1017 following:

1018 (A) A list of the individuals granted a certification under
1019 subdivision (15) of this section, including the name and taxpayer

1020 identification number of each individual;

1021 (B) The name and taxpayer identification number of each individual
1022 who was an employee of an employer but who was determined to be
1023 eligible for the premium tax credit under Section 36B of the Internal
1024 Revenue Code because:

1025 (i) The employer did not provide minimum essential health benefits
1026 coverage; or

1027 (ii) The employer provided the minimum essential coverage but it
1028 was determined under Section 36B(c)(2)(C) of the Internal Revenue
1029 Code to be unaffordable to the employee or not provide the required
1030 minimum actuarial value; and

1031 (C) The name and taxpayer identification number of:

1032 (i) Each individual who notifies the exchange under Section
1033 1411(b)(4) of the Affordable Care Act that such individual has changed
1034 employers; and

1035 (ii) Each individual who ceases coverage under a qualified health
1036 plan during a plan year and the effective date of that cessation;

1037 (17) Provide to each employer the name of each employee, as
1038 described in subparagraph (B) of subdivision (16) of this section, of the
1039 employer who ceases coverage under a qualified health plan during a
1040 plan year and the effective date of the cessation;

1041 (18) Perform duties required of, or delegated to, the exchange by the
1042 Secretary or the Secretary of the Treasury of the United States related
1043 to determining eligibility for premium tax credits, reduced cost-
1044 sharing or individual responsibility requirement exemptions;

1045 (19) Select entities qualified to serve as Navigators in accordance
1046 with Section 1311(i) of the Affordable Care Act and award grants to
1047 enable Navigators to:

1048 (A) Conduct public education activities to raise awareness of the
1049 availability of qualified health plans;

1050 (B) Distribute fair and impartial information concerning enrollment
1051 in qualified health plans and the availability of premium tax credits
1052 under Section 36B of the Internal Revenue Code and cost-sharing
1053 reductions under Section 1402 of the Affordable Care Act;

1054 (C) Facilitate enrollment in qualified health plans;

1055 (D) Provide referrals to the Office of the Healthcare Advocate or
1056 health insurance ombudsman established under Section 2793 of the
1057 Public Health Service Act, 42 USC 300gg-93, as amended from time to
1058 time, or any other appropriate state agency or agencies, for any
1059 enrollee with a grievance, complaint or question regarding the
1060 enrollee's health benefit plan, coverage or a determination under that
1061 plan or coverage; and

1062 (E) Provide information in a manner that is culturally and
1063 linguistically appropriate to the needs of the population being served
1064 by the exchange;

1065 (20) Review the rate of premium growth within and outside the
1066 exchange and consider such information in developing
1067 recommendations on whether to continue limiting qualified employer
1068 status to small employers;

1069 (21) Credit the amount, in accordance with Section 10108 of the
1070 Affordable Care Act, of any free choice voucher to the monthly
1071 premium of the plan in which a qualified employee is enrolled and
1072 collect the amount credited from the offering employer;

1073 (22) Consult with stakeholders relevant to carrying out the activities
1074 required under sections 38a-1080 to 38a-1090, inclusive, including, but
1075 not limited to:

1076 (A) Individuals who are knowledgeable about the health care

1077 system, have background or experience in making informed decisions
1078 regarding health, medical and scientific matters and are enrollees in
1079 qualified health plans;

1080 (B) Individuals and entities with experience in facilitating
1081 enrollment in qualified health plans;

1082 (C) Representatives of small employers and self-employed
1083 individuals;

1084 (D) The Department of Social Services; and

1085 (E) Advocates for enrolling hard-to-reach populations;

1086 (23) Meet the following financial integrity requirements:

1087 (A) Keep an accurate accounting of all activities, receipts and
1088 expenditures and annually submit to the Secretary, the Governor, the
1089 Insurance Commissioner and the General Assembly a report
1090 concerning such accountings;

1091 (B) Fully cooperate with any investigation conducted by the
1092 Secretary pursuant to the Secretary's authority under the Affordable
1093 Care Act and allow the Secretary, in coordination with the Inspector
1094 General of the United States Department of Health and Human
1095 Services, to:

1096 (i) Investigate the affairs of the exchange;

1097 (ii) Examine the properties and records of the exchange; and

1098 (iii) Require periodic reports in relation to the activities undertaken
1099 by the exchange; and

1100 (C) Not use any funds in carrying out its activities under sections
1101 38a-1080 to 38a-1089, inclusive, and section 38a-1091 that are intended
1102 for the administrative and operational expenses of the exchange, for
1103 staff retreats, promotional giveaways, excessive executive

1104 compensation or promotion of federal or state legislative and
1105 regulatory modifications;

1106 (24) (A) Seek to include the most comprehensive health benefit
1107 plans that offer high quality benefits at the most affordable price in the
1108 exchange, (B) encourage health carriers to offer tiered health care
1109 provider network plans that have different cost-sharing rates for
1110 different health care provider tiers and reward enrollees for choosing
1111 low-cost, high-quality health care providers by offering lower
1112 copayments, deductibles or other out-of-pocket expenses, and (C) offer
1113 any such tiered health care provider network plans through the
1114 exchange;

1115 (25) Report at least annually to the General Assembly on the effect
1116 of adverse selection on the operations of the exchange and make
1117 legislative recommendations, if necessary, to reduce the negative
1118 impact from any such adverse selection on the sustainability of the
1119 exchange, including recommendations to ensure that regulation of
1120 insurers and health benefit plans are similar for qualified health plans
1121 offered through the exchange and health benefit plans offered outside
1122 the exchange. The exchange shall evaluate whether adverse selection is
1123 occurring with respect to health benefit plans that are grandfathered
1124 under the Affordable Care Act, self-insured plans, plans sold through
1125 the exchange and plans sold outside the exchange; and

1126 (26) Seek funding for and oversee the planning, implementation and
1127 development of policies and procedures for the administration of the
1128 all-payer claims database program established under section 38a-1091.

1129 Sec. 17. (*Effective from passage*) (a) The Health Care Cabinet
1130 established under section 19a-725 of the general statutes, as amended
1131 by this act, shall, within available appropriations, study health care
1132 cost containment models in other states, including, but not limited to,
1133 Massachusetts, Maryland, Oregon, Rhode Island, Washington and
1134 Vermont, to identify successful practices and programs that may be
1135 implemented in the state for the purposes of (1) monitoring and

1136 controlling health care costs, (2) enhancing competition in the health
1137 care market, (3) promoting the use of high-quality health care
1138 providers with low total medical expenses and prices, (4) improving
1139 health care cost and quality transparency, (5) increasing cost-
1140 effectiveness in the health care market, and (6) improving the quality
1141 of care and health outcomes.

1142 (b) Not later than December 1, 2016, said cabinet shall submit a
1143 report, in accordance with the provisions of section 11-4a of the general
1144 statutes, to the General Assembly of the findings of such study and
1145 shall include, but not be limited to, recommendations for
1146 administrative, regulatory and policy changes that will provide for (1)
1147 a framework for (A) the monitoring of and responding to health care
1148 cost growth on a health care provider and state-wide basis that may
1149 include establishing state-wide or health care provider or service-
1150 specific benchmarks or limits on health care cost growth, (B) the
1151 identification of health care providers that exceed such benchmarks or
1152 limits, and (C) the provision of assistance for such health care
1153 providers to meet such benchmarks or to hold them accountable to
1154 such limits, (2) mechanisms to identify and mitigate factors that
1155 contribute to health care cost growth as well as price disparity between
1156 health care providers of similar services, including, but not limited to,
1157 (A) consolidation among health care providers of similar services, (B)
1158 vertical integration of health care providers of different services, (C)
1159 affiliations among health care providers that impact referral and
1160 utilization practices, (D) insurance contracting and reimbursement
1161 policies, and (E) government reimbursement policies and regulatory
1162 practices, (3) the authority to implement and monitor delivery system
1163 reforms designed to promote value-based care and improved health
1164 outcomes, (4) the development and promotion of insurance contracting
1165 standards and products that reward value-based care and promote the
1166 utilization of low-cost, high-quality health care providers, and (5) the
1167 implementation of other policies to mitigate factors that contribute to
1168 unnecessary health care cost growth and to promote high-quality,
1169 affordable care.

1170 (c) Any recommendations included pursuant to subsection (b) of
1171 this section shall, to the extent possible, seek to limit any
1172 administrative burdens on health care providers and payers, be
1173 consistent and integrated with existing regulatory practices and reduce
1174 or eliminate existing administrative, regulatory and reporting
1175 requirements, to improve the overall efficiency of the state's health care
1176 regulatory environment.

1177 Sec. 18. Section 19a-725 of the general statutes is repealed and the
1178 following is substituted in lieu thereof (*Effective July 1, 2015*):

1179 (a) There is established within the office of the Lieutenant Governor,
1180 the [SustiNet] Health Care Cabinet for the purpose of advising the
1181 Governor on the matters set forth in subsection (c) of this section.

1182 (b) (1) The [SustiNet] Health Care Cabinet shall consist of the
1183 following members who shall be appointed on or before August 1,
1184 2011: (A) Five appointed by the Governor, two of whom may represent
1185 the health care industry and shall serve for terms of four years, one of
1186 whom shall represent community health centers and shall serve for a
1187 term of three years, one of whom shall represent insurance producers
1188 and shall serve for a term of three years and one of whom shall be an
1189 at-large appointment and shall serve for a term of three years; (B) one
1190 appointed by the president pro tempore of the Senate, who shall be an
1191 oral health specialist engaged in active practice and shall serve for a
1192 term of four years; (C) one appointed by the majority leader of the
1193 Senate, who shall represent labor and shall serve for a term of three
1194 years; (D) one appointed by the minority leader of the Senate, who
1195 shall be an advanced practice registered nurse engaged in active
1196 practice and shall serve for a term of two years; (E) one appointed by
1197 the speaker of the House of Representatives, who shall be a consumer
1198 advocate and shall serve for a term of four years; (F) one appointed by
1199 the majority leader of the House of Representatives, who shall be a
1200 primary care physician engaged in active practice and shall serve for a
1201 term of four years; (G) one appointed by the minority leader of the
1202 House of Representatives, who shall represent the health information

1203 technology industry and shall serve for a term of three years; (H) five
1204 appointed jointly by the chairpersons of the Sustinet Health
1205 Partnership board of directors, one of whom shall represent faith
1206 communities, one of whom shall represent small businesses, one of
1207 whom shall represent the home health care industry, one of whom
1208 shall represent hospitals, and one of whom shall be an at-large
1209 appointment, all of whom shall serve for terms of five years; (I) the
1210 Lieutenant Governor; (J) the Secretary of the Office of Policy and
1211 Management, or the secretary's designee; the Comptroller, or the
1212 Comptroller's designee; the chief executive officer of the Connecticut
1213 Health Insurance Exchange, or said officer's designee; the
1214 Commissioners of Social Services and Public Health, or their
1215 designees; and the Healthcare Advocate, or the Healthcare Advocate's
1216 designee, all of whom shall serve as ex-officio voting members; and (K)
1217 the Commissioners of Children and Families, Developmental Services
1218 and Mental Health and Addiction Services, and the Insurance
1219 Commissioner, or their designees, and the nonprofit liaison to the
1220 Governor, or the nonprofit liaison's designee, all of whom shall serve
1221 as ex-officio nonvoting members.

1222 (2) Following the expiration of initial cabinet member terms,
1223 subsequent cabinet terms shall be for four years, commencing on
1224 August first of the year of the appointment. If an appointing authority
1225 fails to make an initial appointment to the cabinet or an appointment
1226 to fill a cabinet vacancy within ninety days of the date of such vacancy,
1227 the appointed cabinet members shall, by majority vote, make such
1228 appointment to the cabinet.

