General Assembly

Amendment

January Session, 2015

LCO No. **8003**

Offered by:
SEN. LOONEY, 11th Dist.
SEN. FASANO, 34th Dist.

To: Senate Bill No. **811** File No. 655 Cal. No. 378

"AN ACT CONCERNING PARITY IN HOSPITAL SALES OVERSIGHT."

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

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 Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

The exchange shall:

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

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

(3) Implement procedures for the certification, recertification and

decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, of health benefit plans as qualified health plans;

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

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

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

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

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

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42

USC 300gg-15, as amended from time to time;

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

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

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

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

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

(15) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an

individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

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

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

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

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

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

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

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

(C) The name and taxpayer identification number of:

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

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

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

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

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

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

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

(C) Facilitate enrollment in qualified health plans;

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

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

(20) Review the rate of premium growth within and outside the

exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

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

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

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

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

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

(D) The Department of Social Services; and

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

(23) Meet the following financial integrity requirements:

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

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector

General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

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

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

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

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

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

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

Sec. 2. (NEW) (*Effective from passage*) (a) For purposes of this section and sections 3 to 7, inclusive, of this act:

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

(2) "Episode of care" means all health care services related to the treatment of a condition and, for acute conditions, includes health care services and treatment provided from the onset of the condition to its resolution and, for chronic conditions, includes health care services and treatment provided over a given period of time;

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

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

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

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

(7) "Out-of-pocket costs" means costs that are not reimbursed by a health insurance policy and includes deductibles, coinsurance and copayments for covered services and other costs to the consumer associated with a procedure or service;

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

(9) "Public or private third party" means the state, the federal government, employers, a health carrier, third-party administrator or managed care organization.

(b) (1) The exchange shall establish and maintain a consumer health information Internet web site to assist consumers in making informed decisions concerning their health care and informed choices among health care providers. Such Internet web site shall: (A) Contain information comparing the quality, price and cost of health care services, including, to the extent practicable, (i) comparative price and cost information for the most common referrals or prescribed services categorized by payer and listed by health care provider, (ii) comparative quality information by health care provider for each service or category of services for which comparative price and cost information is provided, (iii) data concerning health care-associated infections and serious reportable events, (iv) definitions of common health insurance and medical terms, as determined by the Insurance Commissioner pursuant to section 7 of this act, so consumers may compare health coverage and understand the terms of their coverage, (v) a list of health care provider types, including primary care physicians, advanced practices registered nurses and physician assistants and the types of services each type of health care provider is authorized to provide, (vi) factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost-sharing, covered services and tier information, (vii) patient decision aids, (viii) a list of provider services that are physically and programmatically accessible for persons with disabilities, and (ix) descriptions of standard quality measures; (B) be designed to assist consumers and institutional purchasers in making informed decisions regarding their health care and informed choices among health care providers and allows comparisons between prices paid by various health carriers to health care providers; (C) present information in language and a format that is understandable to the average consumer; and (D) be publicized to the general public. All information received by the exchange pursuant to the provisions of

this section shall be posted on the Internet web site.

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

(c) Not later than October 1, 2015, and annually thereafter, the Insurance Commissioner and the Commissioner of Public Health shall jointly report to the exchange and make available to the public on the Insurance Department's and Department of Public Health's Internet web sites: (1) The one hundred most frequently provided inpatient admissions in the state; (2) the one hundred most frequently provided outpatient procedures performed in the state; (3) the twenty-five most frequent surgical procedures performed in the state; and (4) the twenty-five most frequent imaging procedures performed in the state. Such lists contained in the report may include bundled episodes of care. At the request of the exchange, such lists may be expanded to include additional admissions and procedures.

(d) Not later than January 1, 2016, and annually thereafter, each health carrier shall submit to the exchange the (1) allowed amounts paid to health care providers in the health carrier's network for each admission and procedure included in the report submitted to the exchange by the commissioners pursuant to subsection (c) of this section, and (2) out-of-pocket costs for each such admission and procedure.

(e) Not later than January 1, 2016, and annually thereafter, each hospital and outpatient surgical facility shall report to the exchange the following information for each admission and procedure reported in accordance with subsection (c) of this section: (1) The amount to be charged to a patient for each such admission or procedure if all charges are paid in full without a public or private third party paying any portion of the charges; (2) the average negotiated settlement on the amount to be charged to a patient as described in subdivision (1) of

this subsection; (3) the amount of Medicaid reimbursement for each such admission or procedure, including claims and pro rata supplement payments; (4) the amount of Medicare reimbursement for each such admission or procedure; and (5) for the hospital's or outpatient surgical facility's five largest health carriers according to the hospital's or facility's previous year's patient volume, the allowed amount for each such admission or procedure, with the health carriers names and other identifying information redacted. Notwithstanding the provisions of this subsection, a hospital or outpatient surgical facility shall not report information that may reasonably lead to the identification of individuals admitted to, or who receive services from, the hospital or outpatient surgical facility.

(f) (1) On and after January 1, 2016, each hospital and outpatient surgical facility shall, not later than two business days after scheduling an admission or procedure included in the report submitted to the exchange by the Insurance Commissioner and the Commissioner of Public Health pursuant to subsection (c) of this section, provide written notice to the patient that is the subject of the admission or procedure concerning: (A) If the patient is uninsured, the amount to be charged for the admission or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital or outpatient surgical facility is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee; (B) the Medicare reimbursement amount; (C) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs; (D) The Joint Commission's composite accountability rating and the Medicare compare hospital star rating for the hospital or outpatient surgical facility, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare Hospital Compare tool where the

patient may obtain information concerning the hospital or outpatient surgical facility.

(2) If the patient is insured and the hospital or outpatient surgical facility is out-of-network under the patient's health insurance policy, such written notice shall include a statement that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy will apply.

(g) The Commissioner of Public Health, in consultation with the Insurance Commissioner, the Director of the State Innovation Model Initiative program and the Healthcare Advocate, shall (1) develop quality measures for health carriers to include when providing information to patients concerning the costs of health care services, and (2) determine quality measures to be reported by health carriers and health care providers to the exchange. In developing such measures, said commissioners, said director and the Healthcare Advocate shall consider those quality measures recommended by the National Quality Forum's Measures Applications Partnership and the National Priorities Partnership and solicit information from, and involvement by, hospitals, physicians, health carriers and patient advocates.

(h) The Commissioner of Social Services shall submit to the exchange all Medicaid data requested for the all-payer claims database, established pursuant to section 38a-1091 of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2015*) (a) (1) Each health care provider shall, prior to any scheduled admission, procedure or service determine whether the patient is covered under a health insurance policy. If the patient is determined to be covered under a health insurance policy, such health care provider shall notify the patient, in writing, as to whether such health care provider is in-network or out-of-network under such policy and provide the toll-free telephone number and Internet web site address of the patient's health carrier. If

the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, such health care provider shall notify the patient in writing (A) of the actual charges for the admission, procedure or service, (B) that such patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission, procedure or service, and (C) if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy will apply. Nothing in this subsection shall prevent a health care provider from charging a patient for such unforeseen services.

(2) The notice provisions under subdivision (1) of this subsection shall not apply to any admission or procedure subject to subsection (c) of section 2 of this act.

(b) Each hospital and outpatient surgical facility shall, prior to any scheduled admission, procedure, or service that is not included on a list contained in the report submitted pursuant to subsection (c) of section 2 of this act, in addition to the information required pursuant to subsection (a) of this section, notify the patient of (1) The Joint Commission's composite accountability rating and the Medicare compare hospital star rating for the hospital or outpatient surgical facility, as applicable; and (2) the Internet web site addresses for The Joint Commission and the Medicare Hospital Compare tool where the patient may obtain information concerning the hospital or outpatient surgical facility.

(c) The notices required under subsections (a) and (b) of this section shall be provided to the patient prior to the date of the scheduled admission, procedure or service and not less than two days after the date the appointment for such admission, procedure or service is made. For appointments made on the same date as the admission, procedure or service is scheduled to take place or in circumstances when, the patient arrives for an admission, procedure or service

without a previously-scheduled appointment, such notice shall be provided to the patient upon arrival for the admission, procedure or service.

