



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."**

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

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 Section 38a-1084 of the general statutes is repealed and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

5 The exchange shall:

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

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

11 (3) Implement procedures for the certification, recertification and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

118 (C) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

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

148 (D) The Department of Social Services; and

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

150 (23) Meet the following financial integrity requirements:

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

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

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

160 (i) Investigate the affairs of the exchange;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

250 this section shall be posted on the Internet web site.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

402 Sec. 5. (NEW) (*Effective October 1, 2015*) (a) On and after March 1,
403 2016, each health carrier shall maintain an Internet web site and
404 institute the use of a mobile device application and toll-free telephone
405 number that enables consumers to request and obtain: (1) Information
406 on in-network costs for inpatient admissions, health care procedures
407 and services, including (A) the allowed amount for (i) at a minimum,
408 admissions and procedures reported to the Connecticut Health
409 Insurance Exchange pursuant to section 2 of this act for each health
410 care provider in the state, and (ii) prescribed drugs and durable
411 medical equipment; (B) the estimated out-of-pocket costs that the
412 consumer would be responsible for paying for any such admission or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

497 (b) Each insurance company, fraternal benefit society, hospital
498 service corporation, medical service corporation and health care center
499 licensed to do business in the state shall comply with Sections 1251,
500 1252 and 1304 of the Affordable Care Act and the following Sections of
501 the Public Health Service Act, as amended by the Affordable Care Act:
502 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
503 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

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

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

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

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

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

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

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

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

566 (3) "Health care plan" means an individual or a group health
567 insurance policy or health benefit plan that provides coverage of the
568 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
569 469 of the general statutes;

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

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

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

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

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

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

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

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

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

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

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

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

625 (c) With respect to a surprise bill:

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

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

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

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

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

667 (d) Each health carrier shall:

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

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

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

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

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

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

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

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

696 subsection (a) of section 10 of this act;

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

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

712 [(3)] (4) Inform a covered person and the covered person's health
713 care professional of the health carrier's grievance procedures whenever
714 the health carrier denies certification of a benefit requested by a
715 covered person's health care professional;

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

718 [(4)] (6) Include in materials intended for prospective covered
719 persons a summary of its utilization review and benefit determination
720 procedures;

721 [(5)] (7) Print on its membership or identification cards a toll-free
722 telephone number for utilization review and benefit determinations;

723 [(6)] (8) Maintain records of all benefit requests, claims and notices
724 associated with utilization review and benefit determinations made in
725 accordance with section 38a-591d for not less than six years after such

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

729 ~~[(7)]~~ (9) Maintain records in accordance with section 38a-591h of all
730 grievances received. Each health carrier shall make such records
731 available for examination by covered persons, to the extent such
732 records are permitted to be disclosed by law, the commissioner and
733 appropriate federal oversight agencies upon request.

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

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

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

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

748 ~~[(2)]~~ (3) Include, under a separate category or heading, participating
749 advanced practice registered nurses in the listing of providers
750 specified under subdivision (1) of this section; and

751 ~~[(3)]~~ (4) For a managed care plan that requires the selection of a
752 primary care provider, ~~[: (A) Allow]~~ allow an enrollee to designate a
753 participating, in-network physician or a participating, in-network
754 advanced practice registered nurse as such enrollee's primary care
755 provider. ~~]; and~~

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

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

761 (a) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

827 (a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

959 ~~(j)~~ ~~(1)~~ If any transaction, as described in subsection (c) of section 19a-
960 486i, as amended by this act, results in the establishment of a hospital-
961 based facility at which facility fees will likely be billed, the hospital or
962 health system, that is the purchaser in such transaction shall, not later
963 than thirty days after such transaction, provide written notice, by first
964 class mail, of the transaction to each patient served within the previous
965 three years by the health care facility that has been purchased as part
966 of such transaction.

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

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

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

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

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

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

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

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

994 (4) A hospital, health system or hospital-based facility shall not
995 collect a facility fee for services provided at a hospital-based facility
996 that is subject to the provisions of this subsection from the date of the
997 transaction until at least thirty days after the written notice required
998 pursuant to this subsection is mailed to the patient or a copy of such
999 notice is filed with the Office of Health Care Access, whichever is later.
1000 A violation of this subsection shall be considered an unfair trade

1001 practice pursuant to section 42-110b.

1002 (k) Notwithstanding the provisions of this section, on and after
1003 October 1, 2015, no hospital, health system or hospital-based facility
1004 shall collect a facility fee for (1) outpatient health care services that use
1005 a current procedural terminology evaluation and management code
1006 and are provided at a hospital-based facility located off-site from a
1007 hospital campus, or (2) outpatient services received by a patient who is
1008 uninsured of more than the Medicare rate. Notwithstanding the
1009 provisions of this subsection, in circumstances when an insurance
1010 contract that is in effect on October 1, 2015, provides reimbursement
1011 for facility fees prohibited under the provisions of this section, a
1012 hospital or health system may continue to collect reimbursement from
1013 the health insurer for such facility fees until the date of expiration of
1014 such contract. A violation of this subsection shall be considered an
1015 unfair trade practice pursuant to chapter 735a.

1016 (l) (1) Each hospital and health system shall report not later than
1017 July 1, 2016, and annually thereafter to the Commissioner of Public
1018 Health concerning facility fees charged or billed during the preceding
1019 calendar year. Such report shall include (A) the name and location of
1020 each facility owned or operated by the hospital or health system that
1021 provides services for which a facility fee is charged or billed, (B) the
1022 number of patient visits at each such facility for which a facility fee
1023 was charged or billed, (C) the number, total amount and range of
1024 allowable facility fees paid at each such facility by Medicare, Medicaid
1025 or under private insurance policies, (D) for each facility, the total
1026 amount of revenue received by the hospital or health system derived
1027 from facility fees, (E) the total amount of revenue received by the
1028 hospital or health system from all facilities derived from facility fees,
1029 (F) a description of the ten procedures or services that generated the
1030 greatest amount of facility fee revenue and, for each such procedure or
1031 service, the total amount of revenue received by the hospital or health
1032 system derived from facility fees, and (G) the top ten procedures for
1033 which facility fees are charged based on patient volume. For purposes

1034 of this subsection, "facility" means a hospital-based facility that is
1035 located outside a hospital campus.

1036 (2) The commissioner shall publish the information reported
1037 pursuant to subdivision (1) of this subsection, or post a link to such
1038 information, on the Internet web site of the Office of Health Care
1039 Access.

1040 Sec. 17. (NEW) (*Effective October 1, 2015*) (a) As used in this section,
1041 "campus", "facility fee", "health system", "hospital" and "hospital-based
1042 facility" have the same meanings as provided in section 19a-508c of the
1043 general statutes, as amended by this act.

1044 (b) (1) Each health insurer, health care center or other entity that
1045 delivers, issues for delivery, renews, amends or continues, on or after
1046 January 1, 2016, an individual or a group health insurance policy or
1047 health benefit plan providing coverage of the type specified in
1048 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
1049 statutes in this state, and includes in a contract entered into, renewed
1050 or amended on or after October 1, 2015, with a hospital, a health
1051 system or a hospital-based facility, reimbursement to such hospital,
1052 health system or hospital-based facility for a facility fee for outpatient
1053 health care services that are provided at a hospital-based facility
1054 located off-site from a hospital campus, shall not impose any
1055 additional copayment for such fee.

1056 (2) With respect to an insured covered under such policy or plan,
1057 who has not satisfied the deductible applicable to such policy or plan
1058 at the time of the provision of the applicable health care service, no
1059 such hospital, health system or hospital-based facility may collect from
1060 such insured for any applicable facility fee more than the facility fee
1061 reimbursement rate agreed to by such insurer, center or other entity
1062 pursuant to such contract.

1063 Sec. 18. (NEW) (*Effective October 1, 2015*) (a) Each health insurer,
1064 health care center, hospital service corporation, medical service

1065 corporation or other entity that delivers, issues for delivery, renews,
1066 amends or continues an individual or group health insurance policy
1067 providing coverage of the type specified in subdivisions (1), (2), (4),
1068 (11) and (12) of section 38a-469 of the general statutes in this state may
1069 offer plans with a tiered health care provider network that has
1070 different cost-sharing rates for different health care provider tiers and
1071 rewards insureds and enrollees for choosing low-cost, high-quality
1072 health care providers by offering lower copayments, deductibles or
1073 other out-of-pocket expenses.

1074 (b) Each tiered provider network plan shall only include variations
1075 on cost-sharing between health care provider tiers that are reasonable
1076 in relation to the premiums charged and shall provide adequate access
1077 to covered services.

1078 (c) (1) For the purposes of a tiered provider network plan, a health
1079 insurer, health care center, hospital service corporation, medical
1080 service corporation or other entity may (A) reclassify a health care
1081 provider tier, or (B) determine health care provider participation in a
1082 tiered provider network plan not more than once per calendar year,
1083 except a health carrier may reclassify a health care provider from a
1084 higher cost tier to a lower cost tier or add new health care providers to
1085 its tiered provider network plan at any time.

1086 (2) If such insurer, center, corporation or other entity reclassifies a
1087 health care provider tier or a health care provider during a plan year, it
1088 shall notify any insured or enrollee affected by such change at least
1089 thirty days before such change takes effect.

1090 (d) The commissioner may adopt regulations, in accordance with
1091 the provisions of chapter 54 of the general statutes, to implement the
1092 provisions of this section.

1093 (e) Each insurer, center, corporation or other entity that offers a
1094 tiered provider network plan shall post on its Internet web site
1095 information about its tiered provider network plan, including, but not

1096 limited to, a current list of health care providers participating in such
1097 plan, the selection criteria for a health care provider to participate in
1098 such plan and the tier under which each participating health care
1099 provider is classified.