1229 (3) Upon the expiration of the initial terms of the five cabinet
1230 members appointed by Sustinet Health Partnership board of directors,
1231 five successor cabinet members shall be appointed as follows: (A) One
1232 appointed by the Governor; (B) one appointed by the president pro
1233 tempore of the Senate; (C) one appointed by the speaker of the House
1234 of Representatives; and (D) two appointed by majority vote of the
1235 appointed board members. Successor board members appointed

1236 pursuant to this subdivision shall be at-large appointments.

1237 (4) The Lieutenant Governor shall serve as the chairperson of the
1238 [SustiNet] Health Care Cabinet. [The Lieutenant Governor shall
1239 schedule the first meeting of the SustiNet Health Care Cabinet, which
1240 meeting shall be held not later than September 1, 2011.]

1241 (c) The [SustiNet] Health Care Cabinet shall advise the Governor
1242 regarding the development of an integrated health care system for
1243 Connecticut and shall:

1244 (1) Evaluate the means of ensuring an adequate health care
1245 workforce in the state;

1246 (2) Jointly evaluate, with the chief executive officer of the
1247 Connecticut Health Insurance Exchange, the feasibility of
1248 implementing a basic health program option as set forth in Section
1249 1331 of the Affordable Care Act;

1250 (3) Identify short and long-range opportunities, issues and gaps
1251 created by the enactment of federal health care reform;

1252 (4) Review the effectiveness of delivery system reforms and other
1253 efforts to control health care costs, including, but not limited to,
1254 reforms and efforts implemented by state agencies; and

1255 (5) Advise the Governor on matters relating to: (A) The design,
1256 implementation, actionable objectives and evaluation of state and
1257 federal health care policies, priorities and objectives relating to the
1258 state's efforts to improve access to health care, and (B) the quality of
1259 such care and the affordability and sustainability of the state's health
1260 care system.

1261 (d) The [SustiNet] Health Care Cabinet may convene working
1262 groups, which include volunteer health care experts, to make
1263 recommendations concerning the development and implementation of
1264 service delivery and health care provider payment reforms, including

1265 multipayer initiatives, medical homes, electronic health records and
1266 evidenced-based health care quality improvement.

1267 (e) The office of the Lieutenant Governor and the Office of the
1268 Healthcare Advocate shall provide support staff to the [SustiNet]
1269 Health Care Cabinet.

1270 Sec. 19. (*Effective July 1, 2015*) (a) The Insurance Commissioner shall,
1271 within available appropriations, convene a working group that
1272 includes the Comptroller, the Commissioner of Public Health and the
1273 Healthcare Advocate to study the rising cost of health care, including,
1274 but not limited to, (1) increases in the prices charged for health care
1275 services, (2) the variation in such prices among health care providers,
1276 (3) the impact on such prices and price variation of reimbursement
1277 rates paid by health insurers to health care providers, and (4) the
1278 impact of the variation of such prices among health care providers on
1279 health care spending by the state as both a payer and a provider of
1280 health care services, health insurance premiums and consumer out-of-
1281 pocket expenses. Said officials shall examine policies aimed at
1282 enhancing competition, fairness and cost-effectiveness in the health
1283 care market and the reduction of disparities in reimbursement rates
1284 and prices charged by health care providers.

1285 (b) Said officials shall examine: (1) The variation in prices charged
1286 by health care providers within similar health care provider groups; (2)
1287 the variation in prices charged by health care providers for services of
1288 comparable acuity, quality and complexity; (3) the variation in the
1289 volume of care provided by health care providers with low and high
1290 levels of relative health care provider prices or health status adjusted
1291 total medical expenses; (4) the correlation between prices charged by
1292 health care providers and (A) the quality of care provided, (B) the
1293 acuity of the patient population, (C) health care providers' payer mix,
1294 (D) unique services provided by health care providers, including
1295 specialty teaching services and community services, and (E) health
1296 care providers' operational costs, including administrative and
1297 management costs; (5) in the case of hospitals, the correlation between

1298 prices charged by hospitals and their respective statuses as
1299 disproportionate share hospitals, specialty hospitals, pediatric
1300 specialty hospitals or academic teaching hospitals; (6) the correlation
1301 between prices charged by health care providers and market share,
1302 horizontal consolidation and vertical integration and referral policies
1303 and patterns; and (7) the correlation between facility fees, as defined in
1304 section 19a-508c of the general statutes, as amended by this act, and
1305 total medical spending, consumer out-of-pocket expenses and the
1306 variation in prices charged by health care providers for services of
1307 comparable acuity, quality and complexity.

1308 (c) Said officials may hold informational hearings, consult with the
1309 Attorney General and solicit information from, and the participation
1310 of, parties likely to be affected by the results of the study and
1311 recommendations the working group may make, including, but not
1312 limited to, hospitals with a high proportion of public payer
1313 reimbursements, primary care providers, community health centers,
1314 health insurers, third-party administrators, as defined in section 38a-
1315 720 of the general statutes, employers, representatives of the Health
1316 Care Cost Containment Committee, as defined in section 3-123aaa of
1317 the general statutes, and organizations representing consumers and
1318 the uninsured.

1319 (d) The Insurance Commissioner may request from health insurers,
1320 health care providers or third-party administrators information or
1321 materials relevant to the study. Any information or materials
1322 submitted or disclosed for such study shall be confidential and not
1323 subject to disclosure under section 1-210 of the general statutes, except
1324 that data that have identifiers removed and do not disclose the names
1325 of any health care provider, health insurer or payer or individual and
1326 are not otherwise protected by law may be disclosed as part of said
1327 officials' report.

1328 (e) (1) Not later than January 1, 2016, the Insurance Commissioner
1329 shall submit a report to the General Assembly, in accordance with the
1330 provisions of section 11-4a of the general statutes, of the findings of the

1331 study and recommendations for legislation to (A) reduce price
1332 variations among health care providers, (B) promote the use of high-
1333 quality health care providers with low total medical expenses and
1334 health care provider prices, and (C) mitigate the impact of facility fees
1335 on consumer out-of-pocket expenses and total medical spending.

1336 (2) Such recommendations may include (A) expanding or modifying
1337 the limitations on facility fees set forth in subsection (k) of section 19a-
1338 508c of the general statutes, as amended by this act, (B) establishing a
1339 reasonable maximum health care provider price variation limit, (C)
1340 establishing a state-wide median rate for certain health care services
1341 and procedures, and (D) implementing site-neutral payment policies
1342 for the state employee health plan, state-administered programs and
1343 the commercial insurance market.

1344 Sec. 20. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
1345 section:

1346 (1) "Affiliated provider" means a health care provider that is: (A)
1347 Employed by a hospital or health system, (B) under a professional
1348 services agreement with a hospital or health system that permits such
1349 hospital or health system to bill on behalf of such health care provider,
1350 or (C) a clinical faculty member of a medical school, as defined in
1351 section 33-182aa of the general statutes, that is affiliated with a hospital
1352 or health system in a manner that permits such hospital or health
1353 system to bill on behalf of such clinical faculty member;

1354 (2) "Certified electronic health record system" means a health record
1355 system that is certified by the federal Office of the National
1356 Coordinator for Health Information Technology;

1357 (3) "Electronic health record" means any computerized, digital or
1358 other electronic record of individual health-related information that is
1359 created, held, managed or consulted by a health care provider and
1360 may include, but need not be limited to, continuity of care documents,
1361 discharge summaries and other information or data relating to patient

1362 demographics, medical history, medication, allergies, immunizations,
1363 laboratory test results, radiology or other diagnostic images, vital signs
1364 and statistics;

1365 (4) "Electronic health record system" means a computer-based
1366 information system that is used to create, collect, store, manipulate,
1367 share, exchange or make available electronic health records for the
1368 purposes of the delivery of patient care;

1369 (5) "Health care provider" means any individual, corporation,
1370 facility or institution licensed by the state to provide health care
1371 services;

1372 (6) "Health information blocking" means (A) knowingly interfering
1373 with or knowingly engaging in business practices or other conduct that
1374 is reasonably likely to interfere with the ability of patients, health care
1375 providers or other authorized persons to access, exchange or use
1376 electronic health records, or (B) knowingly using an electronic health
1377 record system to both (i) steer patient referrals to affiliated providers,
1378 and (ii) prevent or unreasonably interfere with patient referrals to
1379 health care providers who are not affiliated providers but shall not
1380 include legitimate referrals between providers participating in an
1381 accountable care organizations or similar value-based collaborative
1382 care models;

1383 (7) "Hospital" has the same meaning as provided in section 19a-490
1384 of the general statutes;

1385 (8) "Health system" has the same meaning as provided in section
1386 19a-508c of the general statutes, as amended by this act;

1387 (9) "Seller" means any person or entity that directly, or indirectly
1388 through an employee, agent, independent contractor, vendor or other
1389 person, sells, leases or offers to sell or lease an electronic health record
1390 system or a license or right to use an electronic health record system.

1391 (b) Electronic health records shall, to the fullest extent practicable,

1392 (1) follow the patient, (2) be made accessible to the patient, and (3) be
1393 shared and exchanged with the health care provider of the patient's
1394 choice in a timely manner.

1395 (c) Health information blocking shall be an unfair trade practice
1396 pursuant to section 42-110b of the general statutes.

1397 (d) Health information blocking by a hospital, health system or
1398 seller shall be subject to the penalties contained in subsection (b) of
1399 section 42-110o of the general statutes.

1400 (e) It shall be an unfair trade practice pursuant to section 42-110b of
1401 the general statutes for any seller to make a false, misleading or
1402 deceptive representation that an electronic health record system is a
1403 certified electronic health record system.

1404 (f) The provisions of this section shall be enforced by the Attorney
1405 General.

1406 (g) Nothing contained in this section shall be construed as a
1407 limitation upon the power or authority of the state, the Attorney
1408 General or the Commissioner of Consumer Protection to seek
1409 administrative, legal or equitable relief as provided by any state statute
1410 or common law.

1411 Sec. 21. (NEW) (*Effective from passage*) (a) There shall be established a
1412 State-wide Health Information Exchange to empower consumers to
1413 make effective health care decisions, promote patient-centered care,
1414 improve the quality, safety and value of health care, reduce waste and
1415 duplication of services, support clinical decision-making, keep
1416 confidential health information secure and make progress toward the
1417 state's public health goals.

1418 (b) It shall be the goal of the State-wide Health Information
1419 Exchange to: (1) Allow real-time, secure access to patient health
1420 information and complete medical records across all health care
1421 provider settings; (2) provide patients with secure electronic access to

1422 their health information; (3) allow voluntary participation by patients
1423 to access their health information at no cost; (4) support care
1424 coordination through real-time alerts and timely access to clinical
1425 information; (5) reduce costs associated with preventable
1426 readmissions, duplicative testing and medical errors; (6) promote the
1427 highest level of interoperability; (7) meet all state and federal privacy
1428 and security requirements; (8) support public health reporting, quality
1429 improvement, academic research and health care delivery and
1430 payment reform through data aggregation and analytics; (9) support
1431 population health analytics; (10) be standards-based; and (11) provide
1432 for broad local governance that (A) includes stakeholders, including,
1433 but not limited to, representatives of the Department of Social Services,
1434 hospitals, physicians, behavioral health care providers, long-term care
1435 providers, health insurers, employers, patients and academic or
1436 medical research institutions, and (B) is committed to the successful
1437 development and implementation of the State-wide Health
1438 Information Exchange.