(d) If a health care provider who is out-of-network under a patient's health insurance policy fails to provide the notices required under subsections (a) and (b) of this section to such patient, such patient shall only be required to pay the coinsurance, copayment, deductible or other out-of-pocket expense that would be required from such patient if such admission, service or procedure was provided by an in-network health care provider and such health care provider shall accept reimbursement for such admission, service or procedure at the in-network rate under such health insurance policy.

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

Sec. 4. (NEW) (*Effective October 1, 2015*) On and after October 1, 2015, no contract entered into, or renewed, between a health care provider and a health carrier shall contain a provision prohibiting disclosure of negotiated pricing information, including, but not limited to, pricing information relating to out-of-pocket costs.

Sec. 5. (NEW) (*Effective October 1, 2015*) (a) On and after March 1, 2016, each health carrier shall maintain an Internet web site and institute the use of a mobile device application and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for (i) at a minimum, admissions and procedures reported to the Connecticut Health Insurance Exchange pursuant to section 2 of this act for each health care provider in the state, and (ii) prescribed drugs and durable medical equipment; (B) the estimated out-of-pocket costs that the consumer would be responsible for paying for any such admission or

procedure that is medically necessary, including any facility fee, copayment, deductible, coinsurance or other expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) a list of in-network health care providers, (iv) whether a health care provider is accepting new patients, and (v) languages spoken by health care providers; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services. Each health carrier shall use on its Internet web site the defined terms established by the Insurance Commissioner pursuant to section 7 of this act.

(b) A health carrier shall not require a consumer to pay a higher amount for an inpatient admission, health care procedure or service than that disclosed to the consumer pursuant to subsection (a) of this section, provided a health carrier may impose additional cost-sharing requirements for unforeseen services that arise out of the proposed admission or procedure if (1) such requirements are disclosed in the health benefit plan, and (2) the health carrier advised the consumer when providing the information on out-of-pocket costs that the amounts are estimates and that the consumer's actual cost may vary due to the need for unforeseen services that arise out of the proposed admission or procedure.

(c) Each health carrier shall submit to the Insurance Commissioner not later than July 1, 2016, and annually thereafter, a detailed description of (1) the manner in which information on costs is communicated to consumers, as required pursuant to subsection (a) of this section, (2) any marketing efforts undertaken to inform consumers of the information available pursuant to the provisions of this section, (3) any surveys of consumers conducted to determine consumer satisfaction with the manner in which cost-sharing information is communicated, and (4) the tools used to provide cost-sharing information to consumers.

Sec. 6. (NEW) (*Effective October 1, 2015*) Not later than thirty days

after the date that a health care provider stops accepting patients who are enrolled in an insurance plan, such health care provider shall notify, in writing, the applicable health carrier.

Sec. 7. (NEW) (*Effective October 1, 2015*) The Insurance Commissioner shall establish standard terms with definitions to be used by health carriers and health care providers for the purposes of complying with sections 2, 3 and 5 of this act, to ensure consumers obtain accurate, relevant and complete price information.

Sec. 8. (NEW) (*Effective January 1, 2016*) (a) Each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state, shall:

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

(2) Make available to consumers a way to determine accurately (A) whether a specific prescription drug is available under such policy's drug formulary; (B) the coinsurance, copayment, deductible or other out-of-pocket expense applicable to such drug; (C) whether such drug is covered when dispensed by a physician or a clinic; (D) whether such drug requires preauthorization or the use of step therapy; (E) whether

specific types of health care specialists are in-network; and (F) whether a specific health care provider or hospital is in-network.

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

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

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

Sec. 9. Section 38a-591 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

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

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

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

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

(e) (1) The Insurance Commissioner shall, within available appropriations, evaluate whether insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers subject to the Affordable Care Act are in compliance with the requirements under said act, including, but not limited to, the prohibition against discriminatory benefit designs. Any such company, society, corporation or center shall submit to the commissioner, upon request, the following information for a specific health insurance policy or plan: (A) The benefits covered under each of the categories of the essential health benefits package, as defined by the Secretary of Health and Human Services; (B) any coverage exclusions or restrictions on covered benefits, including under the prescription drug benefit; (C) any drug formulary used, the tier structure of such formulary and a list of each prescription drug on such formulary and its tier placement; (D) any applicable coinsurance, copayment, deductible or other out-of-pocket expenses for each covered benefit; and (E) any other information the commissioner deems necessary to evaluate such company, society, corporation or center.

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

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

Sec. 10. (NEW) (*Effective January 1, 2016*) (a) As used in this section:

(1) "Emergency condition" means a medical condition, or a mental or nervous condition as set forth in sections 38a-488a and 38a-514 of the general statutes, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the individual afflicted with a medical condition in serious jeopardy, or in the case of an individual afflicted with a mental or nervous condition, placing the health of such individual or others in serious jeopardy, (B) serious impairment to such individual's bodily functions, (C) serious dysfunction of any bodily organ or body part of such individual, (D) serious disfigurement of such individual, or (E) a condition described in Section 1867 (e)(1)(A) of the Social Security Act, as amended from time to time;

(2) "Emergency services" means, with respect to an emergency condition, (A) a medical screening examination as required under Section 1867 of the Social Security Act, as amended from time to time, that is within the capability of a hospital emergency department, including ancillary services routinely available to such department to evaluate such condition, and (B) such further medical examinations and treatment required under said Section 1867 to stabilize such individual, that are within the capability of the hospital staff and facilities;

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

(4) "Health care provider" means an individual licensed to provide health care services under chapters 370 to 373, inclusive, of the general statutes, chapters 375 to 383b, inclusive, of the general statutes, and

chapters 384a to 384c, inclusive, of the general statutes;

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

(6) (A) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where:

(i) (I) An in-network health care provider was unavailable at the time such services were rendered to such insured, (II) such services were rendered without such out-of-network health care provider notifying such insured that such provider was out-of-network under such insured's health care plan and that such services would likely be deemed out-of-network and out-of-network rates would apply, or (III) unforeseen services were rendered by such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier; or

(ii) Such services were referred to such out-of-network provider by an in-network health care provider without the written consent of the insured explicitly acknowledging (I) such referral to an out-of-network health care provider, and (II) that the referral may result in costs not covered by the insured's health care plan.

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

(C) A referral occurs when (i) an out-of-network health care provider renders health care services to an insured in an in-network health care provider's office or facility during the course of the same

visit, (ii) an in-network health care provider sends a specimen taken from the insured in such provider's office to an out-of-network health care provider or an out-of-network laboratory or other out-of-network facility, or (iii) an insured's health care plan requires a referral for a health care service and an out-of-network health care provider renders such service to the insured.

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

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

(3) If emergency services were rendered to an insured by an out-of-network health care provider, the health carrier shall reimburse such provider the greatest of the following amounts: (A) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (B) the usual, customary and reasonable rate for such services as determined by the health carrier; or (C) the amount Medicare would reimburse for such services.

(c) With respect to a surprise bill:

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

(2) A health carrier shall reimburse the out-of-network health care provider for health care services rendered at the in-network rate under the insured's health care plan, unless such health carrier and provider agree otherwise.

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

Sec. 11. (NEW) (*Effective October 1, 2015*) Each health care provider that refers a patient to another health care provider that is affiliated with the referring health care provider shall notify the patient, in writing, that the health care providers are affiliated. Such notice shall also (1) inform the patient that the patient is not required to see the provider to whom he or she is referred and that the patient has a right to seek care from the health care provider chosen by the patient, and (2) provide the patient with the Internet web site and toll-free telephone number of the patient's health carrier to obtain information regarding in-network health care providers and estimated out-of-pocket costs for the referred service. For purposes of this subsection, "affiliated" means (A) a relationship between two or more health care providers that permits the health care providers to negotiate jointly or as a member of the same group of health care providers with third parties over rates for professional medical services, or (B) a joint venture, collaboration or agreement, between two or more entities that permits (i) coordination of professional medical services, (ii) monitoring and control or modification of the utilization of professional medical services, or (iii) the referral of patients for professional medical services.