1100 Sec. 19. Section 38a-1084 of the general statutes is repealed and the
1101 following is substituted in lieu thereof (*Effective October 1, 2015*):

1102 The exchange shall:

1103 (1) Administer the exchange for both qualified individuals and
1104 qualified employers;

1105 (2) Commission surveys of individuals, small employers and health
1106 care providers on issues related to health care and health care
1107 coverage;

1108 (3) Implement procedures for the certification, recertification and
1109 decertification, consistent with guidelines developed by the Secretary
1110 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
1111 of health benefit plans as qualified health plans;

1112 (4) Provide for the operation of a toll-free telephone hotline to
1113 respond to requests for assistance;

1114 (5) Provide for enrollment periods, as provided under Section
1115 1311(c)(6) of the Affordable Care Act;

1116 (6) Maintain an Internet web site through which enrollees and
1117 prospective enrollees of qualified health plans may obtain
1118 standardized comparative information on such plans including, but
1119 not limited to, the enrollee satisfaction survey information under
1120 Section 1311(c)(4) of the Affordable Care Act and any other
1121 information or tools to assist enrollees and prospective enrollees
1122 evaluate qualified health plans offered through the exchange;

1123 (7) Publish the average costs of licensing, regulatory fees and any

1124 other payments required by the exchange and the administrative costs
1125 of the exchange, including information on moneys lost to waste, fraud
1126 and abuse, on an Internet web site to educate individuals on such
1127 costs;

1128 (8) On or before the open enrollment period for plan year 2017,
1129 assign a rating to each qualified health plan offered through the
1130 exchange in accordance with the criteria developed by the Secretary
1131 under Section 1311(c)(3) of the Affordable Care Act, and determine
1132 each qualified health plan's level of coverage in accordance with
1133 regulations issued by the Secretary under Section 1302(d)(2)(A) of the
1134 Affordable Care Act;

1135 (9) Use a standardized format for presenting health benefit options
1136 in the exchange, including the use of the uniform outline of coverage
1137 established under Section 2715 of the Public Health Service Act, 42
1138 USC 300gg-15, as amended from time to time;

1139 (10) Inform individuals, in accordance with Section 1413 of the
1140 Affordable Care Act, of eligibility requirements for the Medicaid
1141 program under Title XIX of the Social Security Act, as amended from
1142 time to time, the Children's Health Insurance Program (CHIP) under
1143 Title XXI of the Social Security Act, as amended from time to time, or
1144 any applicable state or local public program, and enroll an individual
1145 in such program if the exchange determines, through screening of the
1146 application by the exchange, that such individual is eligible for any
1147 such program;

1148 (11) Collaborate with the Department of Social Services, to the
1149 extent possible, to allow an enrollee who loses premium tax credit
1150 eligibility under Section 36B of the Internal Revenue Code and is
1151 eligible for HUSKY Plan, Part A or any other state or local public
1152 program, to remain enrolled in a qualified health plan;

1153 (12) Establish and make available by electronic means a calculator to
1154 determine the actual cost of coverage after application of any premium

1155 tax credit under Section 36B of the Internal Revenue Code and any
1156 cost-sharing reduction under Section 1402 of the Affordable Care Act;

1157 (13) Establish a program for small employers through which
1158 qualified employers may access coverage for their employees and that
1159 shall enable any qualified employer to specify a level of coverage so
1160 that any of its employees may enroll in any qualified health plan
1161 offered through the exchange at the specified level of coverage;

1162 (14) Offer enrollees and small employers the option of having the
1163 exchange collect and administer premiums, including through
1164 allocation of premiums among the various insurers and qualified
1165 health plans chosen by individual employers;

1166 (15) Grant a certification, subject to Section 1411 of the Affordable
1167 Care Act, attesting that, for purposes of the individual responsibility
1168 penalty under Section 5000A of the Internal Revenue Code, an
1169 individual is exempt from the individual responsibility requirement or
1170 from the penalty imposed by said Section 5000A because:

1171 (A) There is no affordable qualified health plan available through
1172 the exchange, or the individual's employer, covering the individual; or

1173 (B) The individual meets the requirements for any other such
1174 exemption from the individual responsibility requirement or penalty;

1175 (16) Provide to the Secretary of the Treasury of the United States the
1176 following:

1177 (A) A list of the individuals granted a certification under
1178 subdivision (15) of this section, including the name and taxpayer
1179 identification number of each individual;

1180 (B) The name and taxpayer identification number of each individual
1181 who was an employee of an employer but who was determined to be
1182 eligible for the premium tax credit under Section 36B of the Internal
1183 Revenue Code because:

1184 (i) The employer did not provide minimum essential health benefits
1185 coverage; or

1186 (ii) The employer provided the minimum essential coverage but it
1187 was determined under Section 36B(c)(2)(C) of the Internal Revenue
1188 Code to be unaffordable to the employee or not provide the required
1189 minimum actuarial value; and

1190 (C) The name and taxpayer identification number of:

1191 (i) Each individual who notifies the exchange under Section
1192 1411(b)(4) of the Affordable Care Act that such individual has changed
1193 employers; and

1194 (ii) Each individual who ceases coverage under a qualified health
1195 plan during a plan year and the effective date of that cessation;

1196 (17) Provide to each employer the name of each employee, as
1197 described in subparagraph (B) of subdivision (16) of this section, of the
1198 employer who ceases coverage under a qualified health plan during a
1199 plan year and the effective date of the cessation;

1200 (18) Perform duties required of, or delegated to, the exchange by the
1201 Secretary or the Secretary of the Treasury of the United States related
1202 to determining eligibility for premium tax credits, reduced cost-
1203 sharing or individual responsibility requirement exemptions;

1204 (19) Select entities qualified to serve as Navigators in accordance
1205 with Section 1311(i) of the Affordable Care Act and award grants to
1206 enable Navigators to:

1207 (A) Conduct public education activities to raise awareness of the
1208 availability of qualified health plans;

1209 (B) Distribute fair and impartial information concerning enrollment
1210 in qualified health plans and the availability of premium tax credits
1211 under Section 36B of the Internal Revenue Code and cost-sharing

1212 reductions under Section 1402 of the Affordable Care Act;

1213 (C) Facilitate enrollment in qualified health plans;

1214 (D) Provide referrals to the Office of the Healthcare Advocate or
1215 health insurance ombudsman established under Section 2793 of the
1216 Public Health Service Act, 42 USC 300gg-93, as amended from time to
1217 time, or any other appropriate state agency or agencies, for any
1218 enrollee with a grievance, complaint or question regarding the
1219 enrollee's health benefit plan, coverage or a determination under that
1220 plan or coverage; and

1221 (E) Provide information in a manner that is culturally and
1222 linguistically appropriate to the needs of the population being served
1223 by the exchange;

1224 (20) Review the rate of premium growth within and outside the
1225 exchange and consider such information in developing
1226 recommendations on whether to continue limiting qualified employer
1227 status to small employers;

1228 (21) Credit the amount, in accordance with Section 10108 of the
1229 Affordable Care Act, of any free choice voucher to the monthly
1230 premium of the plan in which a qualified employee is enrolled and
1231 collect the amount credited from the offering employer;

1232 (22) Consult with stakeholders relevant to carrying out the activities
1233 required under sections 38a-1080 to 38a-1090, inclusive, including, but
1234 not limited to:

1235 (A) Individuals who are knowledgeable about the health care
1236 system, have background or experience in making informed decisions
1237 regarding health, medical and scientific matters and are enrollees in
1238 qualified health plans;

1239 (B) Individuals and entities with experience in facilitating
1240 enrollment in qualified health plans;

1241 (C) Representatives of small employers and self-employed
1242 individuals;

1243 (D) The Department of Social Services; and

1244 (E) Advocates for enrolling hard-to-reach populations;

1245 (23) Meet the following financial integrity requirements:

1246 (A) Keep an accurate accounting of all activities, receipts and
1247 expenditures and annually submit to the Secretary, the Governor, the
1248 Insurance Commissioner and the General Assembly a report
1249 concerning such accountings;

1250 (B) Fully cooperate with any investigation conducted by the
1251 Secretary pursuant to the Secretary's authority under the Affordable
1252 Care Act and allow the Secretary, in coordination with the Inspector
1253 General of the United States Department of Health and Human
1254 Services, to:

1255 (i) Investigate the affairs of the exchange;

1256 (ii) Examine the properties and records of the exchange; and

1257 (iii) Require periodic reports in relation to the activities undertaken
1258 by the exchange; and

1259 (C) Not use any funds in carrying out its activities under sections
1260 38a-1080 to 38a-1089, inclusive, and section 38a-1091 that are intended
1261 for the administrative and operational expenses of the exchange, for
1262 staff retreats, promotional giveaways, excessive executive
1263 compensation or promotion of federal or state legislative and
1264 regulatory modifications;

1265 (24) (A) Seek to include the most comprehensive health benefit
1266 plans that offer high quality benefits at the most affordable price in the
1267 exchange, and (B) encourage health carriers to offer, and offer through
1268 the exchange, tiered health care provider network plans, as described

1269 in section 18 of this act:

1270 (25) Report at least annually to the General Assembly on the effect
1271 of adverse selection on the operations of the exchange and make
1272 legislative recommendations, if necessary, to reduce the negative
1273 impact from any such adverse selection on the sustainability of the
1274 exchange, including recommendations to ensure that regulation of
1275 insurers and health benefit plans are similar for qualified health plans
1276 offered through the exchange and health benefit plans offered outside
1277 the exchange. The exchange shall evaluate whether adverse selection is
1278 occurring with respect to health benefit plans that are grandfathered
1279 under the Affordable Care Act, self-insured plans, plans sold through
1280 the exchange and plans sold outside the exchange; and

1281 (26) Seek funding for and oversee the planning, implementation and
1282 development of policies and procedures for the administration of the
1283 all-payer claims database program established under section 38a-1091.

1284 Sec. 20. (NEW) (*Effective October 1, 2015*) (a) As used in this section,
1285 "campus", "health system", "hospital", "hospital-based facility" and
1286 "affiliated provider" have the same meanings as provided in section
1287 19a-508c of the general statutes, as amended by this act.

1288 (b) Each hospital shall, if negotiating reimbursement rates on a fee-
1289 for-service basis or for reimbursements based on bundled services per
1290 diagnosis, condition, procedure or other standardized bundles of
1291 services and at the request of a health insurance company, health care
1292 center or other entity that provides health care benefits to its insureds
1293 or enrollees, (1) negotiate separately with such company, center or
1294 other entity, even if any hospitals are commonly owned, and (2)
1295 negotiate for health care services provided by the hospital at a
1296 hospital-based facility located on the hospital campus separately from
1297 outpatient health care services provided by hospital-affiliated
1298 providers at outpatient facilities, health care providers' offices or other
1299 hospital-based facilities located off-site from the hospital campus.

1300 Sec. 21. (NEW) (*Effective October 1, 2015*) Each health insurer, health
1301 care center, hospital service corporation, medical service corporation,
1302 preferred provider network or other entity that contracts with health
1303 care providers to provide health care services to its insureds or
1304 enrollees shall include in each such contract that is entered into,
1305 renewed or amended on or after July 1, 2016, a provision for site-
1306 neutral reimbursement for outpatient health care services that use a
1307 current procedural terminology evaluation and management code and
1308 are provided off-site from a hospital campus. Such provision shall
1309 require, for reimbursements made on a fee-for-service basis or for
1310 reimbursements based on bundled services per diagnosis, condition,
1311 procedure or other standardized bundles of services, reimbursement
1312 rates that are the same for outpatient health care services described
1313 herein for all health care providers in the same geographic region as
1314 determined by the Insurance Commissioner, regardless of the
1315 employer or affiliation of a health care provider. Each such contract
1316 shall include a conspicuous statement that the contract complies with
1317 the site-neutral reimbursement policy required by this section.