1439 (c) All contracts or agreements entered into by or on behalf of the
1440 state relating to health information technology or the exchange of
1441 health information shall be consistent with the goals articulated in
1442 subsection (b) of this section and shall utilize contractors, vendors and
1443 other partners with a demonstrated commitment to such goals.

1444 (d) (1) The Commissioner of Social Services, in consultation with the
1445 Secretary of the Office of Policy and Management and the State Health
1446 Information Technology Advisory Council, established pursuant to
1447 section 25 of this act, shall, upon the approval by the State Bond
1448 Commission of bond funds authorized by the General Assembly for
1449 the purposes of establishing a State-wide Health Information
1450 Exchange, develop and issue a request for proposals for the
1451 development, management and operation of the State-wide Health
1452 Information Exchange. Such request shall promote the reuse of any
1453 and all enterprise health information technology assets, such as the
1454 existing Provider Directory, Enterprise Master Person Index, Direct

1455 Secure Messaging Health Information Service provider infrastructure,
1456 analytic capabilities and tools that exist in the state or are in the
1457 process of being deployed.

1458 (2) Such request for proposals may require an eligible organization
1459 responding to the request to: (A) Have not less than three years of
1460 experience operating either a state-wide health information exchange
1461 in any state or a regional exchange serving a population of not less
1462 than one million that (i) enables the exchange of patient health
1463 information among health care providers, patients and other
1464 authorized users without regard to location, source of payment or
1465 technology, (ii) includes, with proper consent, behavioral health and
1466 substance abuse treatment information, (iii) supports transitions of
1467 care and care coordination through real-time health care provider
1468 alerts and access to clinical information, (iv) allows health information
1469 to follow each patient, (v) allows patients to access and manage their
1470 health data, and (vi) has demonstrated success in reducing costs
1471 associated with preventable readmissions, duplicative testing or
1472 medical errors; (B) be committed to, and demonstrate, a high level of
1473 transparency in its governance, decision-making and operations; (C) be
1474 capable of providing consulting to ensure effective governance; (D) be
1475 regulated or administratively overseen by a state government agency;
1476 and (E) have sufficient staff and appropriate expertise and experience
1477 to carry out the administrative, operational and financial
1478 responsibilities of the State-wide Health Information Exchange.

1479 (e) Notwithstanding the provisions of subsection (d) of this section,
1480 if, on or before January 1, 2016, the Commissioner of Social Services, in
1481 consultation with the State Health Information Technology Advisory
1482 Council, established pursuant to section 25 of this act, submits a plan
1483 to the Secretary of the Office of Policy and Management for the
1484 establishment of a State-wide Health Information Exchange consistent
1485 with subsections (a), (b) and (c) of this section, and such plan is
1486 approved by the Secretary, the commissioner may implement such
1487 plan and enter into any contracts or agreements to implement such

1488 plan.

1489 (f) The Department of Social Services shall have administrative
1490 authority over the State-wide Health Information Exchange.

1491 Sec. 22. (NEW) (*Effective from passage*) (a) For purposes of this
1492 section:

1493 (1) "Health care provider" means any individual, corporation,
1494 facility or institution licensed by the state to provide health care
1495 services; and

1496 (2) "Electronic health record system" means a computer-based
1497 information system that is used to create, collect, store, manipulate,
1498 share, exchange or make available electronic health records for the
1499 purposes of the delivery of patient care.

1500 (b) Not later than one year after commencement of the operation of
1501 the State-wide Health Information Exchange, each hospital licensed
1502 under chapter 368v of the general statutes and clinical laboratory
1503 licensed under section 19a-30 of the general statutes shall maintain an
1504 electronic health record system capable of connecting to and
1505 participating in the State-wide Health Information Exchange and shall
1506 apply to begin the process of connecting to, and participating in, the
1507 State-wide Health Information Exchange.

1508 (c) Not later than two years after commencement of the operation of
1509 the State-wide Health Information Exchange, each health care provider
1510 with an electronic health record system capable of connecting to, and
1511 participating in, the State-wide Health Information Exchange shall
1512 apply to begin the process of connecting to, and participating in, the
1513 State-wide Health Information Exchange.

1514 Sec. 23. Section 4-60i of the general statutes is repealed and the
1515 following is substituted in lieu thereof (*Effective July 1, 2015*):

1516 (a) As used in this section:

1517 (1) "Electronic health information system" means an information
1518 processing system, involving both computer hardware and software
1519 that deals with the storage, retrieval, sharing and use of health care
1520 information, data and knowledge for communication and decision
1521 making, and includes: (A) An electronic health record that provides
1522 access in real time to a patient's complete medical record; (B) a
1523 personal health record through which an individual, and anyone
1524 authorized by such individual, can maintain and manage such
1525 individual's health information; (C) computerized order entry
1526 technology that permits a health care provider to order diagnostic and
1527 treatment services, including prescription drugs electronically; (D)
1528 electronic alerts and reminders to health care providers to improve
1529 compliance with best practices, promote regular screenings and other
1530 preventive practices, and facilitate diagnoses and treatments; (E) error
1531 notification procedures that generate a warning if an order is entered
1532 that is likely to lead to a significant adverse outcome for a patient; and
1533 (F) tools to allow for the collection, analysis and reporting of data on
1534 adverse events, near misses, the quality and efficiency of care, patient
1535 satisfaction and other healthcare-related performance measures.

1536 (2) "Interoperability" means the ability of two or more systems or
1537 components to exchange information and to use the information that
1538 has been exchanged and includes: (A) The capacity to physically
1539 connect to a network for the purpose of exchanging data with other
1540 users; and (B) the capacity of a connected user to access, transmit,
1541 receive and exchange usable information with other users.

1542 (3) "Standard electronic format" means a format using open
1543 electronic standards that: (A) Enable health information technology to
1544 be used for the collection of clinically specific data; (B) promote the
1545 interoperability of health care information across health care settings,
1546 including reporting to local, state and federal agencies; and (C)
1547 facilitate clinical decision support.

1548 [(a)] (b) The Commissioner of Social Services shall (1) develop,
1549 throughout the Departments of Developmental Services, Public

1550 Health, Correction, Children and Families, Veterans' Affairs and
1551 Mental Health and Addiction Services, uniform management
1552 information, uniform statistical information, uniform terminology for
1553 similar facilities, uniform electronic health information technology
1554 standards and uniform regulations for the licensing of human services
1555 facilities, (2) plan for increased participation of the private sector in the
1556 delivery of human services, (3) provide direction and coordination to
1557 federally funded programs in the human services agencies and
1558 recommend uniform system improvements and reallocation of
1559 physical resources and designation of a single responsibility across
1560 human services agencies lines to eliminate duplication.

1561 [(b)] (c) The Commissioner of Social Services shall, in consultation
1562 with [the Departments of Public Health and Mental Health and
1563 Addiction Services] the Health Information Technology Advisory
1564 Council, established pursuant to section 25 of this act, implement and
1565 periodically revise the state-wide health information technology plan
1566 established pursuant to [section 19a-25d] this section and shall
1567 establish electronic data standards to facilitate the development of
1568 integrated electronic health information systems [, as defined in
1569 subsection (a) of section 19a-25d,] for use by health care providers and
1570 institutions that receive state funding. Such electronic data standards
1571 shall: (1) Include provisions relating to security, privacy, data content,
1572 structures and format, vocabulary and transmission protocols; (2) limit
1573 the use and dissemination of an individual's Social Security number
1574 and require the encryption of any Social Security number provided by
1575 an individual; (3) require privacy standards no less stringent than the
1576 "Standards for Privacy of Individually Identifiable Health Information"
1577 established under the Health Insurance Portability and Accountability
1578 Act of 1996, P.L. 104-191, as amended from time to time, and contained
1579 in 45 CFR 160, 164; (4) require that individually identifiable health
1580 information be secure and that access to such information be traceable
1581 by an electronic audit trail; (5) be compatible with any national data
1582 standards in order to allow for interstate interoperability; [, as defined
1583 in subsection (a) of section 19a-25d;] (6) permit the collection of health

1584 information in a standard electronic format; [, as defined in subsection
1585 (a) of section 19a-25d;] and (7) be compatible with the requirements for
1586 an electronic health information system. [, as defined in subsection (a)
1587 of section 19a-25d.]

1588 (d) The Commissioner of Social Services shall, within existing
1589 resources and in consultation with the State Health Information
1590 Technology Advisory Council: (1) Oversee the development and
1591 implementation of the State-wide Health Information Exchange in
1592 conformance with section 21 of this act; (2) coordinate the state's health
1593 information technology and health information exchange efforts to
1594 ensure consistent and collaborative cross-agency planning and
1595 implementation; and (3) serve as the state liaison to, and work
1596 collaboratively with, the State-wide Health Information Exchange
1597 established pursuant to section 21 of this act to ensure consistency
1598 between the state-wide health information technology plan and the
1599 State-wide Health Information Exchange and to support the state's
1600 health information technology and exchange goals.

1601 (e) The state-wide health information technology plan, implemented
1602 and periodically revised pursuant to subsection (c) of this section, shall
1603 enhance interoperability to support optimal health outcomes and
1604 include, but not be limited to (1) general standards and protocols for
1605 health information exchange, and (2) national data standards to
1606 support secure data exchange data standards to facilitate the
1607 development of a state-wide, integrated electronic health information
1608 system for use by health care providers and institutions that are
1609 licensed by the state. Such electronic data standards shall (A) include
1610 provisions relating to security, privacy, data content, structures and
1611 format, vocabulary and transmission protocols, (B) be compatible with
1612 any national data standards in order to allow for interstate
1613 interoperability, (C) permit the collection of health information in a
1614 standard electronic format, and (D) be compatible with the
1615 requirements for an electronic health information system.

1616 (f) Not later than February 1, 2016, and annually thereafter, the

1617 Commissioner of Social Services, in consultation with the State Health
1618 Information Technology Advisory Council, shall report in accordance
1619 with the provisions of section 11-4a to the joint standing committees of
1620 the General Assembly having cognizance of matters relating to human
1621 services and public health concerning: (1) The development and
1622 implementation of the state-wide health information technology plan
1623 and data standards, established and implemented by the
1624 Commissioner of Social Services pursuant to section 4-60i, as amended
1625 by this act; (2) the establishment of the State-wide Health Information
1626 Exchange; and (3) recommendations for policy, regulatory and
1627 legislative changes and other initiatives to promote the state's health
1628 information technology and exchange goals.

1629 Sec. 24. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
1630 section:

1631 (1) "Electronic health record" means any computerized, digital or
1632 other electronic record of individual health-related information that is
1633 created, held, managed or consulted by a health care provider and
1634 may include, but need not be limited to, continuity of care documents,
1635 discharge summaries and other information or data relating to patient
1636 demographics, medical history, medication, allergies, immunizations,
1637 laboratory test results, radiology or other diagnostic images, vital signs
1638 and statistics;

1639 (2) "Electronic health record system" means a computer-based
1640 information system that is used to create, collect, store, manipulate,
1641 share, exchange or make available electronic health records for the
1642 purpose of the delivery of patient care;

1643 (3) "Health care provider" means any individual, corporation,
1644 facility or institution licensed by the state to provide health care
1645 services; and

1646 (4) "Secure exchange" means the exchange of patient electronic
1647 health records between a hospital and a health care provider in a

1648 manner that complies with all state and federal privacy requirements,
1649 including, but not limited to, the Health Insurance Portability and
1650 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from
1651 time to time.