Sec. 12. Subsection (d) of section 38a-591b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(d) Each health carrier shall:

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

(A) Its utilization review and benefit determination procedures;

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

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

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

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

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

(E) A description of what constitutes a surprise bill, as defined in

subsection (a) of section 10 of this act;

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

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

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

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

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

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

[(6)**]** (8) Maintain records of all benefit requests, claims and notices associated with utilization review and benefit determinations made in accordance with section 38a-591d for not less than six years after such

requests, claims and notices were made. Each health carrier shall make such records available for examination by the commissioner and appropriate federal oversight agencies upon request; and

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

Sec. 13. Section 38a-478d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

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

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

(2) Provide notification to each enrollee of the termination or withdrawal of a provider who was available under the provisions of the enrollee's enrollment agreement, in writing or through the Internet at the option of the enrollee. Such notification shall be provided as soon as possible but not later than thirty days after such termination or withdrawal;

[(2)**]** (3) Include, under a separate category or heading, participating advanced practice registered nurses in the listing of providers specified under subdivision (1) of this section; and

[(3)**]** (4) For a managed care plan that requires the selection of a primary care provider, **[**: (A) Allow**]** allow an enrollee to designate a participating, in-network physician or a participating, in-network advanced practice registered nurse as such enrollee's primary care provider. **[**; and

(B) Provide notification, as soon as possible, to each such enrollee upon the termination or withdrawal of the enrollee's primary care provider.**]**

Sec. 14. Section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) For purposes of this section:

(1) "Request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "This is not a bill".

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

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

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

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

(5) "Health care plan" has the same meaning as provided in subsection (a) of section 10 of this act.

(6) "Health carrier" has the same meaning as provided in subsection (a) of section 10 of this act.

(7) "Emergency services" has the same meaning as provided in subsection (a) of section 10 of this act.

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee, other than a coinsurance, copayment, **[**or**]** deductible or other out-of-pocket expense, for **[**medical**]** (1) health care services or a facility fee, as defined in section 19a-508c, as amended by this act, covered under a **[**managed**]** health care plan, (2) emergency services covered under a health care plan and rendered by an out-of-network health care provider, or (3) a surprise bill, as defined in section 10 of this act.

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

Sec. 15. Subdivision (3) of subsection (c) of section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(3) No participating provider, or agent, trustee or assignee thereof, may: (A) Maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center; **[**or**]** (B) request payment from a subscriber or enrollee for such sums; (C) request payment from a subscriber or enrollee for covered emergency services that are provided by an out-of-network provider; or (D) request payment from a subscriber or enrollee for a surprise bill, as defined in section 10 of this act. For purposes of this subdivision "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL". The contract between a health care center and a participating provider shall inform the participating

provider that pursuant to section 20-7f, as amended by this act, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from a subscriber or an enrollee, other than a coinsurance, copayment, **[**or**]** deductible or other out-of-pocket expense, for covered medical or emergency services or facility fees, as defined in section 19a-508c, as amended by this act, or surprise bills, or to report to a credit reporting agency an enrollee's failure to pay a bill for **[**medical**]** such services when a health care center has primary responsibility for payment of such services, fees or bills.

Sec. 16. Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

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

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

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

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

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

(6) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

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

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

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

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

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of

a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and

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

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

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

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

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's

potential financial liability, if any, for such charges and fees.

(d) Each billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the Medicare facility fee reimbursement rate for the same service as a comparison; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction.

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

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

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is determined not to have an emergency medical condition and before

the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

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

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

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

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

(2) Such notice shall include the following information:

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

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

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

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

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

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

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

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

practice pursuant to section 42-110b.

(k) Notwithstanding the provisions of this section, on and after October 1, 2015, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility located off-site from a hospital campus, or (2) outpatient services received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on October 1, 2015, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.

(l) (1) Each hospital and health system shall report not later than July 1, 2016, and annually thereafter to the Commissioner of Public Health concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and location of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by Medicare, Medicaid or under private insurance policies, (D) for each facility, the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee revenue and, for each such procedure or service, the total amount of revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures for which facility fees are charged based on patient volume. For purposes

of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

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

Sec. 17. (NEW) (*Effective October 1, 2015*) (a) As used in this section, "campus", "facility fee", "health system", "hospital" and "hospital-based facility" have the same meanings as provided in section 19a-508c of the general statutes, as amended by this act.

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

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

Sec. 18. (NEW) (*Effective October 1, 2015*) (a) Each health insurer, health care center, hospital service corporation, medical service

corporation or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes in this state may offer plans with a tiered health care provider network that has different cost-sharing rates for different health care provider tiers and rewards insureds and enrollees for choosing low-cost, high-quality health care providers by offering lower copayments, deductibles or other out-of-pocket expenses.

(b) Each tiered provider network plan shall only include variations on cost-sharing between health care provider tiers that are reasonable in relation to the premiums charged and shall provide adequate access to covered services.

(c) (1) For the purposes of a tiered provider network plan, a health insurer, health care center, hospital service corporation, medical service corporation or other entity may (A) reclassify a health care provider tier, or (B) determine health care provider participation in a tiered provider network plan not more than once per calendar year, except a health carrier may reclassify a health care provider from a higher cost tier to a lower cost tier or add new health care providers to its tiered provider network plan at any time.

(2) If such insurer, center, corporation or other entity reclassifies a health care provider tier or a health care provider during a plan year, it shall notify any insured or enrollee affected by such change at least thirty days before such change takes effect.

(d) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

(e) Each insurer, center, corporation or other entity that offers a tiered provider network plan shall post on its Internet web site information about its tiered provider network plan, including, but not

limited to, a current list of health care providers participating in such plan, the selection criteria for a health care provider to participate in such plan and the tier under which each participating health care provider is classified.

Sec. 19. Section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

The exchange shall:

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

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

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

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

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

(6) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange;

(7) Publish the average costs of licensing, regulatory fees and any

other payments required by the exchange and the administrative costs of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

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

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

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

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

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium

tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

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

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

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

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

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

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

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

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

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

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

(C) The name and taxpayer identification number of:

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

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

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

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

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

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

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing

reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

(D) The Department of Social Services; and

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

(23) Meet the following financial integrity requirements:

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

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

(i) Investigate the affairs of the exchange;

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

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

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

(24) (A) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange, and (B) encourage health carriers to offer, and offer through the exchange, tiered health care provider network plans, as described

in section 18 of this act;

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

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

Sec. 20. (NEW) (*Effective October 1, 2015*) (a) As used in this section, "campus", "health system", "hospital", "hospital-based facility" and "affiliated provider" have the same meanings as provided in section 19a-508c of the general statutes, as amended by this act.

(b) Each hospital shall, if negotiating reimbursement rates on a fee-for-service basis or for reimbursements based on bundled services per diagnosis, condition, procedure or other standardized bundles of services and at the request of a health insurance company, health care center or other entity that provides health care benefits to its insureds or enrollees, (1) negotiate separately with such company, center or other entity, even if any hospitals are commonly owned, and (2) negotiate for health care services provided by the hospital at a hospital-based facility located on the hospital campus separately from outpatient health care services provided by hospital-affiliated providers at outpatient facilities, health care providers' offices or other hospital-based facilities located off-site from the hospital campus.

Sec. 21. (NEW) (*Effective October 1, 2015*) Each health insurer, health care center, hospital service corporation, medical service corporation, preferred provider network or other entity that contracts with health care providers to provide health care services to its insureds or enrollees shall include in each such contract that is entered into, renewed or amended on or after July 1, 2016, a provision for site-neutral reimbursement for outpatient health care services that use a current procedural terminology evaluation and management code and are provided off-site from a hospital campus. Such provision shall require, for reimbursements made on a fee-for-service basis or for reimbursements based on bundled services per diagnosis, condition, procedure or other standardized bundles of services, reimbursement rates that are the same for outpatient health care services described herein for all health care providers in the same geographic region as determined by the Insurance Commissioner, regardless of the employer or affiliation of a health care provider. Each such contract shall include a conspicuous statement that the contract complies with the site-neutral reimbursement policy required by this section.