1318 Sec. 22. Section 19a-725 of the general statutes is repealed and the
1319 following is substituted in lieu thereof (*Effective July 1, 2015*):

1320 (a) There is established within the office of the Lieutenant Governor,
1321 the [SustiNet] Health Care Cabinet for the purpose of advising the
1322 Governor on the matters set forth in subsection (c) of this section.

1323 (b) (1) [The SustiNet] (A) Prior to July 1, 2015, the Health Care
1324 Cabinet shall consist of the following members who shall be appointed
1325 on or before August 1, 2011: [(A)] (i) Five appointed by the Governor,
1326 two of whom may represent the health care industry and shall serve
1327 for terms of four years, one of whom shall represent community health
1328 centers and shall serve for a term of three years, one of whom shall
1329 represent insurance producers and shall serve for a term of three years
1330 and one of whom shall be an at-large appointment and shall serve for a
1331 term of three years; [(B)] (ii) one appointed by the president pro
1332 tempore of the Senate, who shall be an oral health specialist engaged in

1333 active practice and shall serve for a term of four years; [(C)] (iii) one
1334 appointed by the majority leader of the Senate, who shall represent
1335 labor and shall serve for a term of three years; [(D)] (iv) one appointed
1336 by the minority leader of the Senate, who shall be an advanced practice
1337 registered nurse engaged in active practice and shall serve for a term of
1338 two years; [(E)] (v) one appointed by the speaker of the House of
1339 Representatives, who shall be a consumer advocate and shall serve for
1340 a term of four years; [(F)] (vi) one appointed by the majority leader of
1341 the House of Representatives, who shall be a primary care physician
1342 engaged in active practice and shall serve for a term of four years; [(G)]
1343 (vii) one appointed by the minority leader of the House of
1344 Representatives, who shall represent the health information
1345 technology industry and shall serve for a term of three years; [(H)]
1346 (viii) five appointed jointly by the chairpersons of the SustiNet Health
1347 Partnership board of directors, one of whom shall represent faith
1348 communities, one of whom shall represent small businesses, one of
1349 whom shall represent the home health care industry, one of whom
1350 shall represent hospitals, and one of whom shall be an at-large
1351 appointment, all of whom shall serve for terms of five years; [(I)] (ix)
1352 the Lieutenant Governor; [(J)] (x) the Secretary of the Office of Policy
1353 and Management, or the secretary's designee; the Comptroller, or the
1354 Comptroller's designee; the chief executive officer of the Connecticut
1355 Health Insurance Exchange, or said officer's designee; the
1356 Commissioners of Social Services and Public Health, or their
1357 designees; and the Healthcare Advocate, or the Healthcare Advocate's
1358 designee, all of whom shall serve as ex-officio voting members; and
1359 [(K)] (xi) the Commissioners of Children and Families, Developmental
1360 Services and Mental Health and Addiction Services, and the Insurance
1361 Commissioner, or their designees, and the nonprofit liaison to the
1362 Governor, or the nonprofit liaison's designee, all of whom shall serve
1363 as ex-officio nonvoting members.

1364 (B) On and after July 1, 2015, the Health Care Cabinet shall include
1365 the following additional members: (i) Two members appointed by the
1366 Governor on or before August 1, 2015, one of whom shall be a

1367 behavioral health provider and shall serve a term of three years and
1368 one of whom shall be a health economist with expertise in health care
1369 payment models and shall serve a term of three years; and (ii) the
1370 director of the state innovation model initiative program management
1371 office, or said director's designee, who shall serve as an ex-officio
1372 voting member. The provisions of this subparagraph shall not affect
1373 the terms of the cabinet members set forth in subparagraphs (A)(i) to
1374 (A)(viii), inclusive, of subdivision (1) of this subsection.

1375 (2) Following the expiration of initial cabinet member terms,
1376 subsequent cabinet terms shall be for four years, commencing on
1377 August first of the year of the appointment. If an appointing authority
1378 fails to make an initial appointment to the cabinet or an appointment
1379 to fill a cabinet vacancy within ninety days of the date of such vacancy,
1380 the appointed cabinet members shall, by majority vote, make such
1381 appointment to the cabinet.

1382 (3) Upon the expiration of the initial terms of the five cabinet
1383 members appointed by SustiNet Health Partnership board of directors,
1384 five successor cabinet members shall be appointed as follows: (A) One
1385 appointed by the Governor; (B) one appointed by the president pro
1386 tempore of the Senate; (C) one appointed by the speaker of the House
1387 of Representatives; and (D) two appointed by majority vote of the
1388 appointed board members. Successor board members appointed
1389 pursuant to this subdivision shall be at-large appointments.

1390 (4) The Lieutenant Governor shall serve as the chairperson of the
1391 [SustiNet] Health Care Cabinet. [The Lieutenant Governor shall
1392 schedule the first meeting of the SustiNet Health Care Cabinet, which
1393 meeting shall be held not later than September 1, 2011.]

1394 (c) The [SustiNet] Health Care Cabinet shall advise the Governor
1395 regarding the development of an integrated health care system for
1396 Connecticut and shall:

1397 (1) Evaluate the means of ensuring an adequate health care

1398 workforce in the state;

1399 (2) [Jointly evaluate, with the chief executive officer of the
1400 Connecticut Health Insurance Exchange, the feasibility of
1401 implementing a basic health program option as set forth in Section
1402 1331 of the Affordable Care Act] Set health care cost growth goals for
1403 the state and consider recommendations for (A) the establishment of
1404 annual health care cost growth benchmarks for the state for the
1405 average growth in total health care expenditures in the next calendar
1406 year and the posting of such benchmarks on an Internet web site that is
1407 maintained by the cabinet, and (B) the establishment of procedures to
1408 assist health care providers that exceed such benchmarks without
1409 either corresponding improvements in quality or other causes not
1410 related to efficiency to improve efficiency and reduce cost growth,
1411 including, but not limited to, procedures for such providers to
1412 implement performance improvement plans;

1413 (3) Identify short and long-range opportunities, issues and gaps
1414 created by the enactment of federal health care reform;

1415 (4) Review the effectiveness of delivery system reforms and other
1416 efforts to control health care costs, enhance competition, improve cost-
1417 effectiveness in the health care market and improve the quality of care,
1418 including, but not limited to, reforms and efforts implemented by state
1419 agencies; [and]

1420 (5) Review cost containment models in other states, including, but
1421 not limited to, Massachusetts, Maryland, Oregon, Rhode Island,
1422 Washington and Vermont, to identify successful practices and
1423 programs that may be relevant for this state and implemented in this
1424 state;

1425 (6) Collect and analyze data as the cabinet deems necessary to make
1426 recommendations to enhance the transparency of health care provider
1427 costs, prices and business organizations and affiliations;

1428 (7) Collect and analyze data as the cabinet deems necessary to

1429 monitor, by payer and provider type, variations in prices charged for
1430 health care services and reimbursement rates paid. Such analysis may
1431 include, but is not limited to, (A) identification of factors contributing
1432 to such price and reimbursement variation, (B) assessment of the
1433 impact of such price and reimbursement variation on health care costs,
1434 health insurance premium rates and access to care, and (C) the
1435 recommendation of policy changes to reduce health care provider
1436 price variations the cabinet finds to be unrelated to actual cost or
1437 quality differences or that unnecessarily contribute to health care cost
1438 inflation; and

1439 [(5)] (8) Advise the Governor on matters relating to: (A) The design,
1440 implementation, actionable objectives and evaluation of state and
1441 federal health care policies, priorities and objectives relating to the
1442 state's efforts to improve access to health care, and (B) the quality of
1443 such care and the affordability and sustainability of the state's health
1444 care system.

1445 (d) The [SustiNet] Health Care Cabinet may convene working
1446 groups, which include volunteer health care experts, to make
1447 recommendations concerning the development and implementation of
1448 service delivery and health care provider payment reforms, including
1449 multipayer initiatives, medical homes, electronic health records and
1450 evidenced-based health care quality improvement.

1451 (e) On or before January 1, 2016, and annually thereafter, the Health
1452 Care Cabinet shall submit a report on the activities of the cabinet, in
1453 accordance with the provisions of section 11-4a, to the Governor and
1454 the joint standing committee of the General Assembly having
1455 cognizance of matters relating to public health.

1456 [(e)] (f) The office of the Lieutenant Governor and the Office of the
1457 Healthcare Advocate shall provide support staff to the [SustiNet]
1458 Health Care Cabinet.

1459 Sec. 23. (Effective July 1, 2015) (a) Not later than July 15, 2015, the

1460 Health Care Cabinet established under section 19a-725 of the general
1461 statutes, as amended by this act, shall convene a working group to
1462 study the rising cost of health care, including, but not limited to,
1463 increases in the prices charged for health care services, the variation in
1464 such prices among health care providers and the impact on such prices
1465 and price variation of reimbursement rates paid by health insurers to
1466 health care providers. The working group shall examine policies aimed
1467 at enhancing competition, fairness and cost-effectiveness in the health
1468 care market and the reduction of disparities in reimbursement rates
1469 and prices charged by health care providers.

1470 (b) The working group shall examine: (1) The variation in prices
1471 charged by health care providers within similar health care provider
1472 groups; (2) the variation in prices charged by health care providers for
1473 services of comparable acuity, quality and complexity; (3) the variation
1474 in the volume of care provided by health care providers with low and
1475 high levels of relative health care provider prices or health status
1476 adjusted total medical expenses; (4) the correlation between prices
1477 charged by health care providers and (A) the quality of care provided,
1478 (B) the acuity of the patient population, (C) health care providers'
1479 payer mix, (D) unique services provided by health care providers,
1480 including specialty teaching services and community services, and (E)
1481 health care providers' operational costs, including administrative and
1482 management costs; (5) in the case of hospitals, the correlation between
1483 prices charged by hospitals and their respective statuses as
1484 disproportionate share hospitals, specialty hospitals, pediatric
1485 specialty hospitals or academic teaching hospitals; (6) the correlation
1486 between prices charged by health care providers and market share,
1487 horizontal consolidation and vertical integration and referral policies
1488 and patterns; and (7) the correlation between facility fees, as defined in
1489 section 19a-508c of the general statutes, as amended by this act, and
1490 total medical spending, consumer out-of-pocket expenses and the
1491 variation in prices charged by health care providers for services of
1492 comparable acuity, quality and complexity.