1652 (b) Each hospital licensed under chapter 368v of the general statutes
1653 shall, to the fullest extent practicable, use its electronic health records
1654 system to enable bidirectional connectivity and the secure exchange of
1655 patient electronic health records between the hospital and any other
1656 health care provider who (1) maintains an electronic health records
1657 system capable of exchanging such records, and (2) provides health
1658 care services to a patient whose records are the subject of the exchange.
1659 The requirements of this section apply to at least the following: (A)
1660 Laboratory and diagnostic tests; (B) radiological and other diagnostic
1661 imaging; (C) continuity of care documents; and (D) discharge
1662 notifications and documents.

1663 (c) Each hospital shall implement the use of any hardware, software,
1664 bandwidth or program functions or settings already purchased or
1665 available to it to support the secure exchange of electronic health
1666 records and information as described in subsection (b) of this section.

1667 (d) Nothing in this section shall be construed as requiring a hospital
1668 to pay for any new or additional information technology, equipment,
1669 hardware or software, including interfaces, where such additional
1670 items are necessary to enable such exchange.

1671 (e) The failure of a hospital to take all reasonable steps to comply
1672 with this section shall constitute evidence of health information
1673 blocking pursuant to section 20 of this act.

1674 (f) A hospital that connects to, and actively participates in, the State-
1675 wide Health Information Exchange, established pursuant to section 21
1676 of this act shall be deemed to have satisfied the requirements of this
1677 section.

1678 Sec. 25. (NEW) (*Effective July 1, 2015*) (a) There shall be a State

1679 Health Information Technology Advisory Council to advise the
1680 Commissioner of Social Services in developing priorities and policy
1681 recommendations for advancing the state's health information
1682 technology and health information exchange efforts and goals and to
1683 advise the commissioner in the development and implementation of
1684 the state-wide health information technology plan and standards and
1685 the State-wide Health Information Exchange, established pursuant to
1686 section 21 of this act. The advisory council shall also advise the
1687 commissioner regarding the development of appropriate governance,
1688 oversight and accountability measures to ensure success in achieving
1689 the state's health information technology and exchange goals.

1690 (b) The council shall consist of the following members:

1691 (1) The Commissioners of Social Services, Mental Health and
1692 Addiction Services, Children and Families, Correction, Public Health
1693 and Developmental Services, or the commissioners' designees;

1694 (2) The Chief Information Officer of the state, or the Chief
1695 Information Officer's designee;

1696 (3) The chief executive officer of the Connecticut Health Insurance
1697 Exchange, or the chief executive officer's designee;

1698 (4) The director of the state innovation model initiative program
1699 management office, or the director's designee;

1700 (5) The chief information officer of The University of Connecticut
1701 Health Center, or said chief information officer's designee;

1702 (6) The Healthcare Advocate, or the Healthcare Advocate's
1703 designee;

1704 (7) Five members appointed by the Governor, one each of whom
1705 shall be (A) a representative of a health system that includes more than
1706 one hospital, (B) a representative of the health insurance industry, (C)
1707 an expert in health information technology, (D) a health care consumer

1708 or consumer advocate, and (E) an employee or trustee of a plan
1709 established pursuant to subdivision (5) of subsection (c) of 29 USC 186.

1710 (8) Two members appointed by the president pro tempore of the
1711 Senate, one each who shall be (A) a representative of a federally
1712 qualified health center, and (B) a provider of behavioral health
1713 services;

1714 (9) Two members appointed by the speaker of the House of
1715 Representatives, one each who shall be (A) a representative of an
1716 outpatient surgical facility, and (B) a provider of home health care
1717 services;

1718 (10) One member appointed by the majority leader of the Senate,
1719 who shall be a representative of an independent community hospital;

1720 (11) One member appointed by the majority leader of the House of
1721 Representatives, who shall be a physician who provides services in a
1722 multispecialty group and who is not employed by a hospital;

1723 (12) One member appointed by the minority leader of the Senate,
1724 who shall be a primary care physician who provides services in a small
1725 independent practice;

1726 (13) One member appointed by the minority leader of the House of
1727 Representatives, who shall be an expert in health care analytics and
1728 quality analysis;

1729 (14) The president pro tempore of the Senate, or the president's
1730 designee;

1731 (15) The speaker of the House of Representatives, or the speaker's
1732 designee;

1733 (16) The minority leader of the Senate, or the minority leader's
1734 designee; and

1735 (17) The minority leader of the House of Representatives, or the

1736 minority leader's designee.

1737 (c) Any member appointed or designated under subdivisions (8) to
1738 (17), inclusive, of subsection (c) of this section may be a member of the
1739 General Assembly.

1740 (d) All appointments to the council shall be made not later than
1741 August 1, 2015. The Commissioner of Social Services shall schedule the
1742 first meeting of the council, which shall be held not later than
1743 September 1, 2015. The Commissioner of Social Services shall serve as
1744 a chairperson of the council. The council shall elect a second
1745 chairperson from among its members, who shall not be a state official.
1746 The council shall meet not less than three times prior to January 1,
1747 2016. The terms of the members shall be coterminous with the terms of
1748 the appointing authority for each member and subject to the
1749 provisions of section 4-1a of the general statutes. If any vacancy occurs
1750 on the council, the appointing authority having the power to make the
1751 appointment under the provisions of this section and shall appoint a
1752 person in accordance with the provisions of this section. A majority of
1753 the members of the council shall constitute a quorum. Members of the
1754 council shall serve without compensation, but shall be reimbursed for
1755 all reasonable expenses incurred in the performance of their duties.

1756 (e) Prior to submitting any application, proposal, planning
1757 document or other request seeking federal grants, matching funds or
1758 other federal support for health information technology or health
1759 information exchange, the Commissioner of Social Services shall
1760 present such application, proposal, document or other request to the
1761 council for review and comment.

1762 Sec. 26. Section 4-60j of the general statutes is repealed and the
1763 following is substituted in lieu thereof (*Effective October 1, 2015*):

1764 In fulfilling his or her responsibilities under sections 4-60i, as
1765 amended by this act, and 4-60l and complying with the requirements
1766 of [section 19a-25d] said sections, the Commissioner of Social Services

1767 shall take into consideration such advice as may be provided to the
1768 commissioner by advisory boards and councils in the human services
1769 areas.

1770 Sec. 27. Section 19a-486i of the general statutes is repealed and the
1771 following is substituted in lieu thereof (*Effective October 1, 2015*):

1772 (a) As used in this section:

1773 (1) "Affiliation" means the formation of a relationship between two
1774 or more entities that permits the entities to negotiate jointly with third
1775 parties over rates for professional medical services;

1776 (2) "Captive professional entity" means a professional corporation,
1777 limited liability company or other entity formed to render professional
1778 services in which a beneficial owner is a physician employed by or
1779 otherwise designated by a hospital or hospital system;

1780 (3) "Hospital" has the same meaning as provided in section 19a-490;

1781 (4) "Hospital system" means: (A) A parent corporation of one or
1782 more hospitals and any entity affiliated with such parent corporation
1783 through ownership, governance or membership, or (B) a hospital and
1784 any entity affiliated with such hospital through ownership,
1785 governance or membership;

1786 (5) "Health care provider" has the same meaning as provided in
1787 section 19a-17b;

1788 (6) "Medical foundation" means a medical foundation formed under
1789 chapter 594b;

1790 (7) "Physician" has the same meaning as provided in section 20-13a;

1791 (8) "Person" has the same meaning as provided in section 35-25;

1792 (9) "Professional corporation" has the same meaning as provided in
1793 section 33-182a;

1794 (10) "Group practice" means two or more physicians, legally
1795 organized in a partnership, professional corporation, limited liability
1796 company formed to render professional services, medical foundation,
1797 not-for-profit corporation, faculty practice plan or other similar entity
1798 (A) in which each physician who is a member of the group provides
1799 substantially the full range of services that the physician routinely
1800 provides, including, but not limited to, medical care, consultation,
1801 diagnosis or treatment, through the joint use of shared office space,
1802 facilities, equipment or personnel; (B) for which substantially all of the
1803 services of the physicians who are members of the group are provided
1804 through the group and are billed in the name of the group practice and
1805 amounts so received are treated as receipts of the group; or (C) in
1806 which the overhead expenses of, and the income from, the group are
1807 distributed in accordance with methods previously determined by
1808 members of the group. An entity that otherwise meets the definition of
1809 group practice under this section shall be considered a group practice
1810 although its shareholders, partners or owners of the group practice
1811 include single-physician professional corporations, limited liability
1812 companies formed to render professional services or other entities in
1813 which beneficial owners are individual physicians; and

1814 (11) "Primary service area" means the smallest number of zip codes
1815 from which the group practice draws at least seventy-five per cent of
1816 its patients.

1817 (b) At the same time that any person conducting business in this
1818 state that files merger, acquisition or any other information regarding
1819 market concentration with the Federal Trade Commission or the
1820 United States Department of Justice, in compliance with the Hart-
1821 Scott-Rodino Antitrust Improvements Act, 15 USC 18a, where a
1822 hospital, hospital system or other health care provider is a party to the
1823 merger or acquisition that is the subject of such information, such
1824 person shall provide written notification to the Attorney General of
1825 such filing and, upon the request of the Attorney General, provide a
1826 copy of such merger, acquisition or other information.

1827 (c) Not less than thirty days prior to the effective date of any
1828 transaction that results in a material change to the business or
1829 corporate structure of a group practice, the parties to the transaction
1830 shall submit written notice to the Attorney General of such material
1831 change. For purposes of this subsection, a material change to the
1832 business or corporate structure of a group practice includes: (1) The
1833 merger, consolidation or other affiliation of a group practice with (A)
1834 another group practice that results in a group practice comprised of
1835 eight or more physicians, or (B) a hospital, hospital system, captive
1836 professional entity, medical foundation or other entity organized or
1837 controlled by such hospital or hospital system; (2) the acquisition of all
1838 or substantially all of (A) the properties and assets of a group practice,
1839 or (B) the capital stock, membership interests or other equity interests
1840 of a group practice by (i) another group practice that results in a group
1841 practice comprised of eight or more physicians, or (ii) a hospital,
1842 hospital system, captive professional entity, medical foundation or
1843 other entity organized or controlled by such hospital or hospital
1844 system; (3) the employment of all or substantially all of the physicians
1845 of a group practice by (A) another group practice that results in a
1846 group practice comprised of eight or more physicians, or (B) a hospital,
1847 hospital system, captive professional entity, medical foundation or
1848 other entity organized by, controlled by or otherwise affiliated with
1849 such hospital or hospital system; and (4) the acquisition of one or more
1850 insolvent group practices by (A) another group practice that results in
1851 a group practice comprised of eight or more physicians, or (B) a
1852 hospital, hospital system, captive professional entity, medical
1853 foundation or other entity organized by, controlled by or otherwise
1854 affiliated with such hospital or hospital system.

1855 (d) (1) The written notice required under subsection (c) of this
1856 section shall identify each party to the transaction and describe the
1857 material change as of the date of such notice to the business or
1858 corporate structure of the group practice, including: [(1)] (A) A
1859 description of the nature of the proposed relationship among the
1860 parties to the proposed transaction; [(2)] (B) the names and specialties

1861 of each physician that is a member of the group practice that is the
1862 subject of the proposed transaction and who will practice medicine
1863 with the resulting group practice, hospital, hospital system, captive
1864 professional entity, medical foundation or other entity organized by,
1865 controlled by, or otherwise affiliated with such hospital or hospital
1866 system following the effective date of the transaction; [(3)] (C) the
1867 names of the business entities that are to provide services following the
1868 effective date of the transaction; [(4)] (D) the address for each location
1869 where such services are to be provided; [(5)] (E) a description of the
1870 services to be provided at each such location; and [(6)] (F) the primary
1871 service area to be served by each such location.