Sec. 22. Section 19a-725 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

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

(b) (1) **[**The SustiNet**]** (A) Prior to July 1, 2015, the Health Care Cabinet shall consist of the following members who shall be appointed on or before August 1, 2011: **[**(A)**]** (i) Five appointed by the Governor, two of whom may represent the health care industry and shall serve for terms of four years, one of whom shall represent community health centers and shall serve for a term of three years, one of whom shall represent insurance producers and shall serve for a term of three years and one of whom shall be an at-large appointment and shall serve for a term of three years; **[**(B)**]** (ii) one appointed by the president pro tempore of the Senate, who shall be an oral health specialist engaged in

active practice and shall serve for a term of four years; **[**(C)**]** (iii) one appointed by the majority leader of the Senate, who shall represent labor and shall serve for a term of three years; **[**(D)**]** (iv) one appointed by the minority leader of the Senate, who shall be an advanced practice registered nurse engaged in active practice and shall serve for a term of two years; **[**(E)**]** (v) one appointed by the speaker of the House of Representatives, who shall be a consumer advocate and shall serve for a term of four years; **[**(F)**]** (vi) one appointed by the majority leader of the House of Representatives, who shall be a primary care physician engaged in active practice and shall serve for a term of four years; **[**(G)**]** (vii) one appointed by the minority leader of the House of Representatives, who shall represent the health information technology industry and shall serve for a term of three years; **[**(H)**]** (viii) five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one of whom shall represent faith communities, one of whom shall represent small businesses, one of whom shall represent the home health care industry, one of whom shall represent hospitals, and one of whom shall be an at-large appointment, all of whom shall serve for terms of five years; **[**(I)**]** (ix) the Lieutenant Governor; **[**(J)**]** (x) the Secretary of the Office of Policy and Management, or the secretary's designee; the Comptroller, or the Comptroller's designee; the chief executive officer of the Connecticut Health Insurance Exchange, or said officer's designee; the Commissioners of Social Services and Public Health, or their designees; and the Healthcare Advocate, or the Healthcare Advocate's designee, all of whom shall serve as ex-officio voting members; and **[**(K)**]** (xi) the Commissioners of Children and Families, Developmental Services and Mental Health and Addiction Services, and the Insurance Commissioner, or their designees, and the nonprofit liaison to the Governor, or the nonprofit liaison's designee, all of whom shall serve as ex-officio nonvoting members.

(B) On and after July 1, 2015, the Health Care Cabinet shall include the following additional members: (i) Two members appointed by the Governor on or before August 1, 2015, one of whom shall be a

behavioral health provider and shall serve a term of three years and one of whom shall be a health economist with expertise in health care payment models and shall serve a term of three years; and (ii) the director of the state innovation model initiative program management office, or said director's designee, who shall serve as an ex-officio voting member. The provisions of this subparagraph shall not affect the terms of the cabinet members set forth in subparagraphs (A)(i) to (A)(viii), inclusive, of subdivision (1) of this subsection.

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

(3) Upon the expiration of the initial terms of the five cabinet members appointed by SustiNet Health Partnership board of directors, five successor cabinet members shall be appointed as follows: (A) One appointed by the Governor; (B) one appointed by the president pro tempore of the Senate; (C) one appointed by the speaker of the House of Representatives; and (D) two appointed by majority vote of the appointed board members. Successor board members appointed pursuant to this subdivision shall be at-large appointments.

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

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

(1) Evaluate the means of ensuring an adequate health care

workforce in the state;

(2) **[**Jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act**]** Set health care cost growth goals for the state and consider recommendations for (A) the establishment of annual health care cost growth benchmarks for the state for the average growth in total health care expenditures in the next calendar year and the posting of such benchmarks on an Internet web site that is maintained by the cabinet, and (B) the establishment of procedures to assist health care providers that exceed such benchmarks without either corresponding improvements in quality or other causes not related to efficiency to improve efficiency and reduce cost growth, including, but not limited to, procedures for such providers to implement performance improvement plans;

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

(4) Review the effectiveness of delivery system reforms and other efforts to control health care costs, enhance competition, improve cost-effectiveness in the health care market and improve the quality of care, including, but not limited to, reforms and efforts implemented by state agencies; **[**and**]**

(5) Review cost containment models in other states, including, but not limited to, Massachusetts, Maryland, Oregon, Rhode Island, Washington and Vermont, to identify successful practices and programs that may be relevant for this state and implemented in this state;

(6) Collect and analyze data as the cabinet deems necessary to make recommendations to enhance the transparency of health care provider costs, prices and business organizations and affiliations;

(7) Collect and analyze data as the cabinet deems necessary to

monitor, by payer and provider type, variations in prices charged for health care services and reimbursement rates paid. Such analysis may include, but is not limited to, (A) identification of factors contributing to such price and reimbursement variation, (B) assessment of the impact of such price and reimbursement variation on health care costs, health insurance premium rates and access to care, and (C) the recommendation of policy changes to reduce health care provider price variations the cabinet finds to be unrelated to actual cost or quality differences or that unnecessarily contribute to health care cost inflation; and

[(5)**]** (8) Advise the Governor on matters relating to: (A) The design, implementation, actionable objectives and evaluation of state and federal health care policies, priorities and objectives relating to the state's efforts to improve access to health care, and (B) the quality of such care and the affordability and sustainability of the state's health care system.

(d) The **[**SustiNet**]** Health Care Cabinet may convene working groups, which include volunteer health care experts, to make recommendations concerning the development and implementation of service delivery and health care provider payment reforms, including multipayer initiatives, medical homes, electronic health records and evidenced-based health care quality improvement.

(e) On or before January 1, 2016, and annually thereafter, the Health Care Cabinet shall submit a report on the activities of the cabinet, in accordance with the provisions of section 11-4a, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

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

Sec. 23. (*Effective July 1, 2015*) (a) Not later than July 15, 2015, the

Health Care Cabinet established under section 19a-725 of the general statutes, as amended by this act, shall convene a working group to study the rising cost of health care, including, but not limited to, increases in the prices charged for health care services, the variation in such prices among health care providers and the impact on such prices and price variation of reimbursement rates paid by health insurers to health care providers. The working group shall examine policies aimed at enhancing competition, fairness and cost-effectiveness in the health care market and the reduction of disparities in reimbursement rates and prices charged by health care providers.

(b) The working group shall examine: (1) The variation in prices charged by health care providers within similar health care provider groups; (2) the variation in prices charged by health care providers for services of comparable acuity, quality and complexity; (3) the variation in the volume of care provided by health care providers with low and high levels of relative health care provider prices or health status adjusted total medical expenses; (4) the correlation between prices charged by health care providers and (A) the quality of care provided, (B) the acuity of the patient population, (C) health care providers' payer mix, (D) unique services provided by health care providers, including specialty teaching services and community services, and (E) health care providers' operational costs, including administrative and management costs; (5) in the case of hospitals, the correlation between prices charged by hospitals and their respective statuses as disproportionate share hospitals, specialty hospitals, pediatric specialty hospitals or academic teaching hospitals; (6) the correlation between prices charged by health care providers and market share, horizontal consolidation and vertical integration and referral policies and patterns; and (7) the correlation between facility fees, as defined in section 19a-508c of the general statutes, as amended by this act, and total medical spending, consumer out-of-pocket expenses and the variation in prices charged by health care providers for services of comparable acuity, quality and complexity.

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

(d) The chairperson of the Health Care Cabinet may request from health insurers, health care providers or third-party administrators information or materials relevant to the study. Any information or materials submitted or disclosed to the working group for such study shall be confidential and not subject to disclosure under section 1-210 of the general statutes, except that data that have identifiers removed and do not disclose the names of any health care provider, health insurer or payer or individual and are not otherwise protected by law may be disclosed as part of the working group's report.

(e) (1) (A) Not later than January 1, 2016, or a later date as provided in subdivision (2) of this subsection, the working group shall submit a report to the General Assembly, in accordance with the provisions of section 11-4a of the general statutes, of the findings of the study and recommendations to (i) reduce price variations among health care providers, (ii) promote the use of high-quality health care providers with low total medical expenses and health care provider prices, and (iii) mitigate the impact of facility fees on consumer out-of-pocket expenses and total medical spending.