1493 (c) The working group may hold informational hearings, consult
1494 with the Attorney General and solicit information from, and the
1495 participation of, parties likely to be affected by the results of the study
1496 and recommendations the working group may make, including, but
1497 not limited to, hospitals with a high proportion of public payer
1498 reimbursements, primary care providers, community health centers,
1499 health insurers, third-party administrators, as defined in section 38a-
1500 720 of the general statutes, employers, representatives of the Health
1501 Care Cost Containment Committee, as defined in section 3-123aaa of
1502 the general statutes, and organizations representing consumers and
1503 the uninsured.

1504 (d) The chairperson of the Health Care Cabinet may request from
1505 health insurers, health care providers or third-party administrators
1506 information or materials relevant to the study. Any information or
1507 materials submitted or disclosed to the working group for such study
1508 shall be confidential and not subject to disclosure under section 1-210
1509 of the general statutes, except that data that have identifiers removed
1510 and do not disclose the names of any health care provider, health
1511 insurer or payer or individual and are not otherwise protected by law
1512 may be disclosed as part of the working group's report.

1513 (e) (1) (A) Not later than January 1, 2016, or a later date as provided
1514 in subdivision (2) of this subsection, the working group shall submit a
1515 report to the General Assembly, in accordance with the provisions of
1516 section 11-4a of the general statutes, of the findings of the study and
1517 recommendations to (i) reduce price variations among health care
1518 providers, (ii) promote the use of high-quality health care providers
1519 with low total medical expenses and health care provider prices, and
1520 (iii) mitigate the impact of facility fees on consumer out-of-pocket
1521 expenses and total medical spending.

1522 (B) Such recommendations may include (i) expanding or modifying
1523 the site-neutral reimbursement provision set forth in section 21 of this
1524 act, (ii) expanding or modifying the limitations on facility fees set forth
1525 in subsection (k) of section 19a-508c of the general statutes, as

1526 amended by this act, and (iii) establishing a reasonable maximum
1527 health care provider price variation limit and establishing a state-wide
1528 median rate for certain health care services and procedures.

1529 (2) The chairperson of the Health Care Cabinet may notify the
1530 speaker of the House of Representatives, the president pro tempore of
1531 the Senate, the minority leader of the House of Representatives and the
1532 minority leader of the Senate of the need to extend the date of
1533 submission of the study. Such notice shall identify a date certain for
1534 submission of the study, not to be later than January 1, 2017, and the
1535 working group shall submit a preliminary report not later than
1536 January 1, 2016.

1537 (3) The working group shall terminate on January 1, 2016, or if said
1538 date was extended pursuant to subdivision (2) of this subsection, on
1539 the date the study is submitted or January 1, 2017, whichever is later.

1540 Sec. 24. Subdivision (17) of subsection (c) of section 38a-1083 of the
1541 general statutes is repealed and the following is substituted in lieu
1542 thereof (*Effective July 1, 2015*):

1543 (17) Evaluate [jointly with the SustiNet Health Care Cabinet] the
1544 feasibility of implementing a basic health program option as set forth
1545 in Section 1331 of the Affordable Care Act;

1546 Sec. 25. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
1547 section:

1548 (1) "Affiliated provider" means a health care provider that is: (A)
1549 Employed by a hospital or health system, (B) under a professional
1550 services agreement with a hospital or health system that permits such
1551 hospital or health system to bill on behalf of such health care provider,
1552 or (C) a clinical faculty member of a medical school, as defined in
1553 section 33-182aa of the general statutes, that is affiliated with a hospital
1554 or health system in a manner that permits such hospital or health
1555 system to bill on behalf of such clinical faculty member;

1556 (2) "Certified electronic health record system" means a health record
1557 system that is certified by the federal Office of the National
1558 Coordinator for Health Information Technology;

1559 (3) "Electronic health record" means any computerized, digital or
1560 other electronic record of individual health-related information that is
1561 created, held, managed or consulted by a health care provider and
1562 may include, but need not be limited to, continuity of care documents,
1563 discharge summaries and other information or data relating to patient
1564 demographics, medical history, medication, allergies, immunizations,
1565 laboratory test results, radiology or other diagnostic images, vital signs
1566 and statistics;

1567 (4) "Electronic health record system" means a computer-based
1568 information system that is used to create, collect, store, manipulate,
1569 share, exchange or make available electronic health records for the
1570 purposes of the delivery of patient care;

1571 (5) "Health care provider" means any individual, corporation,
1572 facility or institution licensed by the state to provide health care
1573 services;

1574 (6) "Health information blocking" means (A) knowingly interfering
1575 with or knowingly engaging in business practices or other conduct that
1576 is reasonably likely to interfere with the ability of patients, health care
1577 providers or other authorized persons to access, exchange or use
1578 electronic health records, or (B) knowingly using an electronic health
1579 record system to (i) steer patient referrals to affiliated providers, (ii)
1580 prevent patient referrals to health care providers who are not affiliated
1581 providers, or (iii) otherwise unreasonably interfere with patient
1582 referrals to health care providers who are not affiliated providers;

1583 (7) "Hospital" has the same meaning as provided in section 19a-490
1584 of the general statutes;

1585 (8) "Health system" has the same meaning as provided in section
1586 19a-508c of the general statutes, as amended by this act;

1587 (9) "Seller" means any person or entity that directly, or indirectly
1588 through an employee, agent, independent contractor or other person,
1589 sells, leases or offers to sell or lease an electronic health record system
1590 or a license or right to use an electronic health record system.

1591 (b) Electronic health records shall, to the fullest extent practicable,
1592 (1) follow the patient, (2) be made accessible to the patient, and (3) be
1593 shared and exchanged with the health care provider of the patient's
1594 choice in a timely manner.

1595 (c) Health information blocking shall be an unfair trade practice
1596 pursuant to section 42-110b of the general statutes.

1597 (d) Health information blocking by a hospital, health system or
1598 seller shall be subject to the penalties contained in subsection (b) of
1599 section 42-110o of the general statutes.

1600 (e) It shall be an unfair trade practice pursuant to section 42-110b of
1601 the general statutes for any seller to make a false, misleading or
1602 deceptive representation that an electronic health record system is a
1603 certified electronic health record system.

1604 (f) The provisions of this section shall be enforced by the Attorney
1605 General.

1606 (g) Nothing contained in this section shall be construed as a
1607 limitation upon the power or authority of the state, the Attorney
1608 General or the Commissioner of Consumer Protection to seek
1609 administrative, legal or equitable relief as provided by any state statute
1610 or common law.

1611 Sec. 26. (NEW) (*Effective from passage*) (a) There shall be established a
1612 State-wide Health Information Exchange to empower consumers to
1613 make effective health care decisions, promote patient-centered care,
1614 improve the quality, safety and value of health care, reduce waste and
1615 duplication of services, support clinical decision-making, keep
1616 confidential health information secure and make progress toward the

1617 state's public health goals.

1618 (b) It shall be the goal of the State-wide Health Information
1619 Exchange to: (1) Allow real-time, secure access to patient health
1620 information and complete medical records across all health care
1621 provider settings; (2) provide patients with secure electronic access to
1622 their health information; (3) allow voluntary participation by patients
1623 to access their health information at no cost; (4) support care
1624 coordination through real-time alerts and timely access to clinical
1625 information; (5) reduce costs associated with preventable
1626 readmissions, duplicative testing and medical errors; (6) promote the
1627 highest level of interoperability; (7) meet all state and federal privacy
1628 and security requirements; and (8) support public health reporting,
1629 quality improvement, academic research and health care delivery and
1630 payment reform through data aggregation and analytics.

1631 (c) All contracts or agreements entered into by or on behalf of the
1632 state relating to health information technology or the exchange of
1633 health information shall be consistent with the goals articulated in
1634 subsection (b) of this section and shall utilize contractors, vendors and
1635 other partners with a demonstrated commitment to such goals.

1636 (d) (1) The Commissioner of Social Services, in consultation with the
1637 Secretary of the Office of Policy and Management, shall, upon the State
1638 Bond Commission's approval of bond funds authorized by the General
1639 Assembly for the purposes of establishing a State-wide Health
1640 Information Exchange, issue a request for proposals from eligible
1641 nonprofit organizations for the development, management and
1642 operation of the State-wide Health Information Exchange.

1643 (2) An eligible nonprofit organization responding to the request for
1644 proposals shall: (A) Have not less than three years of experience
1645 operating either a state-wide health information exchange in any state
1646 or a regional exchange serving a population of not less than one
1647 million that (i) enables the exchange of patient health information
1648 among health care providers, patients and other authorized users

1649 without regard to location, source of payment or technology, (ii)
1650 includes, with proper consent, behavioral health and substance abuse
1651 treatment information, (iii) supports transitions of care and care
1652 coordination through real-time health care provider alerts and access
1653 to clinical information, (iv) allows health information to follow each
1654 patient, (v) allows patients to access and manage their health data, and
1655 (vi) has demonstrated success in reducing costs associated with
1656 preventable readmissions, duplicative testing or medical errors; (B) be
1657 committed to, and demonstrate, a high level of transparency in its
1658 governance, decision-making and operations; (C) be capable of
1659 providing consulting to ensure effective governance; (D) is regulated
1660 or administratively overseen by a state government agency; and (E)
1661 have sufficient staff and appropriate expertise and experience to carry
1662 out the administrative, operational and financial responsibilities of the
1663 State-wide Health Information Exchange.

1664 (e) Such request for proposals shall require: (1) Broad local
1665 governance that (A) includes all stakeholders, including, but not
1666 limited to, a representative of the Department of Social Services,
1667 hospitals, physicians, behavioral health providers, long-term care
1668 providers, health insurers, employers, patients, and academic or
1669 medical research institutions, and (B) is committed to the successful
1670 development and implementation of the State-wide Health
1671 Information Exchange; (2) provision of a health information exchange
1672 plan that (A) improves upon existing infrastructure and is coordinated
1673 with existing programs, (B) ensures the privacy and security of patient
1674 information at all levels and, at a minimum, complies with all
1675 applicable state and federal privacy and security laws, (C) focuses on
1676 efforts to maximize utility with minimal cost and burden on
1677 stakeholders, (D) promotes the highest level of interoperability and
1678 utilization of national information technology standards, and (E) aligns
1679 with the state-wide health information technology plan and data
1680 standards established and implemented by the Commissioner of Social
1681 Services pursuant to section 4-60i of the general statutes, as amended
1682 by this act; and (3) provision of a business plan that includes (A) a

1683 collaborative process engaging all stakeholders in the development of
1684 recommended funding streams sufficient to support the annual
1685 operating expenses of the State-wide Health Information Exchange,
1686 and (B) the development of services and products to support the long-
1687 term sustainability of the State-wide Health Information Exchange.