1872 (2) Not later than thirty days after the effective date of any
1873 transaction described in subsection (c) of this section, the parties to the
1874 transaction shall submit written notice to the Commissioner of Public
1875 Health. Such written notice shall include, but need not be limited to,
1876 the same information described in subdivision (1) of this subsection.
1877 The commissioner shall post a link to such notice on the Department of
1878 Public Health's Internet web site.

1879 (e) Not less than thirty days prior to the effective date of any
1880 transaction that results in an affiliation between one hospital or
1881 hospital system and another hospital or hospital system, the parties to
1882 the affiliation shall submit written notice to the Attorney General of
1883 such affiliation. Such written notice shall identify each party to the
1884 affiliation and describe the affiliation as of the date of such notice,
1885 including: (1) A description of the nature of the proposed relationship
1886 among the parties to the affiliation; (2) the names of the business
1887 entities that are to provide services following the effective date of the
1888 affiliation; (3) the address for each location where such services are to
1889 be provided; (4) a description of the services to be provided at each
1890 such location; and (5) the primary service area to be served by each
1891 such location.

1892 [(e)] (f) Written information submitted to the Attorney General
1893 pursuant to subsections (b) to [(d)] (e), inclusive, of this section shall be

1894 maintained and used by the Attorney General in the same manner as
1895 provided in section 35-42.

1896 ~~[(f)]~~ (g) Not later than December 31, 2014, and annually thereafter,
1897 each hospital and hospital system shall file with the Attorney General
1898 and the Commissioner of Public Health a written report describing the
1899 activities of the group practices owned or affiliated with such hospital
1900 or hospital system. Such report shall include, for each such group
1901 practice: (1) A description of the nature of the relationship between the
1902 hospital or hospital system and the group practice; (2) the names and
1903 specialties of each physician practicing medicine with the group
1904 practice; (3) the names of the business entities that provide services as
1905 part of the group practice and the address for each location where such
1906 services are provided; (4) a description of the services provided at each
1907 such location; and (5) the primary service area served by each such
1908 location.

1909 ~~[(g)]~~ (h) Not later than December 31, 2014, and annually thereafter,
1910 each group practice comprised of thirty or more physicians that is not
1911 the subject of a report filed under subsection ~~[(f)]~~ (g) of this section
1912 shall file with the Attorney General and the Commissioner of Public
1913 Health a written report concerning the group practice. Such report
1914 shall include, for each such group practice: (1) The names and
1915 specialties of each physician practicing medicine with the group
1916 practice; (2) the names of the business entities that provide services as
1917 part of the group practice and the address for each location where such
1918 services are provided; (3) a description of the services provided at each
1919 such location; and (4) the primary service area served by each such
1920 location.

1921 (i) Not later than December 31, 2015, and annually thereafter, each
1922 hospital and hospital system shall file with the Attorney General and
1923 the Commissioner of Public Health a written report describing each
1924 affiliation with another hospital or hospital system. Such report shall
1925 include: (1) The name and address of each party to the affiliation; (2) a
1926 description of the nature of the relationship among the parties to the

1927 affiliation; (3) the names of the business entities that provide services
1928 as part of the affiliation and the address for each location where such
1929 services are provided; (4) a description of the services provided at each
1930 such location; and (5) the primary service area served by each such
1931 location.

1932 Sec. 28. Section 19a-639 of the general statutes is repealed and the
1933 following is substituted in lieu thereof (*Effective July 1, 2015*):

1934 (a) In any deliberations involving a certificate of need application
1935 filed pursuant to section 19a-638, as amended by this act, the office
1936 shall take into consideration and make written findings concerning
1937 each of the following guidelines and principles:

1938 (1) Whether the proposed project is consistent with any applicable
1939 policies and standards adopted in regulations by the Department of
1940 Public Health;

1941 (2) The relationship of the proposed project to the state-wide health
1942 care facilities and services plan;

1943 (3) Whether there is a clear public need for the health care facility or
1944 services proposed by the applicant;

1945 (4) Whether the applicant has satisfactorily demonstrated how the
1946 proposal will impact the financial strength of the health care system in
1947 the state or that the proposal is financially feasible for the applicant;

1948 (5) Whether the applicant has satisfactorily demonstrated how the
1949 proposal will improve quality, accessibility and cost effectiveness of
1950 health care delivery in the region, including, but not limited to, (A)
1951 provision of or any change in the access to services for Medicaid
1952 recipients and indigent persons; [, and (B) the impact upon the cost
1953 effectiveness of providing access to services provided under the
1954 Medicaid program;]

1955 (6) The applicant's past and proposed provision of health care

1956 services to relevant patient populations and payer mix, including, but
1957 not limited to, access to services by Medicaid recipients and indigent
1958 persons;

1959 (7) Whether the applicant has satisfactorily identified the population
1960 to be served by the proposed project and satisfactorily demonstrated
1961 that the identified population has a need for the proposed services;

1962 (8) The utilization of existing health care facilities and health care
1963 services in the service area of the applicant;

1964 (9) Whether the applicant has satisfactorily demonstrated that the
1965 proposed project shall not result in an unnecessary duplication of
1966 existing or approved health care services or facilities;

1967 (10) Whether an applicant, who has failed to provide or reduced
1968 access to services by Medicaid recipients or indigent persons, has
1969 demonstrated good cause for doing so, which shall not be
1970 demonstrated solely on the basis of differences in reimbursement rates
1971 between Medicaid and other health care payers;

1972 (11) Whether the applicant has satisfactorily demonstrated that the
1973 proposal will not negatively impact the diversity of health care
1974 providers and patient choice in the geographic region; and

1975 (12) Whether the applicant has satisfactorily demonstrated that any
1976 consolidation resulting from the proposal will not adversely affect
1977 health care costs or accessibility to care.

1978 (b) In deliberations as described in subsection (a) of this section,
1979 there shall be a presumption in favor of approving the certificate of
1980 need application for a transfer of ownership of a large group practice,
1981 as described in subdivision (3) of subsection (a) of section 19a-638, as
1982 amended by this act, when an offer was made in response to a request
1983 for proposal or similar voluntary offer for sale.

1984 (c) The office, as it deems necessary, may revise or supplement the

1985 guidelines and principles through regulation prescribed in subsection
1986 (a) of this section.

1987 (d) (1) For purposes of this subsection and subsection (e) of this
1988 section:

1989 (A) "Affected community" means a municipality where a hospital is
1990 physically located or a municipality whose inhabitants are regularly
1991 served by a hospital;

1992 (B) "Hospital" has the same meaning as provided in section 19a-490;

1993 (C) "New hospital" means a hospital as it exists after the approval of
1994 an agreement pursuant to section 19a-486b, as amended by this act, or
1995 a certificate of need application for a transfer of ownership of a
1996 hospital;

1997 (D) "Purchaser" means a person who is acquiring, or has acquired,
1998 any assets of a hospital through a transfer of ownership of a hospital;

1999 (E) "Transacting party" means a purchaser and any person who is a
2000 party to a proposed agreement for transfer of ownership of a hospital;

2001 (F) "Transfer" means to sell, transfer, lease, exchange, option,
2002 convey, give or otherwise dispose of or transfer control over,
2003 including, but not limited to, transfer by way of merger or joint
2004 venture not in the ordinary course of business; and

2005 (G) "Transfer of ownership of a hospital" means a transfer that
2006 impacts or changes the governance or controlling body of a hospital,
2007 including, but not limited to, all affiliations, mergers or any sale or
2008 transfer of net assets of a hospital and for which a certificate of need
2009 application or a certificate of need determination letter is filed on or
2010 after December 1, 2015.

2011 (2) In any deliberations involving a certificate of need application
2012 filed pursuant to section 19a-638, as amended by this act, that involves

2013 the transfer of ownership of a hospital, the office shall, in addition to
2014 the guidelines and principles set forth in subsection (a) of this section
2015 and those prescribed through regulation pursuant to subsection (c) of
2016 this section, take into consideration and make written findings
2017 concerning each of the following guidelines and principles:

2018 (A) Whether the applicant fairly considered alternative proposals or
2019 offers in light of the purpose of maintaining health care provider
2020 diversity and consumer choice in the health care market and access to
2021 affordable quality health care for the affected community; and

2022 (B) Whether the plan submitted pursuant to section 19a-639a, as
2023 amended by this act, demonstrates, in a manner consistent with this
2024 chapter, how health care services will be provided by the new hospital
2025 for the first three years following the transfer of ownership of the
2026 hospital, including any consolidation, reduction, elimination or
2027 expansion of existing services or introduction of new services.

2028 (3) The office shall deny any certificate of need application involving
2029 a transfer of ownership of a hospital unless the commissioner finds
2030 that the affected community will be assured of continued access to
2031 high quality and affordable health care after accounting for any
2032 proposed change impacting hospital staffing.

2033 (4) The office may deny any certificate of need application involving
2034 a transfer of ownership of a hospital subject to a cost and market
2035 impact review pursuant to section 29 of this act if the commissioner
2036 finds that (A) the affected community will not be assured of continued
2037 access to high quality and affordable health care after accounting for
2038 any consolidation in the hospital and health care market that may
2039 lessen health care provider diversity, consumer choice and access to
2040 care, and (B) any likely increases in the prices for health care services
2041 or total health care spending in the state may negatively impact the
2042 affordability of care.

2043 (5) The office may place any conditions on the approval of a

2044 certificate of need application involving a transfer of ownership of a
2045 hospital consistent with the provisions of this chapter. Before placing
2046 any such conditions, the office shall weigh the value of such conditions
2047 in promoting the purposes of this chapter against the individual and
2048 cumulative burden of such conditions on the transacting parties and
2049 the new hospital. For each condition imposed, the office shall include a
2050 concise statement of the legal and factual basis for such condition and
2051 the provision or provisions of this chapter that it is intended to
2052 promote. Each condition shall be reasonably tailored in time and
2053 scope. The transacting parties or the new hospital shall have the right
2054 to make a request to the office for an amendment to, or relief from, any
2055 condition based on changed circumstances, hardship or for other good
2056 cause.

2057 (e) (1) If the certificate of need application (A) involves the transfer
2058 of ownership of a hospital, (B) the purchaser is a hospital, as defined in
2059 section 19a-490, whether located within or outside the state, that had
2060 net patient revenue for fiscal year 2013 in an amount greater than one
2061 billion five hundred million dollars or a hospital system, as defined in
2062 section 19a-486i, as amended by this act, whether located within or
2063 outside the state, that had net patient revenue for fiscal year 2013 in an
2064 amount greater than one billion five hundred million dollars, or any
2065 person that is organized or operated for profit, and (D) such
2066 application is approved, the office shall hire an independent consultant
2067 to serve as a post-transfer compliance reporter for a period of three
2068 years after completion of the transfer of ownership of the hospital.
2069 Such reporter shall, at a minimum: (i) Meet with representatives of the
2070 purchaser, the new hospital and members of the affected community
2071 served by the new hospital not less than quarterly; and (ii) report to
2072 the office not less than quarterly concerning (I) efforts the purchaser
2073 and representatives of the new hospital have taken to comply with any
2074 conditions the office placed on the approval of the certificate of need
2075 application and plans for future compliance, and (II) community
2076 benefits and uncompensated care provided by the new hospital. The
2077 purchaser shall give the reporter access to its records and facilities for

2078 the purposes of carrying out the reporter's duties. The purchaser shall
2079 hold a public hearing in the municipality in which the new hospital is
2080 located not less than annually during the reporting period to provide
2081 for public review and comment on the reporter's reports and findings.