(B) Such recommendations may include (i) expanding or modifying the site-neutral reimbursement provision set forth in section 21 of this act, (ii) expanding or modifying the limitations on facility fees set forth in subsection (k) of section 19a-508c of the general statutes, as

amended by this act, and (iii) establishing a reasonable maximum health care provider price variation limit and establishing a state-wide median rate for certain health care services and procedures.

(2) The chairperson of the Health Care Cabinet may notify the speaker of the House of Representatives, the president pro tempore of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate of the need to extend the date of submission of the study. Such notice shall identify a date certain for submission of the study, not to be later than January 1, 2017, and the working group shall submit a preliminary report not later than January 1, 2016.

(3) The working group shall terminate on January 1, 2016, or if said date was extended pursuant to subdivision (2) of this subsection, on the date the study is submitted or January 1, 2017, whichever is later.

Sec. 24. Subdivision (17) of subsection (c) of section 38a-1083 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(17) Evaluate **[**jointly with the SustiNet Health Care Cabinet**]** the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;

Sec. 25. (NEW) (*Effective October 1, 2015*) (a) For purposes of this section:

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

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

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

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

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

(6) "Health information blocking" means (A) knowingly interfering with or knowingly engaging in business practices or other conduct that is reasonably likely to interfere with the ability of patients, health care providers or other authorized persons to access, exchange or use electronic health records, or (B) knowingly using an electronic health record system to (i) steer patient referrals to affiliated providers, (ii) prevent patient referrals to health care providers who are not affiliated providers, or (iii) otherwise unreasonably interfere with patient referrals to health care providers who are not affiliated providers;

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

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

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

(b) Electronic health records shall, to the fullest extent practicable, (1) follow the patient, (2) be made accessible to the patient, and (3) be shared and exchanged with the health care provider of the patient's choice in a timely manner.

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

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

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

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

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

Sec. 26. (NEW) (*Effective from passage*) (a) There shall be established a State-wide Health Information Exchange to empower consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the

state's public health goals.

(b) It shall be the goal of the State-wide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; and (8) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics.

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

(d) (1) The Commissioner of Social Services, in consultation with the Secretary of the Office of Policy and Management, shall, upon the State Bond Commission's approval of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, issue a request for proposals from eligible nonprofit organizations for the development, management and operation of the State-wide Health Information Exchange.

(2) An eligible nonprofit organization responding to the request for proposals shall: (A) Have not less than three years of experience operating either a state-wide health information exchange in any state or a regional exchange serving a population of not less than one million that (i) enables the exchange of patient health information among health care providers, patients and other authorized users

without regard to location, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time health care provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing or medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and operations; (C) be capable of providing consulting to ensure effective governance; (D) is regulated or administratively overseen by a state government agency; and (E) have sufficient staff and appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the State-wide Health Information Exchange.

(e) Such request for proposals shall require: (1) Broad local governance that (A) includes all stakeholders, including, but not limited to, a representative of the Department of Social Services, hospitals, physicians, behavioral health providers, long-term care providers, health insurers, employers, patients, and academic or medical research institutions, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange; (2) provision of a health information exchange plan that (A) improves upon existing infrastructure and is coordinated with existing programs, (B) ensures the privacy and security of patient information at all levels and, at a minimum, complies with all applicable state and federal privacy and security laws, (C) focuses on efforts to maximize utility with minimal cost and burden on stakeholders, (D) promotes the highest level of interoperability and utilization of national information technology standards, and (E) aligns with the state-wide health information technology plan and data standards established and implemented by the Commissioner of Social Services pursuant to section 4-60i of the general statutes, as amended by this act; and (3) provision of a business plan that includes (A) a

collaborative process engaging all stakeholders in the development of recommended funding streams sufficient to support the annual operating expenses of the State-wide Health Information Exchange, and (B) the development of services and products to support the long-term sustainability of the State-wide Health Information Exchange.

(f) Notwithstanding the provisions of subsections (d) and (e) of this section, if, on or before December 1, 2015, the Commissioner of Social Services, with the advice and consent of the State Health Information Technology Advisory Council, established pursuant to section 30 of this act, submits a plan to the Secretary of the Office of Policy and Management for the establishment of a State-wide Health Information Exchange consistent with subsections (a), (b) and (c) of this section, and such plan is approved by the Secretary, the commissioner may implement such plan and enter into any contracts or agreements to implement such plan.

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

Sec. 27. (NEW) (*Effective from passage*) (a) For purposes of this section:

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

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

(b) Not later than one year after commencement of the operation of the State-wide Health Information Exchange, each hospital licensed under chapter 368v of the general statutes and clinical laboratory licensed under section 19a-30 of the general statutes shall maintain an electronic health record system capable of connecting to and

participating in the State-wide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

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

Sec. 28. Section 4-60i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) As used in this section:

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

(2) "Interoperability" means the ability of two or more systems or components to exchange information and to use the information that has been exchanged and includes: (A) The capacity to physically connect to a network for the purpose of exchanging data with other users; (B) the ability of a connected user to demonstrate appropriate permissions to participate in the instant transaction over the network; and (C) the capacity of a connected user with such permissions to access, transmit, receive and exchange usable information with other users.

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

[(a)**]** (b) The Commissioner of Social Services shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families and Mental Health and Addiction Services, uniform management information, uniform statistical information, uniform terminology for similar facilities, uniform electronic health information technology standards and uniform regulations for the licensing of human services facilities, (2) plan for increased participation of the private sector in the delivery of human services, (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to eliminate duplication.

[(b)**]** (c) The Commissioner of Social Services shall, in consultation with **[**the Departments of Public Health and Mental Health and Addiction Services**]** the Health Information Technology Advisory Council, established pursuant to section 30 of this act, implement and periodically revise the state-wide health information technology plan

established pursuant to **[**section 19a-25d**]** this section and shall establish electronic data standards to facilitate the development of integrated electronic health information systems **[**, as defined in subsection (a) of section 19a-25d,**]** for use by health care providers and institutions that receive state funding. Such electronic data standards shall: (1) Include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) limit the use and dissemination of an individual's Social Security number and require the encryption of any Social Security number provided by an individual; (3) require privacy standards no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and contained in 45 CFR 160, 164; (4) require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail; (5) be compatible with any national data standards in order to allow for interstate interoperability; **[**, as defined in subsection (a) of section 19a-25d;**]** (6) permit the collection of health information in a standard electronic format; **[**, as defined in subsection (a) of section 19a-25d;**]** and (7) be compatible with the requirements for an electronic health information system. **[**, as defined in subsection (a) of section 19a-25d.**]**

(d) The Commissioner of Social Services shall, within existing resources and in consultation with the Health Information Technology Advisory Council: (1) Oversee the development and implementation of the State-wide Health Information Exchange in conformance with section 26 of this act; (2) coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation; (3) serve as the state liaison to, and work collaboratively with, the State-wide Health Information Exchange established pursuant to section 26 of this act to ensure consistency between the state-wide health information technology plan and the State-wide Health Information Exchange and to support the state's

health information technology and exchange goals; and (4) make recommendations to the Commissioner of Social Services and the General Assembly regarding health information technology and health information exchange policy and legislation.

(e) The state-wide health information technology plan, implemented and periodically revised pursuant to subsection (c) of this section, shall include, but not be limited to (A) general standards and protocols for health information exchange, and (B) electronic data standards to facilitate the development of a state-wide, integrated electronic health information system for use by health care providers and institutions that are licensed by the state. Such electronic data standards shall (i) include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols, (ii) be compatible with any national data standards in order to allow for interstate interoperability, (iii) permit the collection of health information in a standard electronic format, and (iv) be compatible with the requirements for an electronic health information system.

Sec. 29. (NEW) (*Effective October 1, 2015*) (a) For purposes of this section:

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

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

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

(4) "Secure exchange" means the exchange of patient electronic health records between a hospital and a health care provider in a manner that complies with all state and federal privacy requirements, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time.