1688 (f) Notwithstanding the provisions of subsections (d) and (e) of this
1689 section, if, on or before December 1, 2015, the Commissioner of Social
1690 Services, with the advice and consent of the State Health Information
1691 Technology Advisory Council, established pursuant to section 30 of
1692 this act, submits a plan to the Secretary of the Office of Policy and
1693 Management for the establishment of a State-wide Health Information
1694 Exchange consistent with subsections (a), (b) and (c) of this section,
1695 and such plan is approved by the Secretary, the commissioner may
1696 implement such plan and enter into any contracts or agreements to
1697 implement such plan.

1698 (g) The Department of Social Services shall have administrative
1699 authority over the State-wide Health Information Exchange.

1700 Sec. 27. (NEW) (*Effective from passage*) (a) For purposes of this
1701 section:

1702 (1) "Health care provider" means any individual, corporation,
1703 facility or institution licensed by the state to provide health care
1704 services; and

1705 (2) "Electronic health record system" means a computer-based
1706 information system that is used to create, collect, store, manipulate,
1707 share, exchange or make available electronic health records for the
1708 purposes of the delivery of patient care.

1709 (b) Not later than one year after commencement of the operation of
1710 the State-wide Health Information Exchange, each hospital licensed
1711 under chapter 368v of the general statutes and clinical laboratory
1712 licensed under section 19a-30 of the general statutes shall maintain an
1713 electronic health record system capable of connecting to and

1714 participating in the State-wide Health Information Exchange and shall
1715 apply to begin the process of connecting to, and participating in, the
1716 State-wide Health Information Exchange.

1717 (c) Not later than two years after commencement of the operation of
1718 the State-wide Health Information Exchange, each health care provider
1719 with an electronic health record system capable of connecting to, and
1720 participating in, the State-wide Health Information Exchange shall
1721 apply to begin the process of connecting to, and participating in, the
1722 State-wide Health Information Exchange.

1723 Sec. 28. Section 4-60i of the general statutes is repealed and the
1724 following is substituted in lieu thereof (*Effective October 1, 2015*):

1725 (a) As used in this section:

1726 (1) "Electronic health information system" means an information
1727 processing system, involving both computer hardware and software
1728 that deals with the storage, retrieval, sharing and use of health care
1729 information, data and knowledge for communication and decision
1730 making, and includes: (A) An electronic health record that provides
1731 access in real time to a patient's complete medical record; (B) a
1732 personal health record through which an individual, and anyone
1733 authorized by such individual, can maintain and manage such
1734 individual's health information; (C) computerized order entry
1735 technology that permits a health care provider to order diagnostic and
1736 treatment services, including prescription drugs electronically; (D)
1737 electronic alerts and reminders to health care providers to improve
1738 compliance with best practices, promote regular screenings and other
1739 preventive practices, and facilitate diagnoses and treatments; (E) error
1740 notification procedures that generate a warning if an order is entered
1741 that is likely to lead to a significant adverse outcome for a patient; and
1742 (F) tools to allow for the collection, analysis and reporting of data on
1743 adverse events, near misses, the quality and efficiency of care, patient
1744 satisfaction and other healthcare-related performance measures.

1745 (2) "Interoperability" means the ability of two or more systems or
1746 components to exchange information and to use the information that
1747 has been exchanged and includes: (A) The capacity to physically
1748 connect to a network for the purpose of exchanging data with other
1749 users; (B) the ability of a connected user to demonstrate appropriate
1750 permissions to participate in the instant transaction over the network;
1751 and (C) the capacity of a connected user with such permissions to
1752 access, transmit, receive and exchange usable information with other
1753 users.

1754 (3) "Standard electronic format" means a format using open
1755 electronic standards that: (A) Enable health information technology to
1756 be used for the collection of clinically specific data; (B) promote the
1757 interoperability of health care information across health care settings,
1758 including reporting to local, state and federal agencies; and (C)
1759 facilitate clinical decision support.

1760 [(a)] (b) The Commissioner of Social Services shall (1) develop,
1761 throughout the Departments of Developmental Services, Public
1762 Health, Correction, Children and Families and Mental Health and
1763 Addiction Services, uniform management information, uniform
1764 statistical information, uniform terminology for similar facilities,
1765 uniform electronic health information technology standards and
1766 uniform regulations for the licensing of human services facilities, (2)
1767 plan for increased participation of the private sector in the delivery of
1768 human services, (3) provide direction and coordination to federally
1769 funded programs in the human services agencies and recommend
1770 uniform system improvements and reallocation of physical resources
1771 and designation of a single responsibility across human services
1772 agencies lines to eliminate duplication.

1773 [(b)] (c) The Commissioner of Social Services shall, in consultation
1774 with [the Departments of Public Health and Mental Health and
1775 Addiction Services] the Health Information Technology Advisory
1776 Council, established pursuant to section 30 of this act, implement and
1777 periodically revise the state-wide health information technology plan

1778 established pursuant to [section 19a-25d] this section and shall
1779 establish electronic data standards to facilitate the development of
1780 integrated electronic health information systems [, as defined in
1781 subsection (a) of section 19a-25d,] for use by health care providers and
1782 institutions that receive state funding. Such electronic data standards
1783 shall: (1) Include provisions relating to security, privacy, data content,
1784 structures and format, vocabulary and transmission protocols; (2) limit
1785 the use and dissemination of an individual's Social Security number
1786 and require the encryption of any Social Security number provided by
1787 an individual; (3) require privacy standards no less stringent than the
1788 "Standards for Privacy of Individually Identifiable Health Information"
1789 established under the Health Insurance Portability and Accountability
1790 Act of 1996, P.L. 104-191, as amended from time to time, and contained
1791 in 45 CFR 160, 164; (4) require that individually identifiable health
1792 information be secure and that access to such information be traceable
1793 by an electronic audit trail; (5) be compatible with any national data
1794 standards in order to allow for interstate interoperability; [, as defined
1795 in subsection (a) of section 19a-25d;] (6) permit the collection of health
1796 information in a standard electronic format; [, as defined in subsection
1797 (a) of section 19a-25d;] and (7) be compatible with the requirements for
1798 an electronic health information system. [, as defined in subsection (a)
1799 of section 19a-25d.]

1800 (d) The Commissioner of Social Services shall, within existing
1801 resources and in consultation with the Health Information Technology
1802 Advisory Council: (1) Oversee the development and implementation
1803 of the State-wide Health Information Exchange in conformance with
1804 section 26 of this act; (2) coordinate the state's health information
1805 technology and health information exchange efforts to ensure
1806 consistent and collaborative cross-agency planning and
1807 implementation; (3) serve as the state liaison to, and work
1808 collaboratively with, the State-wide Health Information Exchange
1809 established pursuant to section 26 of this act to ensure consistency
1810 between the state-wide health information technology plan and the
1811 State-wide Health Information Exchange and to support the state's

1812 health information technology and exchange goals; and (4) make
1813 recommendations to the Commissioner of Social Services and the
1814 General Assembly regarding health information technology and health
1815 information exchange policy and legislation.

1816 (e) The state-wide health information technology plan, implemented
1817 and periodically revised pursuant to subsection (c) of this section, shall
1818 include, but not be limited to (A) general standards and protocols for
1819 health information exchange, and (B) electronic data standards to
1820 facilitate the development of a state-wide, integrated electronic health
1821 information system for use by health care providers and institutions
1822 that are licensed by the state. Such electronic data standards shall (i)
1823 include provisions relating to security, privacy, data content,
1824 structures and format, vocabulary and transmission protocols, (ii) be
1825 compatible with any national data standards in order to allow for
1826 interstate interoperability, (iii) permit the collection of health
1827 information in a standard electronic format, and (iv) be compatible
1828 with the requirements for an electronic health information system.

1829 Sec. 29. (NEW) (*Effective October 1, 2015*) (a) For purposes of this
1830 section:

1831 (1) "Electronic health record" means any computerized, digital or
1832 other electronic record of individual health-related information that is
1833 created, held, managed or consulted by a health care provider and
1834 may include, but need not be limited to, continuity of care documents,
1835 discharge summaries and other information or data relating to patient
1836 demographics, medical history, medication, allergies, immunizations,
1837 laboratory test results, radiology or other diagnostic images, vital signs
1838 and statistics;

1839 (2) "Electronic health record system" means a computer-based
1840 information system that is used to create, collect, store, manipulate,
1841 share, exchange or make available electronic health records for the
1842 purpose of the delivery of patient care;

1843 (3) "Health care provider" means any individual, corporation,
1844 facility or institution licensed by the state to provide health care
1845 services; and

1846 (4) "Secure exchange" means the exchange of patient electronic
1847 health records between a hospital and a health care provider in a
1848 manner that complies with all state and federal privacy requirements,
1849 including, but not limited to, the Health Insurance Portability and
1850 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from
1851 time to time.

1852 (b) Each hospital licensed under chapter 368v of the general statutes
1853 shall, to the fullest extent practicable, use its electronic health records
1854 system to enable bidirectional connectivity and the secure exchange of
1855 patient electronic health records between the hospital and any other
1856 health care provider who (A) maintains an electronic health records
1857 system capable of exchanging such records, and (B) provides health
1858 care services to a patient whose records are the subject of the exchange.
1859 The requirements of this section apply to at least the following: (i)
1860 Laboratory and diagnostic tests; (ii) radiological and other diagnostic
1861 imaging; (iii) continuity of care documents; and (iv) discharge
1862 notifications and documents.

1863 (c) Each hospital shall implement the use of any hardware, software,
1864 bandwidth or program functions or settings already purchased or
1865 available to it to support the secure exchange of electronic health
1866 records and information as described in subsection (b) of this section.

1867 (d) Nothing in this section shall be construed as requiring a hospital
1868 to pay for any new or additional information technology, equipment,
1869 hardware or software, including interfaces, where such additional
1870 items are necessary to enable such exchange.

1871 (e) The failure of a hospital to take all reasonable steps to comply
1872 with this section shall constitute evidence of health information
1873 blocking pursuant to section 25 of this act.