2082 (2) If the reporter finds that the purchaser has breached a condition
2083 of the approval of the certificate of need application, the office may, in
2084 consultation with the purchaser, the reporter and any other interested
2085 parties it deems appropriate, implement a performance improvement
2086 plan designed to remedy the conditions identified by the reporter and
2087 continue the reporting period for up to one year following a
2088 determination by the office that such conditions have been resolved.

2089 (3) The purchaser shall provide funds, in an amount determined by
2090 the office not to exceed two hundred thousand dollars annually, for
2091 the hiring of the post-transfer compliance reporter.

2092 (f) Nothing in subsection (d) or (e) of this section shall apply to a
2093 transfer of ownership of a hospital in which either a certificate of need
2094 application is filed on or before December 1, 2015, or where a
2095 certificate of need determination letter is filed on or before December 1,
2096 2015.

2097 Sec. 29. (NEW) (*Effective July 1, 2015*) (a) The Office of Healthcare
2098 Access division within the Department of Public Health shall conduct
2099 a cost and market impact review in each case where (1) an application
2100 for a certificate of need filed pursuant to section 19a-638 of the general
2101 statutes, as amended by this act, involves the transfer of ownership of
2102 a hospital, as defined in section 19a-639 of the general statutes, as
2103 amended by this act, and (2) the purchaser is a hospital, as defined in
2104 section 19a-490 of the general statutes, whether located within or
2105 outside the state, that had net patient revenue for fiscal year 2013 in an
2106 amount greater than one billion five hundred million dollars, or a
2107 hospital system, as defined in section 19a-486i of the general statutes,
2108 as amended by this act, whether located within or outside the state,
2109 that had net patient revenue for fiscal year 2013 in an amount greater

2110 than one billion five hundred million dollars or any person that is
2111 organized or operated for profit.

2112 (b) Not later than twenty-one days after receipt of a properly filed
2113 certificate of need application involving the transfer of ownership of a
2114 hospital filed on or after December 1, 2015, as described in subsection
2115 (a) of this section, the office shall initiate such cost and market impact
2116 review by sending the transacting parties a written notice that shall
2117 contain a description of the basis for the cost and market impact
2118 review as well as a request for information and documents. Not later
2119 than thirty days after receipt of such notice, the transacting parties
2120 shall submit to the office a written response. Such response shall
2121 include, but need not be limited to, any information or documents
2122 requested by the office concerning the transfer of ownership of the
2123 hospital. The office shall have the powers with respect to the cost and
2124 market impact review as provided in section 19a-633 of the general
2125 statutes.

2126 (c) The office shall keep confidential all nonpublic information and
2127 documents obtained pursuant to this section and shall not disclose the
2128 information or documents to any person without the consent of the
2129 person that produced the information or documents, except in a
2130 preliminary report or final report issued in accordance with this
2131 section if the office believes that such disclosure should be made in the
2132 public interest after taking into account any privacy, trade secret or
2133 anti-competitive considerations. Such information and documents
2134 shall not be deemed a public record, under section 1-210 of the general
2135 statutes, and shall be exempt from disclosure.

2136 (d) The cost and market impact review conducted pursuant to this
2137 section shall examine factors relating to the businesses and relative
2138 market positions of the transacting parties as defined in subsection (d)
2139 of section 19a-639 of the general statutes, as amended by this act, and
2140 may include, but need not be limited to: (1) The transacting parties'
2141 size and market share within its primary service area, by major service
2142 category and within its dispersed service areas; (2) the transacting

2143 parties' prices for services, including the transacting parties' relative
2144 prices compared to other health care providers for the same services in
2145 the same market; (3) the transacting parties' health status adjusted total
2146 medical expense, including the transacting parties' health status
2147 adjusted total medical expense compared to that of similar health care
2148 providers; (4) the quality of the services provided by the transacting
2149 parties, including patient experience; (5) the transacting parties' cost
2150 and cost trends in comparison to total health care expenditures state
2151 wide; (6) the availability and accessibility of services similar to those
2152 provided by each transacting party, or proposed to be provided as a
2153 result of the transfer of ownership of a hospital within each transacting
2154 party's primary service areas and dispersed service areas; (7) the
2155 impact of the proposed transfer of ownership of the hospital on
2156 competing options for the delivery of health care services within each
2157 transacting party's primary service area and dispersed service area
2158 including the impact on existing service providers; (8) the methods
2159 used by the transacting parties to attract patient volume and to recruit
2160 or acquire health care professionals or facilities; (9) the role of each
2161 transacting party in serving at-risk, underserved and government
2162 payer patient populations, including those with behavioral, substance
2163 use disorder and mental health conditions, within each transacting
2164 party's primary service area and dispersed service area; (10) the role of
2165 each transacting party in providing low margin or negative margin
2166 services within each transacting party's primary service area and
2167 dispersed service area; (11) consumer concerns, including, but not
2168 limited to, complaints or other allegations that a transacting party has
2169 engaged in any unfair method of competition or any unfair or
2170 deceptive act or practice; and (12) any other factors that the office
2171 determines to be in the public interest.

2172 (e) Not later than ninety days after the office determines that there is
2173 substantial compliance with any request for documents or information
2174 issued by the office in accordance with this section, or a later date set
2175 by mutual agreement of the office and the transacting parties, the
2176 office shall make factual findings and issue a preliminary report on the

2177 cost and market impact review. Such preliminary report shall include,
2178 but shall not be limited to, an indication as to whether a transacting
2179 party meets the following criteria: (1) Currently has or, following the
2180 proposed transfer of operations of the hospital, is likely to have a
2181 dominant market share for the services the transacting party provides;
2182 and (2) (A) currently charges or, following the proposed transfer of
2183 operations of the hospital, is likely to charge prices for services that are
2184 materially higher than the median prices charged by all other health
2185 care providers for the same services in the same market, or (B)
2186 currently has or, following the proposed transfer of operations of a
2187 hospital, is likely to have a health status adjusted total medical expense
2188 that is materially higher than the median total medical expense for all
2189 other health care providers for the same service in the same market.

2190 (f) The transacting parties that are the subject of the cost and market
2191 impact review may respond in writing to the findings in the
2192 preliminary report issued in accordance with subsection (e) of this
2193 section not later than thirty days after the issuance of the preliminary
2194 report. Not later than sixty days after the issuance of the preliminary
2195 report, the office shall issue a final report of the cost and market impact
2196 review. The office shall refer to the Attorney General any final report
2197 on any proposed transfer of ownership that meets the criteria
2198 described in subsection (e) of this section.

2199 (g) Nothing in this section shall prohibit a transfer of ownership of a
2200 hospital, provided any such proposed transfer shall not be completed
2201 (1) less than thirty days after the office has issued a final report on a
2202 cost and market impact review, if such review is required, or (2) while
2203 any action brought by the Attorney General pursuant to subsection (h)
2204 of this section is pending and before a final judgment on such action is
2205 issued by a court of competent jurisdiction.

2206 (h) After the office refers a final report on a transfer of ownership of
2207 a hospital to the Attorney General under subsection (f) of this section,
2208 the Attorney General may: (1) Conduct an investigation to determine
2209 whether the transacting parties engaged, or, as a result of completing

2210 the transfer of ownership of the hospital, are expected to engage in
2211 unfair methods of competition, anti-competitive behavior or other
2212 conduct in violation of chapter 624 or 735a of the general statutes or
2213 any other state or federal law; and (2) if appropriate, take action under
2214 chapter 624 or 735a of the general statutes or any other state law to
2215 protect consumers in the health care market. The office's final report
2216 may be evidence in any such action.

2217 (i) For the purposes of this section, the provisions of chapter 735a of
2218 the general statutes may be directly enforced by the Attorney General.
2219 Nothing in this section shall be construed to modify, impair or
2220 supersede the operation of any state antitrust law or otherwise limit
2221 the authority of the Attorney General to (1) take any action against a
2222 transacting party as authorized by any law, or (2) protect consumers in
2223 the health care market under any law. Notwithstanding subdivision (1)
2224 of subsection (a) of section 42-110c of the general statutes, the
2225 transacting parties shall be subject to chapter 735a of the general
2226 statutes.

2227 (j) The office shall retain an independent consultant with expertise
2228 on the economic analysis of the health care market and health care
2229 costs and prices to conduct each cost and market impact review, as
2230 described in this section. The office shall submit bills for such services
2231 to the purchaser, as defined in subsection (d) of section 19a-639 of the
2232 general statutes, as amended by this act. Such purchaser shall pay such
2233 bills not later than thirty days after receipt. Such bills shall not exceed
2234 two hundred thousand dollars per application. The provisions of
2235 chapter 57 of the general statutes, sections 4-212 to 4-219, inclusive, of
2236 the general statutes and section 4e-19 of the general statutes shall not
2237 apply to any agreement executed pursuant to this subsection.

2238 (k) Any employee of the office who directly oversees or assists in
2239 conducting a cost and market impact review shall not take part in
2240 factual deliberations or the issuance of a preliminary or final decision
2241 on the certificate of need application concerning the transfer of
2242 ownership of a hospital that is the subject of such cost and market

2243 impact review.

2244 (l) The Commissioner of Public Health shall adopt regulations, in
2245 accordance with the provisions of chapter 54 of the general statutes,
2246 concerning cost and market impact reviews and to administer the
2247 provisions of this section. Such regulations shall include definitions of
2248 the following terms: "Dispersed service area", "health status adjusted
2249 total medical expense", "major service category", "relative prices", "total
2250 health care spending" and "health care services". The commissioner
2251 may implement policies and procedures necessary to administer the
2252 provisions of this section while in the process of adopting such policies
2253 and procedures in regulation form, provided the commissioner
2254 publishes notice of intention to adopt the regulations on the
2255 Department of Public Health's Internet web site and the eRegulations
2256 System not later than twenty days after implementing such policies
2257 and procedures. Policies and procedures implemented pursuant to this
2258 subsection shall be valid until the time such regulations are effective.

2259 Sec. 30. Subsections (c) to (g), inclusive, of section 19a-639a of the
2260 general statutes are repealed and the following is substituted in lieu
2261 thereof (*Effective July 1, 2015*):

2262 (c) (1) Not later than five business days after receipt of a properly
2263 filed certificate of need application, the office shall publish notice of the
2264 application on its web site. Not later than thirty days after the date of
2265 filing of the application, the office may request such additional
2266 information as the office determines necessary to complete the
2267 application. In addition to any information requested by the office, if
2268 the application involves the transfer of ownership of a hospital, as
2269 defined in section 19a-639, as amended by this act, the applicant shall
2270 submit to the office (A) a plan demonstrating how health care services
2271 will be provided by the new hospital for the first three years following
2272 the transfer of ownership of the hospital, including any consolidation,
2273 reduction, elimination or expansion of existing services or introduction
2274 of new services, and (B) the names of persons currently holding a
2275 position with the hospital to be purchased or the purchaser, as defined

2276 in section 19a-639, as amended by this act, as an officer, director, board
2277 member or senior manager, whether or not such person is expected to
2278 hold a position with the hospital after completion of the transfer of
2279 ownership of the hospital and any salary, severance, stock offering or
2280 any financial gain, current or deferred, such person is expected to
2281 receive as a result of, or in relation to, the transfer of ownership of the
2282 hospital.

2283 (2) The applicant shall, not later than sixty days after the date of the
2284 office's request, submit [the] any requested information and any
2285 information required under this subsection to the office. If an applicant
2286 fails to submit [the requested] such information to the office within the
2287 sixty-day period, the office shall consider the application to have been
2288 withdrawn.