(b) Each hospital licensed under chapter 368v of the general statutes shall, to the fullest extent practicable, use its electronic health records system to enable bidirectional connectivity and the secure exchange of patient electronic health records between the hospital and any other health care provider who (A) maintains an electronic health records system capable of exchanging such records, and (B) provides health care services to a patient whose records are the subject of the exchange. The requirements of this section apply to at least the following: (i) Laboratory and diagnostic tests; (ii) radiological and other diagnostic imaging; (iii) continuity of care documents; and (iv) discharge notifications and documents.

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

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

(e) The failure of a hospital to take all reasonable steps to comply with this section shall constitute evidence of health information blocking pursuant to section 25 of this act.

(f) A hospital that connects to, and actively participates in, the State-wide Health Information Exchange, established pursuant to section 26 of this act shall be deemed to have satisfied the requirements of this section.

Sec. 30. (NEW) (*Effective July 1, 2015*) (a) There shall be a State Health Information Technology Advisory Council to advise the Commissioner of Social Services in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts and goals and to advise the commissioner in the development and implementation of the state-wide health information technology plan and standards and the State-wide Health Information Exchange, established pursuant to section 26 of this act. The advisory council shall also advise the commissioner regarding the development of appropriate governance, oversight and accountability measures to ensure success in achieving the state's health information technology and exchange goals.

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

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

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

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

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

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

(6) The Healthcare Advocate, or the Healthcare Advocate's

designee;

(7) Five members appointed by the Governor, one each of whom shall be (A) a representative of a health system that includes more than one hospital, (B) a representative of the health insurance industry, (C) an expert in health information technology, (D) a health care consumer or consumer advocate, and (E) an employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186.

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

(9) Two members appointed by the speaker of the House of Representatives, one each who shall be (A) a representative of the business community, and (B) a provider of home health care services;

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

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

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

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

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

(15) The speaker of the House of Representatives, or the speaker's

designee;

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

(17) The minority leader of the House of Representatives, or the minority leader's designee.

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

(d) All appointments to the council shall be made not later than July 1, 2015. The Commissioner of Social Services shall schedule the first meeting of the council, which shall be held not later than August 1, 2015. The Commissioner of Social Services shall serve as a chairperson of the council. The council shall elect a second chairperson from among its members, who shall not be a state official. The council shall meet not less than monthly. The terms of the members shall be coterminous with the terms of the appointing authority for each member and subject to the provisions of section 4-1a of the general statutes. If any vacancy occurs on the council, the appointing authority having the power to make the appointment under the provisions of this section and shall appoint a person in accordance with the provisions of this section. A majority of the members of the council shall constitute a quorum. Members of the council shall serve without compensation, but shall be reimbursed for all reasonable expenses incurred in the performance of their duties.

(e) Not later than January 1, 2016, and quarterly thereafter, the council shall report to the Commissioner of Social Services and the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health concerning: (1) The development and implementation of the state-wide health information technology plan and standards; (2) the establishment of the State-wide Health Information Exchange and progress in meeting

the goals of the State-wide Health Information Exchange; and (3) recommendations for policy, regulatory and legislative changes and other initiatives to promote the state's health information technology and exchange goals.

(f) Prior to submitting any application, proposal, planning document or other request seeking federal grants, matching funds or other federal support for health information technology or health information exchange, the Commissioner of Social Services shall (1) present such application, proposal, document or other request to the council for review and comment, and (2) not less than thirty days prior to the submission, submit, in accordance with the provisions of section 11-4a of the general statutes, such application, proposal, document or other request together with a summary of the council's comments and recommendations, if any, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, insurance and appropriations.

Sec. 31. Section 4-60j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

In fulfilling his or her responsibilities under sections 4-60i, as amended by this act, and 4-60*l* and complying with the requirements of **[**section 19a-25d**]** said sections, the Commissioner of Social Services shall take into consideration such advice as may be provided to the commissioner by advisory boards and councils in the human services areas.

Sec. 32. Section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) As used in this section:

(1) "Affiliation" means (A) the formation of a relationship between two or more entities that permits the entities to negotiate jointly with third parties over rates for professional medical services, (B) any physician network joint venture, or (C) any collaboration or

agreement, between two or more entities that permits (i) coordination of professional medical services, (ii) monitoring and control or modification of the utilization of professional medical services, or (iii) the referral of patients for professional medical services but does not include a merger of hospitals, hospital systems or health care providers;

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

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

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

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

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

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

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

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

(10) "Group practice" means two or more physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity

(A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians; and

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

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

(c) Not less than thirty days prior to the effective date of any transaction that results in a material change to the business or corporate structure of a group practice, the parties to the transaction shall submit written notice to the Attorney General of such material

change. For purposes of this subsection, a material change to the business or corporate structure of a group practice includes: (1) The merger, consolidation or other affiliation of a group practice with (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (2) the acquisition of all or substantially all of (A) the properties and assets of a group practice, or (B) the capital stock, membership interests or other equity interests of a group practice by (i) another group practice that results in a group practice comprised of eight or more physicians, or (ii) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (3) the employment of all or substantially all of the physicians of a group practice by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system; and (4) the acquisition of one or more insolvent group practices by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system.

(d) (1) The written notice required under subsection (c) of this section shall identify each party to the transaction and describe the material change as of the date of such notice to the business or corporate structure of the group practice, including: **[**(1)**]** (A) A description of the nature of the proposed relationship among the parties to the proposed transaction; **[**(2)**]** (B) the names and specialties of each physician that is a member of the group practice that is the subject of the proposed transaction and who will practice medicine with the resulting group practice, hospital, hospital system, captive professional entity, medical foundation or other entity organized by,

controlled by, or otherwise affiliated with such hospital or hospital system following the effective date of the transaction; **[**(3)**]** (C) the names of the business entities that are to provide services following the effective date of the transaction; **[**(4)**]** (D) the address for each location where such services are to be provided; **[**(5)**]** (E) a description of the services to be provided at each such location; and **[**(6)**]** (F) the primary service area to be served by each such location.

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

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

[(e)**]** (f) Written information submitted to the Attorney General pursuant to subsections (b) to **[**(d)**]** (e), inclusive, of this section shall be maintained and used by the Attorney General in the same manner as provided in section 35-42.

[(f)**]** (g) Not later than December 31, 2014, and annually thereafter,

each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

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

(i) Not later than December 31, 2015, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each

such location; and (5) the primary service area served by each such location.

Sec. 33. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

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

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

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

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

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

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

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

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

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

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

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

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

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

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

(c) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

(d) (1) For purposes of this subsection and subsection (e) of this

section:

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

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

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

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

(E) "Transacting party" means a person who is a party to a proposed agreement for transfer of ownership of a hospital who submits an application to the commissioner and the Attorney General pursuant to section 19a-486a, as amended by this act, or a certificate of need application for a transfer of ownership;

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

(G) "Transfer of ownership of a hospital" means a transfer that impacts or changes the governance or controlling body of a hospital, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a hospital.

(2) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, that involves the transfer of ownership of a hospital, the office shall, in addition to the guidelines and principles set forth in subsection (a) of this section and those prescribed through regulation pursuant to subsection (c) of

this section, take into consideration and make written findings concerning each of the following guidelines and principles:

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

(B) Whether the transacting parties have submitted a plan (i) demonstrating how health care services will be provided by the new hospital for the first five years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination, or expansion of existing services or introduction of new services, and (ii) to account for the employment and workforce retraining needs of its workforce in light of its post-transfer business and service plan; and

(C) Whether the transacting parties' officers, directors, board members or senior managers are expected to receive future contracts or any salary, severance, stock offering, or other financial gain, current or deferred, as a result of, or in relation to, the proposed transfer of ownership of the hospital, or hold a position with either of the transacting parties, or any entity affiliated with the transacting parties, and, if so, has fully disclosed the terms and conditions of such financial gain or position.

(3) The office shall deny any certificate of need application involving a transfer of ownership of a hospital unless the commissioner finds that the affected community will be assured of continued access to high quality and affordable health care after accounting for (A) any proposed change impacting hospital staffing, (B) any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and (C) any likely increases in the prices for health care services or total health care spending in the state that may impact the affordability of care.