1874 (f) A hospital that connects to, and actively participates in, the State-
1875 wide Health Information Exchange, established pursuant to section 26
1876 of this act shall be deemed to have satisfied the requirements of this
1877 section.

1878 Sec. 30. (NEW) (*Effective July 1, 2015*) (a) There shall be a State
1879 Health Information Technology Advisory Council to advise the
1880 Commissioner of Social Services in developing priorities and policy
1881 recommendations for advancing the state's health information
1882 technology and health information exchange efforts and goals and to
1883 advise the commissioner in the development and implementation of
1884 the state-wide health information technology plan and standards and
1885 the State-wide Health Information Exchange, established pursuant to
1886 section 26 of this act. The advisory council shall also advise the
1887 commissioner regarding the development of appropriate governance,
1888 oversight and accountability measures to ensure success in achieving
1889 the state's health information technology and exchange goals.

1890 (b) The council shall consist of the following members:

1891 (1) The Commissioners of Social Services, Mental Health and
1892 Addiction Services, Children and Families, Correction, Public Health
1893 and Developmental Services, or the commissioners' designees;

1894 (2) The Chief Information Officer of the state, or the Chief
1895 Information Officer's designee;

1896 (3) The chief executive officer of the Connecticut Health Insurance
1897 Exchange, or the chief executive officer's designee;

1898 (4) The director of the state innovation model initiative program
1899 management office, or the director's designee;

1900 (5) The chief information officer of The University of Connecticut
1901 Health Center, or said chief information officer's designee;

1902 (6) The Healthcare Advocate, or the Healthcare Advocate's

1903 designee;

1904 (7) Five members appointed by the Governor, one each of whom
1905 shall be (A) a representative of a health system that includes more than
1906 one hospital, (B) a representative of the health insurance industry, (C)
1907 an expert in health information technology, (D) a health care consumer
1908 or consumer advocate, and (E) an employee or trustee of a plan
1909 established pursuant to subdivision (5) of subsection (c) of 29 USC 186.

1910 (8) Two members appointed by the president pro tempore of the
1911 Senate, one each who shall be (A) a representative of a federally
1912 qualified health center, and (B) a provider of behavioral health
1913 services;

1914 (9) Two members appointed by the speaker of the House of
1915 Representatives, one each who shall be (A) a representative of the
1916 business community, and (B) a provider of home health care services;

1917 (10) One member appointed by the majority leader of the Senate,
1918 who shall be a representative of an independent community hospital;

1919 (11) One member appointed by the majority leader of the House of
1920 Representatives, who shall be a physician who provides services in a
1921 multispecialty group and who is not employed by a hospital;

1922 (12) One member appointed by the minority leader of the Senate,
1923 who shall be a primary care physician who provides services in a small
1924 independent practice;

1925 (13) One member appointed by the minority leader of the House of
1926 Representatives, who shall be an expert in health care analytics and
1927 quality analysis;

1928 (14) The president pro tempore of the Senate, or the president's
1929 designee;

1930 (15) The speaker of the House of Representatives, or the speaker's

1931 designee;

1932 (16) The minority leader of the Senate, or the minority leader's
1933 designee; and

1934 (17) The minority leader of the House of Representatives, or the
1935 minority leader's designee.

1936 (c) Any member appointed or designated under subdivisions (8) to
1937 (17), inclusive, of subsection (c) of this section may be a member of the
1938 General Assembly.

1939 (d) All appointments to the council shall be made not later than July
1940 1, 2015. The Commissioner of Social Services shall schedule the first
1941 meeting of the council, which shall be held not later than August 1,
1942 2015. The Commissioner of Social Services shall serve as a chairperson
1943 of the council. The council shall elect a second chairperson from among
1944 its members, who shall not be a state official. The council shall meet
1945 not less than monthly. The terms of the members shall be coterminous
1946 with the terms of the appointing authority for each member and
1947 subject to the provisions of section 4-1a of the general statutes. If any
1948 vacancy occurs on the council, the appointing authority having the
1949 power to make the appointment under the provisions of this section
1950 and shall appoint a person in accordance with the provisions of this
1951 section. A majority of the members of the council shall constitute a
1952 quorum. Members of the council shall serve without compensation,
1953 but shall be reimbursed for all reasonable expenses incurred in the
1954 performance of their duties.

1955 (e) Not later than January 1, 2016, and quarterly thereafter, the
1956 council shall report to the Commissioner of Social Services and the
1957 joint standing committees of the General Assembly having cognizance
1958 of matters relating to human services and public health concerning: (1)
1959 The development and implementation of the state-wide health
1960 information technology plan and standards; (2) the establishment of
1961 the State-wide Health Information Exchange and progress in meeting

1962 the goals of the State-wide Health Information Exchange; and (3)
1963 recommendations for policy, regulatory and legislative changes and
1964 other initiatives to promote the state's health information technology
1965 and exchange goals.

1966 (f) Prior to submitting any application, proposal, planning
1967 document or other request seeking federal grants, matching funds or
1968 other federal support for health information technology or health
1969 information exchange, the Commissioner of Social Services shall (1)
1970 present such application, proposal, document or other request to the
1971 council for review and comment, and (2) not less than thirty days prior
1972 to the submission, submit, in accordance with the provisions of section
1973 11-4a of the general statutes, such application, proposal, document or
1974 other request together with a summary of the council's comments and
1975 recommendations, if any, to the joint standing committees of the
1976 General Assembly having cognizance of matters relating to public
1977 health, human services, insurance and appropriations.

1978 Sec. 31. Section 4-60j of the general statutes is repealed and the
1979 following is substituted in lieu thereof (*Effective October 1, 2015*):

1980 In fulfilling his or her responsibilities under sections 4-60i, as
1981 amended by this act, and 4-60l and complying with the requirements
1982 of [section 19a-25d] said sections, the Commissioner of Social Services
1983 shall take into consideration such advice as may be provided to the
1984 commissioner by advisory boards and councils in the human services
1985 areas.

1986 Sec. 32. Section 19a-486i of the general statutes is repealed and the
1987 following is substituted in lieu thereof (*Effective October 1, 2015*):

1988 (a) As used in this section:

1989 (1) "Affiliation" means (A) the formation of a relationship between
1990 two or more entities that permits the entities to negotiate jointly with
1991 third parties over rates for professional medical services, (B) any
1992 physician network joint venture, or (C) any collaboration or

1993 agreement, between two or more entities that permits (i) coordination
1994 of professional medical services, (ii) monitoring and control or
1995 modification of the utilization of professional medical services, or (iii)
1996 the referral of patients for professional medical services but does not
1997 include a merger of hospitals, hospital systems or health care
1998 providers;

1999 (2) "Captive professional entity" means a professional corporation,
2000 limited liability company or other entity formed to render professional
2001 services in which a beneficial owner is a physician employed by or
2002 otherwise designated by a hospital or hospital system;

2003 (3) "Hospital" has the same meaning as provided in section 19a-490;

2004 (4) "Hospital system" means: (A) A parent corporation of one or
2005 more hospitals and any entity affiliated with such parent corporation
2006 through ownership, governance or membership, or (B) a hospital and
2007 any entity affiliated with such hospital through ownership,
2008 governance or membership;

2009 (5) "Health care provider" has the same meaning as provided in
2010 section 19a-17b;

2011 (6) "Medical foundation" means a medical foundation formed under
2012 chapter 594b;

2013 (7) "Physician" has the same meaning as provided in section 20-13a;

2014 (8) "Person" has the same meaning as provided in section 35-25;

2015 (9) "Professional corporation" has the same meaning as provided in
2016 section 33-182a;

2017 (10) "Group practice" means two or more physicians, legally
2018 organized in a partnership, professional corporation, limited liability
2019 company formed to render professional services, medical foundation,
2020 not-for-profit corporation, faculty practice plan or other similar entity

2021 (A) in which each physician who is a member of the group provides
2022 substantially the full range of services that the physician routinely
2023 provides, including, but not limited to, medical care, consultation,
2024 diagnosis or treatment, through the joint use of shared office space,
2025 facilities, equipment or personnel; (B) for which substantially all of the
2026 services of the physicians who are members of the group are provided
2027 through the group and are billed in the name of the group practice and
2028 amounts so received are treated as receipts of the group; or (C) in
2029 which the overhead expenses of, and the income from, the group are
2030 distributed in accordance with methods previously determined by
2031 members of the group. An entity that otherwise meets the definition of
2032 group practice under this section shall be considered a group practice
2033 although its shareholders, partners or owners of the group practice
2034 include single-physician professional corporations, limited liability
2035 companies formed to render professional services or other entities in
2036 which beneficial owners are individual physicians; and

2037 (11) "Primary service area" means the smallest number of zip codes
2038 from which the group practice draws at least seventy-five per cent of
2039 its patients.

2040 (b) At the same time that any person conducting business in this
2041 state that files merger, acquisition or any other information regarding
2042 market concentration with the Federal Trade Commission or the
2043 United States Department of Justice, in compliance with the Hart-
2044 Scott-Rodino Antitrust Improvements Act, 15 USC 18a, where a
2045 hospital, hospital system or other health care provider is a party to the
2046 merger or acquisition that is the subject of such information, such
2047 person shall provide written notification to the Attorney General of
2048 such filing and, upon the request of the Attorney General, provide a
2049 copy of such merger, acquisition or other information.

2050 (c) Not less than thirty days prior to the effective date of any
2051 transaction that results in a material change to the business or
2052 corporate structure of a group practice, the parties to the transaction
2053 shall submit written notice to the Attorney General of such material

2054 change. For purposes of this subsection, a material change to the
2055 business or corporate structure of a group practice includes: (1) The
2056 merger, consolidation or other affiliation of a group practice with (A)
2057 another group practice that results in a group practice comprised of
2058 eight or more physicians, or (B) a hospital, hospital system, captive
2059 professional entity, medical foundation or other entity organized or
2060 controlled by such hospital or hospital system; (2) the acquisition of all
2061 or substantially all of (A) the properties and assets of a group practice,
2062 or (B) the capital stock, membership interests or other equity interests
2063 of a group practice by (i) another group practice that results in a group
2064 practice comprised of eight or more physicians, or (ii) a hospital,
2065 hospital system, captive professional entity, medical foundation or
2066 other entity organized or controlled by such hospital or hospital
2067 system; (3) the employment of all or substantially all of the physicians
2068 of a group practice by (A) another group practice that results in a
2069 group practice comprised of eight or more physicians, or (B) a hospital,
2070 hospital system, captive professional entity, medical foundation or
2071 other entity organized by, controlled by or otherwise affiliated with
2072 such hospital or hospital system; and (4) the acquisition of one or more
2073 insolvent group practices by (A) another group practice that results in
2074 a group practice comprised of eight or more physicians, or (B) a
2075 hospital, hospital system, captive professional entity, medical
2076 foundation or other entity organized by, controlled by or otherwise
2077 affiliated with such hospital or hospital system.