2289 (d) Upon determining that an application is complete, the office
2290 shall provide notice of this determination to the applicant and to the
2291 public in accordance with regulations adopted by the department. In
2292 addition, the office shall post such notice on its web site. The date on
2293 which the office posts such notice on its web site shall begin the review
2294 period. Except as provided in this subsection, (1) the review period for
2295 a completed application shall be ninety days from the date on which
2296 the office posts such notice on its web site; and (2) the office shall issue
2297 a decision on a completed application prior to the expiration of the
2298 ninety-day review period. The review period for a completed
2299 application that involves a transfer of a large group practice, as
2300 described in subdivision (3) of subsection (a) of section 19a-638, as
2301 amended by this act, when the offer was made in response to a request
2302 for proposal or similar voluntary offer for sale shall be sixty days from
2303 the date on which the office posts notice on its web site. Upon request
2304 or for good cause shown, the office may extend the review period for a
2305 period of time not to exceed sixty days. If the review period is
2306 extended, the office shall issue a decision on the completed application
2307 prior to the expiration of the extended review period. If the office
2308 holds a public hearing concerning a completed application in

2309 accordance with subsection (e) or (f) of this section, the office shall
2310 issue a decision on the completed application not later than sixty days
2311 after the date the office closes the public hearing record.

2312 (e) Except as provided in this subsection, the office shall hold a
2313 public hearing on a properly filed and completed certificate of need
2314 application if three or more individuals or an individual representing
2315 an entity with five or more people submits a request, in writing, that a
2316 public hearing be held on the application. For a properly filed and
2317 completed certificate of need application involving a transfer of
2318 ownership of a large group practice, as described in subdivision (3) of
2319 subsection (a) of section 19a-638, as amended by this act, when an offer
2320 was made in response to a request for proposal or similar voluntary
2321 offer for sale, a public hearing shall be held if twenty-five or more
2322 individuals or an individual representing twenty-five or more people
2323 submits a request, in writing, that a public hearing be held on the
2324 application. Any request for a public hearing shall be made to the
2325 office not later than thirty days after the date the office determines the
2326 application to be complete.

2327 (f) (1) The office shall hold a public hearing with respect to each
2328 certificate of need application filed pursuant to section 19a-638, as
2329 amended by this act, after December 1, 2015, that concerns any transfer
2330 of ownership involving a hospital. Such hearing shall be held in the
2331 municipality in which the hospital that is the subject of the application
2332 is located.

2333 [(f)] (2) The office may hold a public hearing with respect to any
2334 certificate of need application submitted under this chapter. The office
2335 shall provide not less than two weeks' advance notice to the applicant,
2336 in writing, and to the public by publication in a newspaper having a
2337 substantial circulation in the area served by the health care facility or
2338 provider. In conducting its activities under this chapter, the office may
2339 hold hearing on applications of a similar nature at the same time.

2340 (g) The Commissioner of Public Health may implement policies and

2341 procedures necessary to administer the provisions of this section while
2342 in the process of adopting such policies and procedures as regulation,
2343 provided the commissioner holds a public hearing prior to
2344 implementing the policies and procedures and prints notice of intent to
2345 adopt regulations [in the Connecticut Law Journal] on the
2346 department's Internet web site and the eRegulations System not later
2347 than twenty days after the date of implementation. Policies and
2348 procedures implemented pursuant to this section shall be valid until
2349 the time final regulations are adopted. [Final regulations shall be
2350 adopted by December 31, 2011.]

2351 Sec. 31. Subsection (c) of section 19a-486a of the general statutes is
2352 repealed and the following is substituted in lieu thereof (*Effective July*
2353 *1, 2015*):

2354 (c) Not later than thirty days after receipt of the certificate of need
2355 determination letter by the commissioner and the Attorney General,
2356 the purchaser and the nonprofit hospital shall hold a hearing on the
2357 contents of the certificate of need determination letter in the
2358 municipality in which the new hospital is proposed to be located. The
2359 nonprofit hospital shall provide not less than two weeks' advance
2360 notice of the hearing to the public by publication in a newspaper
2361 having a substantial circulation in the affected community for not less
2362 than three consecutive days. Such notice shall contain substantially the
2363 same information as in the certificate of need determination letter. The
2364 purchaser and the nonprofit hospital shall record and transcribe the
2365 hearing and make such recording or transcription available to the
2366 commissioner, the Attorney General or members of the public upon
2367 request. A public hearing held in accordance with the provisions of
2368 section 19a-639a, as amended by this act, shall satisfy the requirements
2369 of this subsection.

2370 Sec. 32. Subsection (a) of section 19a-486d of the general statutes is
2371 repealed and the following is substituted in lieu thereof (*Effective July*
2372 *1, 2015*):

2373 (a) The commissioner shall deny an application filed pursuant to
2374 subsection (d) of section 19a-486a, as amended by this act, unless the
2375 commissioner finds that: (1) [The affected community will be assured
2376 of continued access to high quality and affordable health care after
2377 accounting for any proposed change impacting hospital staffing; (2)] in
2378 a situation where the asset or operation to be transferred provides or
2379 has provided health care services to the uninsured or underinsured,
2380 the purchaser has made a commitment to provide health care to the
2381 uninsured and the underinsured; [(3)] (2) in a situation where health
2382 care providers or insurers will be offered the opportunity to invest or
2383 own an interest in the purchaser or an entity related to the purchaser
2384 safeguard procedures are in place to avoid a conflict of interest in
2385 patient referral; and [(4)] (3) certificate of need authorization is justified
2386 in accordance with chapter 368z. The commissioner may contract with
2387 any person, including, but not limited to, financial or actuarial experts
2388 or consultants, or legal experts with the approval of the Attorney
2389 General, to assist in reviewing the completed application. The
2390 commissioner shall submit any bills for such contracts to the
2391 purchaser. Such bills shall not exceed one hundred fifty thousand
2392 dollars. The purchaser shall pay such bills no later than thirty days
2393 after the date of receipt of such bills.

2394 Sec. 33. Section 19a-644 of the general statutes is repealed and the
2395 following is substituted in lieu thereof (*Effective July 1, 2015*):

2396 (a) On or before February twenty-eighth annually, for the fiscal year
2397 ending on September thirtieth of the immediately preceding year, each
2398 short-term acute care general or children's hospital shall report to the
2399 office with respect to its operations in such fiscal year, in such form as
2400 the office may by regulation require. Such report shall include: (1)
2401 Salaries and fringe benefits for the ten highest paid [positions] hospital
2402 and health system employees; (2) the name of each joint venture,
2403 partnership, subsidiary and corporation related to the hospital; and (3)
2404 the salaries paid to hospital and health system employees by each such
2405 joint venture, partnership, subsidiary and related corporation and by

2406 the hospital to the employees of related corporations. For purposes of
2407 this subsection, "health system" has the same meaning as provided in
2408 section 33-182aa.

2409 (b) The Department of Public Health shall adopt regulations in
2410 accordance with chapter 54 to provide for the collection of data and
2411 information in addition to the annual report required in subsection (a)
2412 of this section. Such regulations shall provide for the submission of
2413 information about the operations of the following entities: Persons or
2414 parent corporations that own or control the health care facility,
2415 institution or provider; corporations, including limited liability
2416 corporations, in which the health care facility, institution, provider, its
2417 parent, any type of affiliate or any combination thereof, owns more
2418 than an aggregate of fifty per cent of the stock or, in the case of
2419 nonstock corporations, is the sole member; and any partnerships in
2420 which the person, health care facility, institution, provider, its parent
2421 or an affiliate or any combination thereof, or any combination of health
2422 care providers or related persons, owns a greater than fifty per cent
2423 interest. For purposes of this section, "affiliate" means any person that
2424 directly or indirectly through one or more intermediaries, controls or is
2425 controlled by or is under common control with any health care facility,
2426 institution, provider or person that is regulated in any way under this
2427 chapter. A person is deemed controlled by another person if the other
2428 person, or one of that other person's affiliates, officers, agents or
2429 management employees, acts as a general partner or manager of the
2430 person in question.

2431 (c) Each nonprofit short-term acute care general or children's
2432 hospital shall include in the annual report required pursuant to
2433 subsection (a) of this section a report of all transfers of assets, transfers
2434 of operations or changes of control involving its clinical or nonclinical
2435 services or functions from such hospital to a person or entity organized
2436 or operated for profit.

2437 (d) Each hospital that is a party to a transfer of ownership involving
2438 a hospital for which a certificate of need application was filed and

2439 approved pursuant to chapter 368z shall, during the fiscal year ending
2440 on September thirtieth of the immediately preceding year, include in
2441 the annual report required pursuant to subsection (a) of this section
2442 any salary, severance payment, stock offering or other financial gain
2443 realized by each officer, director, board member or senior manager of
2444 the hospital as a result of such transaction.

2445 [(d)] (e) The office shall require each hospital licensed by the
2446 Department of Public Health, that is not subject to the provisions of
2447 subsection (a) of this section, to report to said office on its operations in
2448 the preceding fiscal year by filing copies of the hospital's audited
2449 financial statements. Such report shall be due at the office on or before
2450 the close of business on the last business day of the fifth month
2451 following the month in which a hospital's fiscal year ends.

2452 Sec. 34. (Effective July 1, 2015) Not later than January 1, 2016, the
2453 Commissioner of Public Health shall report, in accordance with the
2454 provisions of section 11-4a of the general statutes and within available
2455 appropriations, to the joint standing committee of the General
2456 Assembly having cognizance of matters relating to public health
2457 concerning certificate of need requirements under chapter 368z of the
2458 general statutes. Such report shall include, but need not be limited to,
2459 recommendations (1) to eliminate the requirements to obtain certificate
2460 of need approval or to create an expedited approval process for certain
2461 services, equipment purchases and ownership transfers or other
2462 matters for which such approval is currently required under section
2463 19a-638 of the general statutes, as amended by this act, such as, for
2464 example: (A) Ancillary capital expenditures not related to direct
2465 patient care or services; (B) replacement of outdated or damaged
2466 equipment, the purchase of which was previously approved by the
2467 office; (C) repairs to facilities damaged by floods, storms or other
2468 unexpected occurrences; and (D) facility improvements necessary to
2469 comply with building codes or other legal requirements, and (2)
2470 concerning an expedited automatic approval of certain certificate of
2471 need applications in circumstances where the Department of Public

2472 Health does not notify the applicant within thirty days of its intent to
2473 review such application.

2474 Sec. 35. Section 19a-486b of the general statutes is repealed and the
2475 following is substituted in lieu thereof (*Effective July 1, 2015*):

2476 (a) Not later than one hundred twenty days after the date of receipt
2477 of the completed application pursuant to subsection (d) of section 19a-
2478 486a, the Attorney General and the commissioner shall approve the
2479 application, with or without modification, or deny the application. The
2480 commissioner shall also determine, in accordance with the provisions
2481 of chapter 368z, whether to approve, with or without modification, or
2482 deny the application for a certificate of need that is part of the
2483 completed application. Notwithstanding the provisions of section 19a-
2484 639a, as amended by this act, the commissioner shall complete the
2485 decision on the application for a certificate of need within the same
2486 time period as the completed application. Such one-hundred-twenty-
2487 day period may be extended by (1) agreement of the Attorney General,
2488 the commissioner, the nonprofit hospital and the purchaser, or (2) the
2489 commissioner for an additional one hundred twenty days pending
2490 completion of a cost and market impact review conducted pursuant to
2491 section 29 of this act. If the Attorney General initiates a proceeding to
2492 enforce a subpoena pursuant to section 19a-486c or 19a-486d, as
2493 amended by this act, the one-hundred-twenty-day period shall be
2494 tolled until the final court decision on the last pending enforcement
2495 proceeding, including any appeal or time for the filing of such appeal.
2496 Unless the one-hundred-twenty-day period is extended pursuant to
2497 this section, if the commissioner and Attorney General fail to take
2498 action on an agreement prior to the one hundred twenty-first day after
2499 the date of the filing of the completed application, the application shall
2500 be deemed approved.