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

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

(e) (1) If a transacting party is a hospital system, as defined in section 19a-486i, as amended by this act, whether located within or outside the state, a hospital that is a member of a hospital system, whether located within or outside the state, or any person that is organized or operated for profit and the certificate of need application involving a transfer of ownership of the hospital is approved, the office shall hire an independent consultant to serve as a post-transfer compliance reporter for a period of three years after completion of the transfer of ownership of the hospital. Such reporter shall, at a minimum: (A) Meet with representatives of the new hospital and members of the affected community served by the new hospital not less than quarterly; and (B) report to the office not less than quarterly concerning (i) efforts the new hospital has taken to comply with any conditions the office placed on the approval of the certificate of need application and plans for future compliance, and (ii) community benefits and uncompensated care provided by the new hospital. The purchaser shall give the reporter access to its records and facilities for the purposes of carrying out his or her duties. The purchaser shall hold a public hearing in the municipality in which the new hospital is located not less than annually during the reporting period to provide for public review and comment on the reporter's reports and findings.

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

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

Sec. 34. (NEW) (*Effective October 1, 2015*) (a) The Office of Healthcare Access division within the Department of Public Health shall conduct a cost and market impact review in each case where the applicant for a certificate of need filed pursuant to section 19a-638 of the general statutes, as amended by this act, that involves the transfer of ownership of a hospital, as defined in subsection (d) of section 19a-639 of the general statutes, as amended by this act, or another party to the transfer of ownership of a hospital is (1) a hospital system, as defined in section 19a-486i of the general statutes, as amended by this act, whether located in or out of the state, (2) a hospital, as defined in section 19a-486i of the general statutes, as amended by this act, that is a member of a hospital system, whether located in or out of the state, or (3) any person that is organized or operated for profit.

(b) Not later than twenty-one days after receipt of a properly filed certificate of need application involving the transfer of ownership of a hospital, as described in subsection (a) of this section, the office shall initiate such cost and market impact review by sending the transacting parties a written notice that shall contain a description of the basis for the cost and market impact review as well as a request for information and documents. Not later than thirty days after receipt of such notice, the transacting parties shall submit to the office a written response. Such response shall include, but need not be limited to, any information or documents requested by the office concerning the

transfer of ownership of the hospital. The office shall have the powers with respect to the cost and market impact review as provided in section 19a-633 of the general statutes.

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

(d) The cost and market impact review conducted pursuant to this section shall examine factors relating to the businesses and relative market positions of the transacting parties as defined in subsection (d) of section 19a-639 of the general statutes, as amended by this act, and may include, but need not be limited to: (1) The transacting parties' size and market share within its primary service area, by major service category and within its dispersed service areas; (2) the transacting parties' prices for services, including the transacting parties' relative prices compared to other health care providers for the same services in the same market; (3) the transacting parties' health status adjusted total medical expense, including the transacting parties' health status adjusted total medical expense compared to that of similar health care providers; (4) the quality of the services provided by the transacting parties, including patient experience; (5) the transacting parties' cost and cost trends in comparison to total health care expenditures state wide; (6) the availability and accessibility of services similar to those provided by each transacting party, or proposed to be provided as a result of the transfer of ownership of a hospital within each transacting party's primary service areas and dispersed service areas; (7) the impact of the proposed transfer of ownership of the hospital on

competing options for the delivery of health care services within each transacting party's primary service area and dispersed service area including the impact on existing service providers; (8) the methods used by the transacting parties to attract patient volume and to recruit or acquire health care professionals or facilities; (9) the role of each transacting party in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within each transacting party's primary service area and dispersed service area; (10) the role of each transacting party in providing low margin or negative margin services within each transacting party's primary service area and dispersed service area; (11) consumer concerns, including, but not limited to, complaints or other allegations that a transacting party has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (12) any other factors that the office determines to be in the public interest.

(e) Not later than ninety days after the office certifies substantial compliance with any request for documents or information issued by the office in accordance with this section, or a later date set by mutual agreement of the office and the transacting parties, the office shall make factual findings and issue a preliminary report on the cost and market impact review. Such preliminary report shall include, but shall not be limited to, an indication as to whether a transacting party meets the following criteria: (1) Currently has or, following the proposed transfer of operations of the hospital, is likely to have a dominant market share for the services the transacting party provides; and (2) (A) currently charges or, following the proposed transfer of operations of the hospital, is likely to charge prices for services that are materially higher than the median prices charged by all other health care providers for the same services in the same market, or (B) currently has or, following the proposed transfer of operations of a hospital, is likely to have a health status adjusted total medical expense that is materially higher than the median total medical expense for all other health care providers for the same service in the same market.

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

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

(h) After the office refers a final report on a transfer of ownership of a hospital to the Attorney General under subsection (f) of this section, the Attorney General may: (1) Conduct an investigation to determine whether the transacting parties engaged, or, as a result of completing the transfer of ownership of the hospital, are expected to engage in unfair methods of competition, anti-competitive behavior or other conduct in violation of chapter 624 or 735a of the general statutes or any other state or federal law; and (2) if appropriate, take action under chapter 624 or 735a of the general statutes or any other state law to protect consumers in the health care market. The office's final report may be evidence in any such action.

(i) For the purposes of this section, the provisions of chapter 735a of the general statutes may be directly enforced by the Attorney General. Nothing in this section shall be construed to modify, impair or supersede the operation of any state antitrust law or otherwise limit the authority of the Attorney General to (1) take any action against a transacting party as authorized by any law, or (2) protect consumers in

the health care market under any law. Notwithstanding subdivision (1) of subsection (a) of section 42-110c of the general statutes, the transacting parties shall be subject to chapter 735a of the general statutes.

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

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

(l) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, concerning cost and market impact reviews and to administer the provisions of this section. Such regulations shall include definitions of the following terms: "Dispersed service area", "health status adjusted total medical expense", "major service category", "relative prices", "total health care spending" and "health care services". The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner publishes notice of intention to adopt the regulations on the Department of Public Health's Internet web site and the eRegulations

System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 35. Subsections (d) to (g), inclusive, of section 19a-639a of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(d) Upon determining that an application is complete, the office shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the department. In addition, the office shall post such notice on its web site. The date on which the office posts such notice on its web site shall begin the review period. Except as provided in this subsection, (1) the review period for a completed application shall be ninety days from the date on which the office posts such notice on its web site; and (2) the office shall issue a decision on a completed application prior to the expiration of the ninety-day review period. The review period for a completed application that involves a transfer of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when the offer was made in response to a request for proposal or similar voluntary offer for sale shall be sixty days from the date on which the office posts notice on its web site. Upon request or for good cause shown, the office may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the office shall issue a decision on the completed application prior to the expiration of the extended review period. If the office holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this section, the office shall issue a decision on the completed application not later than sixty days after the date the office closes the public hearing record.

(e) Except as provided in this subsection, the office shall hold a public hearing on a properly filed and completed certificate of need application if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a

public hearing be held on the application. For a properly filed and completed certificate of need application involving a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when an offer was made in response to a request for proposal or similar voluntary offer for sale, a public hearing shall be held if twenty-five or more individuals or an individual representing twenty-five or more people submits a request, in writing, that a public hearing be held on the application. Any request for a public hearing shall be made to the office not later than thirty days after the date the office determines the application to be complete.

(f) (1) The office shall hold a public hearing with respect to each certificate of need application submitted under this chapter that involves the transfer of ownership of a hospital, as defined in subsection (d) of section 19a-639, as amended by this act. Such hearing shall be held in the municipality in which the hospital that is the subject of the application is located.

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

(g) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations **[**in the Connecticut Law Journal**]** on the department's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until

the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 36. Subsection (c) of section 19a-486a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

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

Sec. 37. Subsection (a) of section 19a-486d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) The commissioner shall deny an application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, unless the commissioner finds that: (1) **[**The affected community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing; (2)**]** in a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the

uninsured and the underinsured; **[**(3)**]** (2) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral; and **[**(4)**]** (3) certificate of need authorization is justified in accordance with chapter 368z. The commissioner may contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The commissioner shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. The purchaser shall pay such bills no later than thirty days after the date of receipt of such bills.

Sec. 38. Subsection (a) of section 19a-644 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general, **[**or**]** children's hospital and health system shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. Such report shall include: (1) Salaries and fringe benefits for the ten highest paid positions; (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and (3) the salaries paid to hospital and health system employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations. For purposes of this subsection, "health system" has the same meaning as provided in section 33-182aa.