2078 (d) (1) The written notice required under subsection (c) of this
2079 section shall identify each party to the transaction and describe the
2080 material change as of the date of such notice to the business or
2081 corporate structure of the group practice, including: [(1)] (A) A
2082 description of the nature of the proposed relationship among the
2083 parties to the proposed transaction; [(2)] (B) the names and specialties
2084 of each physician that is a member of the group practice that is the
2085 subject of the proposed transaction and who will practice medicine
2086 with the resulting group practice, hospital, hospital system, captive
2087 professional entity, medical foundation or other entity organized by,

2088 controlled by, or otherwise affiliated with such hospital or hospital
2089 system following the effective date of the transaction; [(3)] (C) the
2090 names of the business entities that are to provide services following the
2091 effective date of the transaction; [(4)] (D) the address for each location
2092 where such services are to be provided; [(5)] (E) a description of the
2093 services to be provided at each such location; and [(6)] (F) the primary
2094 service area to be served by each such location.

2095 (2) Not later than thirty days after the effective date of any
2096 transaction described in subsection (c) of this section, the parties to the
2097 transaction shall submit written notice to the Commissioner of Public
2098 Health. Such written notice shall include, but need not be limited to,
2099 the same information described in subdivision (1) of this subsection.
2100 The commissioner shall post a link to such notice on the Department of
2101 Public Health's Internet web site.

2102 (e) Not less than thirty days prior to the effective date of any
2103 transaction that results in an affiliation between one hospital or
2104 hospital system and another hospital or hospital system, the parties to
2105 the affiliation shall submit written notice to the Attorney General of
2106 such affiliation. Such written notice shall identify each party to the
2107 affiliation and describe the affiliation as of the date of such notice,
2108 including: (1) A description of the nature of the proposed relationship
2109 among the parties to the affiliation; (2) the names of the business
2110 entities that are to provide services following the effective date of the
2111 affiliation; (3) the address for each location where such services are to
2112 be provided; (4) a description of the services to be provided at each
2113 such location; and (5) the primary service area to be served by each
2114 such location.

2115 [(e)] (f) Written information submitted to the Attorney General
2116 pursuant to subsections (b) to [(d)] (e), inclusive, of this section shall be
2117 maintained and used by the Attorney General in the same manner as
2118 provided in section 35-42.

2119 [(f)] (g) Not later than December 31, 2014, and annually thereafter,

2120 each hospital and hospital system shall file with the Attorney General
2121 and the Commissioner of Public Health a written report describing the
2122 activities of the group practices owned or affiliated with such hospital
2123 or hospital system. Such report shall include, for each such group
2124 practice: (1) A description of the nature of the relationship between the
2125 hospital or hospital system and the group practice; (2) the names and
2126 specialties of each physician practicing medicine with the group
2127 practice; (3) the names of the business entities that provide services as
2128 part of the group practice and the address for each location where such
2129 services are provided; (4) a description of the services provided at each
2130 such location; and (5) the primary service area served by each such
2131 location.

2132 ~~[(g)]~~ (h) Not later than December 31, 2014, and annually thereafter,
2133 each group practice comprised of thirty or more physicians that is not
2134 the subject of a report filed under subsection ~~[(f)]~~ (g) of this section
2135 shall file with the Attorney General and the Commissioner of Public
2136 Health a written report concerning the group practice. Such report
2137 shall include, for each such group practice: (1) The names and
2138 specialties of each physician practicing medicine with the group
2139 practice; (2) the names of the business entities that provide services as
2140 part of the group practice and the address for each location where such
2141 services are provided; (3) a description of the services provided at each
2142 such location; and (4) the primary service area served by each such
2143 location.

2144 (i) Not later than December 31, 2015, and annually thereafter, each
2145 hospital and hospital system shall file with the Attorney General and
2146 the Commissioner of Public Health a written report describing each
2147 affiliation with another hospital or hospital system. Such report shall
2148 include: (1) The name and address of each party to the affiliation; (2) a
2149 description of the nature of the relationship among the parties to the
2150 affiliation; (3) the names of the business entities that provide services
2151 as part of the affiliation and the address for each location where such
2152 services are provided; (4) a description of the services provided at each

2153 such location; and (5) the primary service area served by each such
2154 location.

2155 Sec. 33. Section 19a-639 of the general statutes is repealed and the
2156 following is substituted in lieu thereof (*Effective July 1, 2015*):

2157 (a) In any deliberations involving a certificate of need application
2158 filed pursuant to section 19a-638, as amended by this act, the office
2159 shall take into consideration and make written findings concerning
2160 each of the following guidelines and principles:

2161 (1) Whether the proposed project is consistent with any applicable
2162 policies and standards adopted in regulations by the Department of
2163 Public Health;

2164 (2) The relationship of the proposed project to the state-wide health
2165 care facilities and services plan;

2166 (3) Whether there is a clear public need for the health care facility or
2167 services proposed by the applicant;

2168 (4) Whether the applicant has satisfactorily demonstrated how the
2169 proposal will impact the financial strength of the health care system in
2170 the state or that the proposal is financially feasible for the applicant;

2171 (5) Whether the applicant has satisfactorily demonstrated how the
2172 proposal will improve quality, accessibility and cost effectiveness of
2173 health care delivery in the region, including, but not limited to, (A)
2174 provision of or any change in the access to services for Medicaid
2175 recipients and indigent persons, and (B) the impact upon the cost
2176 effectiveness of providing access to services provided under the
2177 Medicaid program;

2178 (6) The applicant's past and proposed provision of health care
2179 services to relevant patient populations and payer mix, including, but
2180 not limited to, access to services by Medicaid recipients and indigent
2181 persons;

2182 (7) Whether the applicant has satisfactorily identified the population
2183 to be served by the proposed project and satisfactorily demonstrated
2184 that the identified population has a need for the proposed services;

2185 (8) The utilization of existing health care facilities and health care
2186 services in the service area of the applicant;

2187 (9) Whether the applicant has satisfactorily demonstrated that the
2188 proposed project shall not result in an unnecessary duplication of
2189 existing or approved health care services or facilities;

2190 (10) Whether an applicant, who has failed to provide or reduced
2191 access to services by Medicaid recipients or indigent persons, has
2192 demonstrated good cause for doing so, which shall not be
2193 demonstrated solely on the basis of differences in reimbursement rates
2194 between Medicaid and other health care payers;

2195 (11) Whether the applicant has satisfactorily demonstrated that the
2196 proposal will not negatively impact the diversity of health care
2197 providers and patient choice in the geographic region; and

2198 (12) Whether the applicant has satisfactorily demonstrated that any
2199 consolidation resulting from the proposal will not adversely affect
2200 health care costs or accessibility to care.

2201 (b) In deliberations as described in subsection (a) of this section,
2202 there shall be a presumption in favor of approving the certificate of
2203 need application for a transfer of ownership of a large group practice,
2204 as described in subdivision (3) of subsection (a) of section 19a-638, as
2205 amended by this act, when an offer was made in response to a request
2206 for proposal or similar voluntary offer for sale.

2207 (c) The office, as it deems necessary, may revise or supplement the
2208 guidelines and principles through regulation prescribed in subsection
2209 (a) of this section.

2210 (d) (1) For purposes of this subsection and subsection (e) of this

2211 section:

2212 (A) "Affected community" means a municipality where a hospital is
2213 physically located or a municipality whose inhabitants are regularly
2214 served by a hospital;

2215 (B) "Hospital" has the same meaning as provided in section 19a-490;

2216 (C) "New hospital" means a hospital as it exists after the approval of
2217 an agreement pursuant to section 19a-486b, as amended by this act, or
2218 a certificate of need application for a transfer of ownership of a
2219 hospital;

2220 (D) "Purchaser" means a person who is acquiring, or has acquired,
2221 any assets of a hospital through a transfer of ownership of a hospital;

2222 (E) "Transacting party" means a person who is a party to a proposed
2223 agreement for transfer of ownership of a hospital who submits an
2224 application to the commissioner and the Attorney General pursuant to
2225 section 19a-486a, as amended by this act, or a certificate of need
2226 application for a transfer of ownership;

2227 (F) "Transfer" means to sell, transfer, lease, exchange, option,
2228 convey, give or otherwise dispose of or transfer control over,
2229 including, but not limited to, transfer by way of merger or joint
2230 venture not in the ordinary course of business; and

2231 (G) "Transfer of ownership of a hospital" means a transfer that
2232 impacts or changes the governance or controlling body of a hospital,
2233 including, but not limited to, all affiliations, mergers or any sale or
2234 transfer of net assets of a hospital.

2235 (2) In any deliberations involving a certificate of need application
2236 filed pursuant to section 19a-638, as amended by this act, that involves
2237 the transfer of ownership of a hospital, the office shall, in addition to
2238 the guidelines and principles set forth in subsection (a) of this section
2239 and those prescribed through regulation pursuant to subsection (c) of

2240 this section, take into consideration and make written findings
2241 concerning each of the following guidelines and principles:

2242 (A) Whether the applicant fairly considered alternative proposals or
2243 offers in light of the purpose of maintaining health care provider
2244 diversity and consumer choice in the health care market and access to
2245 affordable quality health care for the affected community;

2246 (B) Whether the transacting parties have submitted a plan (i)
2247 demonstrating how health care services will be provided by the new
2248 hospital for the first five years following the transfer of ownership of
2249 the hospital, including any consolidation, reduction, elimination, or
2250 expansion of existing services or introduction of new services, and (ii)
2251 to account for the employment and workforce retraining needs of its
2252 workforce in light of its post-transfer business and service plan; and

2253 (C) Whether the transacting parties' officers, directors, board
2254 members or senior managers are expected to receive future contracts
2255 or any salary, severance, stock offering, or other financial gain, current
2256 or deferred, as a result of, or in relation to, the proposed transfer of
2257 ownership of the hospital, or hold a position with either of the
2258 transacting parties, or any entity affiliated with the transacting parties,
2259 and, if so, has fully disclosed the terms and conditions of such financial
2260 gain or position.

2261 (3) The office shall deny any certificate of need application involving
2262 a transfer of ownership of a hospital unless the commissioner finds
2263 that the affected community will be assured of continued access to
2264 high quality and affordable health care after accounting for (A) any
2265 proposed change impacting hospital staffing, (B) any consolidation in
2266 the hospital and health care market that may lessen health care
2267 provider diversity, consumer choice and access to care, and (C) any
2268 likely increases in the prices for health care services or total health care
2269 spending in the state that may impact the affordability of care.