2501 (b) The commissioner and the Attorney General may place any
2502 conditions on the approval of an application that relate to the purposes
2503 of sections 19a-486a to 19a-486h, inclusive, as amended by this act. In
2504 placing any such conditions the commissioner shall follow the

2505 guidelines and criteria described in subdivision (4) of subsection (d) of
2506 section 19a-639, as amended by this act. Any such conditions may be in
2507 addition to any conditions placed by the commissioner pursuant to
2508 subdivision (4) of subsection (d) of section 19a-639, as amended by this
2509 act.

2510 Sec. 36. Subdivisions (10) to (16), inclusive, of section 19a-630 of the
2511 general statutes are repealed and the following is substituted in lieu
2512 thereof (*Effective July 1, 2015*):

2513 (10) ["Group practice"] "Large group practice" means eight or more
2514 full-time equivalent physicians, legally organized in a partnership,
2515 professional corporation, limited liability company formed to render
2516 professional services, medical foundation, not-for-profit corporation,
2517 faculty practice plan or other similar entity (A) in which each physician
2518 who is a member of the group provides substantially the full range of
2519 services that the physician routinely provides, including, but not
2520 limited to, medical care, consultation, diagnosis or treatment, through
2521 the joint use of shared office space, facilities, equipment or personnel;
2522 (B) for which substantially all of the services of the physicians who are
2523 members of the group are provided through the group and are billed
2524 in the name of the group practice and amounts so received are treated
2525 as receipts of the group; or (C) in which the overhead expenses of, and
2526 the income from, the group are distributed in accordance with
2527 methods previously determined by members of the group. An entity
2528 that otherwise meets the definition of group practice under this section
2529 shall be considered a group practice although its shareholders,
2530 partners or owners of the group practice include single-physician
2531 professional corporations, limited liability companies formed to render
2532 professional services or other entities in which beneficial owners are
2533 individual physicians.

2534 (11) "Health care facility" means (A) hospitals licensed by the
2535 Department of Public Health under chapter 368v; (B) specialty
2536 hospitals; (C) freestanding emergency departments; (D) outpatient
2537 surgical facilities, as defined in section 19a-493b and licensed under

2538 chapter 368v; (E) a hospital or other facility or institution operated by
2539 the state that provides services that are eligible for reimbursement
2540 under Title XVIII or XIX of the federal Social Security Act, 42 USC 301,
2541 as amended; (F) a central service facility; (G) mental health facilities;
2542 (H) substance abuse treatment facilities; and (I) any other facility
2543 requiring certificate of need review pursuant to subsection (a) of
2544 section 19a-638, as amended by this act. "Health care facility" includes
2545 any parent company, subsidiary, affiliate or joint venture, or any
2546 combination thereof, of any such facility.

2547 (12) "Nonhospital based" means located at a site other than the main
2548 campus of the hospital.

2549 (13) "Office" means the Office of Health Care Access division within
2550 the Department of Public Health.

2551 (14) "Person" means any individual, partnership, corporation,
2552 limited liability company, association, governmental subdivision,
2553 agency or public or private organization of any character, but does not
2554 include the agency conducting the proceeding.

2555 (15) "Physician" has the same meaning as provided in section 20-
2556 13a.

2557 (16) "Transfer of ownership" means a transfer that impacts or
2558 changes the governance or controlling body of a health care facility,
2559 institution or large group practice, including, but not limited to, all
2560 affiliations, mergers or any sale or transfer of net assets of a health care
2561 facility.

2562 Sec. 37. Subdivision (3) of subsection (a) of section 19a-638 of the
2563 general statutes is repealed and the following is substituted in lieu
2564 thereof (*Effective July 1, 2015*):

2565 (3) A transfer of ownership of a large group practice to any entity
2566 other than a (A) physician, or (B) group of [physicians, except when
2567 the parties have signed a sale agreement to transfer such ownership on

2568 or before September 1, 2014] two or more physicians, legally organized
2569 in a partnership, professional corporation or limited liability company
2570 formed to render professional services and not employed by or an
2571 affiliate of any hospital, medical foundation, insurance company or
2572 other similar entity;

2573 Sec. 38. (*Effective from passage*) (a) The chairperson of the board of
2574 directors of the State of Connecticut Health and Educational Facilities
2575 Authority, established pursuant to section 10a-179 of the general
2576 statutes, in consultation with the Commissioner of Economic and
2577 Community Development and the Office of Health Care Access, shall
2578 consider financing options to enable community hospitals to acquire
2579 medical equipment, update information technology, renovate or
2580 acquire health care facilities, build new health care facilities and
2581 engage in other activities for the purposes of: (1) Improving the ability
2582 of community hospitals to effectively serve members of the
2583 community, including, but not limited to, (A) enhancing care
2584 coordination, (B) advancing the integration of health care services,
2585 including behavioral health services, (C) promoting evidence-based
2586 care practices and efficient health care delivery, and (D) providing
2587 culturally and linguistically appropriate health care services to
2588 members of the community served by the hospital; (2) advancing
2589 hospitals' adoption of health information technology, including the
2590 adoption of interoperable electronic health records systems and clinical
2591 support tools; (3) facilitating the ability of hospitals and other health
2592 care providers to exchange health information electronically to ensure
2593 a continuity of care among all health care providers; (4) supporting
2594 infrastructure investments in health care facilities that are necessary for
2595 (A) the transition to alternative payment methodologies, including
2596 investments in data analysis functions and performance management
2597 programs to promote price transparency for health care services, and
2598 (B) aggregation and analysis of clinical data to facilitate appropriate,
2599 evidence-based intervention and care management practices,
2600 especially for vulnerable populations and persons with complex health
2601 care needs; (5) improving the affordability and quality of health care,

2602 by increasing coordination between hospitals and community-based
2603 health care providers and other community organizations; (6)
2604 improving access to health care services, including behavioral health
2605 services; and (7) ensuring staff-to-patient ratios are sufficient to deliver
2606 high quality health care.

2607 (b) Not later than January 1, 2016, said chairperson shall report, in
2608 accordance with the provisions of section 11-4a of the general statutes,
2609 to the joint standing committees of the General Assembly having
2610 cognizance of matters relating to public health and commerce
2611 concerning such study. Such report shall include, but need not be
2612 limited to, (1) to the extent practicable, a capital needs assessment for
2613 community hospitals; and (2) recommendations concerning (A)
2614 methods to finance improvements currently needed by community
2615 hospitals in the state to fulfill the purposes described in subsection (a)
2616 of this section, including, but not limited to, the use of bond funds,
2617 alternative funding methods and the establishment of a program to
2618 provide low-interest or no-interest loans to community hospitals, (B)
2619 other state programs that may be utilized to support community
2620 hospital improvements, and (C) legislative or regulatory changes that
2621 may be needed to accomplish the purposes described in subsection (a)
2622 of this section. For purposes of this subsection, "community hospital"
2623 means: (i) A hospital that is not a teaching hospital and has twenty-five
2624 or fewer full-time equivalent interns or residents for each one hundred
2625 inpatient beds; (ii) a hospital that charges less for health care services
2626 than the state median prices for those health care services; (iii) a
2627 nonprofit hospital; and (iv) a hospital that is not part of a hospital
2628 system, as defined in section 19a-486i of the general statutes, as
2629 amended by this act.

2630 Sec. 39. Subdivision (10) of subsection (a) of section 19a-638 of the
2631 general statutes is repealed and the following is substituted in lieu
2632 thereof (*Effective July 1, 2015*):

2633 (10) The acquisition of computed tomography scanners, magnetic
2634 resonance imaging scanners, positron emission tomography scanners

2635 or positron emission tomography-computed tomography scanners, by
 2636 any person, physician, provider, short-term acute care general hospital
 2637 or children's hospital, except (A) as provided for in subdivision (22) of
 2638 subsection (b) of this section, and (B) a certificate of need issued by the
 2639 office shall not be required where such scanner is a replacement for a
 2640 scanner that was previously acquired through certificate of need
 2641 approval or a certificate of need determination;

2642 Sec. 40. Subsection (d) of section 19a-644 of the general statutes is
 2643 repealed and the following is substituted in lieu thereof (*Effective July*
 2644 *1, 2015*):

2645 (d) The office shall require each hospital licensed by the Department
 2646 of Public Health, that is not subject to the provisions of subsection (a)
 2647 of this section, to report to said office on its operations in the preceding
 2648 fiscal year by filing copies of the hospital's audited financial
 2649 statements, except a health system, as defined in section 19a-508c, may
 2650 submit to the office one such report that includes the audited financial
 2651 statements for each of its hospitals. Such report shall be due at the
 2652 office on or before the close of business on the last business day of the
 2653 fifth month following the month in which a hospital's fiscal year ends.

2654 Sec. 41. Section 19a-25d of the general statutes is repealed. (*Effective*
 2655 *October 1, 2015*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2015	38a-1084
Sec. 2	October 1, 2015	New section
Sec. 3	October 1, 2015	New section
Sec. 4	October 1, 2015	New section
Sec. 5	October 1, 2015	New section
Sec. 6	October 1, 2015	New section
Sec. 7	January 1, 2016	New section
Sec. 8	July 1, 2016	38a-591
Sec. 9	July 1, 2016	New section
Sec. 10	July 1, 2016	38a-591b(d)

Sec. 11	<i>July 1, 2016</i>	20-7f
Sec. 12	<i>July 1, 2016</i>	38a-193(c)(3)
Sec. 13	<i>October 1, 2015</i>	19a-508c
Sec. 14	<i>October 1, 2015</i>	New section
Sec. 15	<i>October 1, 2015</i>	New section
Sec. 16	<i>October 1, 2015</i>	38a-1084
Sec. 17	<i>from passage</i>	New section
Sec. 18	<i>July 1, 2015</i>	19a-725
Sec. 19	<i>July 1, 2015</i>	New section
Sec. 20	<i>October 1, 2015</i>	New section
Sec. 21	<i>from passage</i>	New section
Sec. 22	<i>from passage</i>	New section
Sec. 23	<i>July 1, 2015</i>	4-60i
Sec. 24	<i>October 1, 2015</i>	New section
Sec. 25	<i>July 1, 2015</i>	New section
Sec. 26	<i>October 1, 2015</i>	4-60j
Sec. 27	<i>October 1, 2015</i>	19a-486i
Sec. 28	<i>July 1, 2015</i>	19a-639
Sec. 29	<i>July 1, 2015</i>	New section
Sec. 30	<i>July 1, 2015</i>	19a-639a(c) to (g)
Sec. 31	<i>July 1, 2015</i>	19a-486a(c)
Sec. 32	<i>July 1, 2015</i>	19a-486d(a)
Sec. 33	<i>July 1, 2015</i>	19a-644
Sec. 34	<i>July 1, 2015</i>	New section
Sec. 35	<i>July 1, 2015</i>	19a-486b
Sec. 36	<i>July 1, 2015</i>	19a-630(10) to (16)
Sec. 37	<i>July 1, 2015</i>	19a-638(a)(3)
Sec. 38	<i>from passage</i>	New section
Sec. 39	<i>July 1, 2015</i>	19a-638(a)(10)
Sec. 40	<i>July 1, 2015</i>	19a-644(d)
Sec. 41	<i>October 1, 2015</i>	Repealer section