Sec. 39. (*Effective July 1, 2015*) Not later than January 1, 2016, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters

relating to public health concerning certificate of need requirements under chapter 368z of the general statutes. Such report shall include, but need not be limited to, recommendations (1) to eliminate the requirements to obtain certificate of need approval or to create an expedited approval process for certain services, equipment purchases and ownership transfers or other matters for which such approval is currently required under section 19a-638 of the general statutes, as amended by this act, such as, for example: (A) Ancillary capital expenditures not related to direct patient care or services; (B) replacement of outdated or damaged equipment, the purchase of which was previously approved by the office; (C) repairs to facilities damaged by floods, storms or other unexpected occurrences; and (D) facility improvements necessary to comply with building codes or other legal requirements, and (2) concerning an expedited automatic approval of certain certificate of need applications in circumstances where the Department of Public Health does not notify the applicant within thirty days of its intent to review such application.

Sec. 40. Section 19a-486b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Not later than one hundred twenty days after the date of receipt of the completed application pursuant to subsection (d) of section 19a-486a, the Attorney General and the commissioner shall approve the application, with or without modification, or deny the application. The commissioner shall also determine, in accordance with the provisions of chapter 368z, whether to approve, with or without modification, or deny the application for a certificate of need that is part of the completed application. Notwithstanding the provisions of section 19a-639a, <u>as amended by this act,</u> the commissioner shall complete the decision on the application for a certificate of need within the same time period as the completed application. Such one-hundred-twenty-day period may be extended by <u>(1)</u> agreement of the Attorney General, the commissioner, the nonprofit hospital and the purchaser<u>, or (2) the commissioner pending completion of a cost and market impact review</u>

conducted pursuant to section 34 of this act. If the Attorney General initiates a proceeding to enforce a subpoena pursuant to section 19a-486c or 19a-486d, as amended by this act, the one-hundred-twenty-day period shall be tolled until the final court decision on the last pending enforcement proceeding, including any appeal or time for the filing of such appeal. Unless the one-hundred-twenty-day period is extended pursuant to this section, if the commissioner and Attorney General fail to take action on an agreement prior to the one hundred twenty-first day after the date of the filing of the completed application, the application shall be deemed approved.

(b) The commissioner and the Attorney General may place any conditions on the approval of an application that relate to the purposes of sections 19a-486a to 19a-486h, inclusive, as amended by this act. In placing any such conditions the commissioner shall follow the guidelines and criteria described in subdivision (4) of subsection (d) of section 19a-639, as amended by this act. Any such conditions may be in addition to any conditions placed by the commissioner pursuant to subdivision (4) of subsection (d) of section 19a-639, as amended by this act.

Sec. 41. Subdivisions (10) to (16), inclusive, of section 19a-630 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(10) **[**"Group practice"**]** "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed

in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

(11) "Health care facility" means (A) hospitals licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C) freestanding emergency departments; (D) outpatient surgical facilities, as defined in section 19a-493b and licensed under chapter 368v; (E) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; (F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638, as amended by this act. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

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

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

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

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

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

Sec. 42. Subdivision (3) of subsection (a) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(3) A transfer of ownership of a large group practice to any entity other than a (A) physician, or (B) group of **[**physicians, except when the parties have signed a sale agreement to transfer such ownership on or before September 1, 2014**]** two or more physicians, legally organized in a partnership, professional corporation, or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity;

Sec. 43. (*Effective from passage*) (a) The chairperson of the board of directors of the State of Connecticut Health and Educational Facilities Authority, established pursuant to section 10a-179 of the general statutes, in consultation with the Commissioner of Economic and Community Development, shall consider financing options to enable community hospitals to acquire medical equipment, update information technology, renovate or acquire health care facilities, build new health care facilities and engage in other activities for the purposes of: (1) Improving the ability of community hospitals to effectively serve members of the community, including, but not limited to, (A) enhancing care coordination, (B) advancing the integration of health care services, including behavioral health services, (C) promoting evidence-based care practices and efficient health care delivery, and (D) providing culturally and linguistically

appropriate health care services to members of the community served by the hospital; (2) advancing hospitals' adoption of health information technology, including the adoption of interoperable electronic health records systems and clinical support tools; (3) facilitating the ability of hospitals and other health care providers to exchange health information electronically to ensure a continuity of care among all health care providers; (4) supporting infrastructure investments in health care facilities that are necessary for (A) the transition to alternative payment methodologies, including investments in data analysis functions and performance management programs to promote price transparency for health care services, and (B) aggregation and analysis of clinical data to facilitate appropriate, evidence-based intervention and care management practices, especially for vulnerable populations and persons with complex health care needs; (5) improving the affordability and quality of health care, by increasing coordination between hospitals and community-based health care providers and other community organizations; (6) improving access to health care services, including behavioral health services; and (7) ensuring staff-to-patient ratios are sufficient to deliver high quality health care.

(b) Not later than January 1, 2016, said chairperson shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and commerce concerning such study. Such report shall include, but need not be limited to, (1) to the extent practicable, a capital needs assessment for community hospitals; and (2) recommendations concerning (A) methods to finance improvements currently needed by community hospitals in the state to fulfill the purposes described in subsection (a) of this section, including, but not limited to, the use of bond funds, alternative funding methods and the establishment of a program to provide low-interest or no-interest loans to community hospitals, (B) other state programs that may be utilized to support community hospital improvements, and (C) legislative or regulatory changes that

may be needed to accomplish the purposes described in subsection (a) of this section. For purposes of this subsection, "community hospital" means: (i) A hospital that is not a teaching hospital and has twenty-five or fewer full-time equivalent interns or residents for each one hundred inpatient beds; (ii) a hospital that charges less for health care services than the state median prices for those health care services; (iii) a nonprofit hospital; and (iv) a hospital that is not part of a hospital system, as defined in section 19a-486i of the general statutes, as amended by this act.

Sec. 44. Section 19a-25d of the general statutes is repealed. (*Effective 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	*from passage*	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	*October 1, 2015*	New section
Sec. 8	*January 1, 2016*	New section
Sec. 9	*January 1, 2016*	38a-591
Sec. 10	*January 1, 2016*	New section
Sec. 11	*October 1, 2015*	New section
Sec. 12	*January 1, 2016*	38a-591b(d)
Sec. 13	*January 1, 2016*	38a-478d
Sec. 14	*January 1, 2016*	20-7f
Sec. 15	*January 1, 2016*	38a-193(c)(3)
Sec. 16	*from passage*	19a-508c
Sec. 17	*October 1, 2015*	New section
Sec. 18	*October 1, 2015*	New section
Sec. 19	*October 1, 2015*	38a-1084
Sec. 20	*October 1, 2015*	New section
Sec. 21	*October 1, 2015*	New section
Sec. 22	*July 1, 2015*	19a-725
Sec. 23	*July 1, 2015*	New section

Sec. 24	*July 1, 2015*	38a-1083(c)(17)
Sec. 25	*October 1, 2015*	New section
Sec. 26	*from passage*	New section
Sec. 27	*from passage*	New section
Sec. 28	*October 1, 2015*	4-60i
Sec. 29	*October 1, 2015*	New section
Sec. 30	*July 1, 2015*	New section
Sec. 31	*October 1, 2015*	4-60j
Sec. 32	*October 1, 2015*	19a-486i
Sec. 33	*July 1, 2015*	19a-639
Sec. 34	*October 1, 2015*	New section
Sec. 35	*July 1, 2015*	19a-639a(d) to (g)
Sec. 36	*July 1, 2015*	19a-486a(c)
Sec. 37	*July 1, 2015*	19a-486d(a)
Sec. 38	*July 1, 2015*	19a-644(a)
Sec. 39	*July 1, 2015*	New section
Sec. 40	*October 1, 2015*	19a-486b
Sec. 41	*July 1, 2015*	19a-630(10) to (16)
Sec. 42	*July 1, 2015*	19a-638(a)(3)
Sec. 43	*from passage*	New section
Sec. 44	*October 1, 2015*	Repealer section