2270 (4) The office may place any conditions on the approval of a

2271 certificate of need application involving a transfer of ownership of a
2272 hospital consistent with the provisions of this chapter. Before placing
2273 any such conditions, the office shall weigh the value of such conditions
2274 in promoting the purposes of this chapter against the individual and
2275 cumulative burden of such conditions on the transacting parties and
2276 the new hospital. For each condition imposed, the office shall include a
2277 concise statement of the legal and factual basis for such condition and
2278 the provision or provisions of this chapter that it is intended to
2279 promote. Each condition shall be reasonably tailored in time and
2280 scope. The transacting parties or the new hospital shall have the right
2281 to petition the office for an amendment to, or relief from, any condition
2282 based on changed circumstances, hardship or for other good cause.

2283 (e) (1) If a transacting party is a hospital system, as defined in
2284 section 19a-486i, as amended by this act, whether located within or
2285 outside the state, a hospital that is a member of a hospital system,
2286 whether located within or outside the state, or any person that is
2287 organized or operated for profit and the certificate of need application
2288 involving a transfer of ownership of the hospital is approved, the office
2289 shall hire an independent consultant to serve as a post-transfer
2290 compliance reporter for a period of three years after completion of the
2291 transfer of ownership of the hospital. Such reporter shall, at a
2292 minimum: (A) Meet with representatives of the new hospital and
2293 members of the affected community served by the new hospital not
2294 less than quarterly; and (B) report to the office not less than quarterly
2295 concerning (i) efforts the new hospital has taken to comply with any
2296 conditions the office placed on the approval of the certificate of need
2297 application and plans for future compliance, and (ii) community
2298 benefits and uncompensated care provided by the new hospital. The
2299 purchaser shall give the reporter access to its records and facilities for
2300 the purposes of carrying out his or her duties. The purchaser shall hold
2301 a public hearing in the municipality in which the new hospital is
2302 located not less than annually during the reporting period to provide
2303 for public review and comment on the reporter's reports and findings.

2304 (2) If the reporter finds that the purchaser has breached a condition
2305 of the approval of the certificate of need application, the office may, in
2306 consultation with the purchaser, the reporter and any other interested
2307 parties it deems appropriate, implement a performance improvement
2308 plan designed to remedy the conditions identified by the reporter and
2309 continue the reporting period for up to one year following a
2310 determination by the office that such conditions have been resolved.

2311 (3) The purchaser shall provide funds, in an amount determined by
2312 the office not to exceed two hundred thousand dollars annually, for
2313 the hiring of the post-transfer compliance reporter.

2314 Sec. 34. (NEW) (*Effective October 1, 2015*) (a) The Office of Healthcare
2315 Access division within the Department of Public Health shall conduct
2316 a cost and market impact review in each case where the applicant for a
2317 certificate of need filed pursuant to section 19a-638 of the general
2318 statutes, as amended by this act, that involves the transfer of
2319 ownership of a hospital, as defined in subsection (d) of section 19a-639
2320 of the general statutes, as amended by this act, or another party to the
2321 transfer of ownership of a hospital is (1) a hospital system, as defined
2322 in section 19a-486i of the general statutes, as amended by this act,
2323 whether located in or out of the state, (2) a hospital, as defined in
2324 section 19a-486i of the general statutes, as amended by this act, that is a
2325 member of a hospital system, whether located in or out of the state, or
2326 (3) any person that is organized or operated for profit.

2327 (b) Not later than twenty-one days after receipt of a properly filed
2328 certificate of need application involving the transfer of ownership of a
2329 hospital, as described in subsection (a) of this section, the office shall
2330 initiate such cost and market impact review by sending the transacting
2331 parties a written notice that shall contain a description of the basis for
2332 the cost and market impact review as well as a request for information
2333 and documents. Not later than thirty days after receipt of such notice,
2334 the transacting parties shall submit to the office a written response.
2335 Such response shall include, but need not be limited to, any
2336 information or documents requested by the office concerning the

2337 transfer of ownership of the hospital. The office shall have the powers
2338 with respect to the cost and market impact review as provided in
2339 section 19a-633 of the general statutes.

2340 (c) The office shall keep confidential all nonpublic information and
2341 documents obtained pursuant to this section and shall not disclose the
2342 information or documents to any person without the consent of the
2343 person that produced the information or documents, except in a
2344 preliminary report or final report issued in accordance with this
2345 section if the office believes that such disclosure should be made in the
2346 public interest after taking into account any privacy, trade secret or
2347 anti-competitive considerations. Such information and documents
2348 shall not be deemed a public record, under section 1-210 of the general
2349 statutes, and shall be exempt from disclosure.

2350 (d) The cost and market impact review conducted pursuant to this
2351 section shall examine factors relating to the businesses and relative
2352 market positions of the transacting parties as defined in subsection (d)
2353 of section 19a-639 of the general statutes, as amended by this act, and
2354 may include, but need not be limited to: (1) The transacting parties'
2355 size and market share within its primary service area, by major service
2356 category and within its dispersed service areas; (2) the transacting
2357 parties' prices for services, including the transacting parties' relative
2358 prices compared to other health care providers for the same services in
2359 the same market; (3) the transacting parties' health status adjusted total
2360 medical expense, including the transacting parties' health status
2361 adjusted total medical expense compared to that of similar health care
2362 providers; (4) the quality of the services provided by the transacting
2363 parties, including patient experience; (5) the transacting parties' cost
2364 and cost trends in comparison to total health care expenditures state
2365 wide; (6) the availability and accessibility of services similar to those
2366 provided by each transacting party, or proposed to be provided as a
2367 result of the transfer of ownership of a hospital within each transacting
2368 party's primary service areas and dispersed service areas; (7) the
2369 impact of the proposed transfer of ownership of the hospital on

2370 competing options for the delivery of health care services within each
2371 transacting party's primary service area and dispersed service area
2372 including the impact on existing service providers; (8) the methods
2373 used by the transacting parties to attract patient volume and to recruit
2374 or acquire health care professionals or facilities; (9) the role of each
2375 transacting party in serving at-risk, underserved and government
2376 payer patient populations, including those with behavioral, substance
2377 use disorder and mental health conditions, within each transacting
2378 party's primary service area and dispersed service area; (10) the role of
2379 each transacting party in providing low margin or negative margin
2380 services within each transacting party's primary service area and
2381 dispersed service area; (11) consumer concerns, including, but not
2382 limited to, complaints or other allegations that a transacting party has
2383 engaged in any unfair method of competition or any unfair or
2384 deceptive act or practice; and (12) any other factors that the office
2385 determines to be in the public interest.

2386 (e) Not later than ninety days after the office certifies substantial
2387 compliance with any request for documents or information issued by
2388 the office in accordance with this section, or a later date set by mutual
2389 agreement of the office and the transacting parties, the office shall
2390 make factual findings and issue a preliminary report on the cost and
2391 market impact review. Such preliminary report shall include, but shall
2392 not be limited to, an indication as to whether a transacting party meets
2393 the following criteria: (1) Currently has or, following the proposed
2394 transfer of operations of the hospital, is likely to have a dominant
2395 market share for the services the transacting party provides; and (2)
2396 (A) currently charges or, following the proposed transfer of operations
2397 of the hospital, is likely to charge prices for services that are materially
2398 higher than the median prices charged by all other health care
2399 providers for the same services in the same market, or (B) currently has
2400 or, following the proposed transfer of operations of a hospital, is likely
2401 to have a health status adjusted total medical expense that is materially
2402 higher than the median total medical expense for all other health care
2403 providers for the same service in the same market.

2404 (f) The transacting parties that are the subject of the cost and market
2405 impact review may respond in writing to the findings in the
2406 preliminary report issued in accordance with subsection (e) of this
2407 section not later than thirty days after the issuance of the preliminary
2408 report. Not later than sixty days after the issuance of the preliminary
2409 report, the office shall issue a final report of the cost and market impact
2410 review. The office shall refer to the Attorney General any final report
2411 on any proposed transfer of ownership that meets the criteria
2412 described in subsection (e) of this section.

2413 (g) Nothing in this section shall prohibit a transfer of ownership of a
2414 hospital, provided any such proposed transfer shall not be completed
2415 (1) less than thirty days after the office has issued a final report on a
2416 cost and market impact review, if such review is required, or (2) while
2417 any action brought by the Attorney General pursuant to subsection (h)
2418 of this section is pending and before a final judgment on such action is
2419 issued by a court of competent jurisdiction.

2420 (h) After the office refers a final report on a transfer of ownership of
2421 a hospital to the Attorney General under subsection (f) of this section,
2422 the Attorney General may: (1) Conduct an investigation to determine
2423 whether the transacting parties engaged, or, as a result of completing
2424 the transfer of ownership of the hospital, are expected to engage in
2425 unfair methods of competition, anti-competitive behavior or other
2426 conduct in violation of chapter 624 or 735a of the general statutes or
2427 any other state or federal law; and (2) if appropriate, take action under
2428 chapter 624 or 735a of the general statutes or any other state law to
2429 protect consumers in the health care market. The office's final report
2430 may be evidence in any such action.

2431 (i) For the purposes of this section, the provisions of chapter 735a of
2432 the general statutes may be directly enforced by the Attorney General.
2433 Nothing in this section shall be construed to modify, impair or
2434 supersede the operation of any state antitrust law or otherwise limit
2435 the authority of the Attorney General to (1) take any action against a
2436 transacting party as authorized by any law, or (2) protect consumers in

2437 the health care market under any law. Notwithstanding subdivision (1)
2438 of subsection (a) of section 42-110c of the general statutes, the
2439 transacting parties shall be subject to chapter 735a of the general
2440 statutes.

2441 (j) The office shall retain an independent consultant with expertise
2442 on the economic analysis of the health care market and health care
2443 costs and prices to conduct each cost and market impact review, as
2444 described in this section. The office shall submit bills for such services
2445 to the purchaser, as defined in subsection (d) of section 19a-639 of the
2446 general statutes, as amended by this act. Such purchaser shall pay such
2447 bills not later than thirty days after receipt. Such bills shall not exceed
2448 two hundred thousand dollars per application. The provisions of
2449 chapter 57 of the general statutes, sections 4-212 to 4-219, inclusive, of
2450 the general statutes and section 4e-19 of the general statutes shall not
2451 apply to any agreement executed pursuant to this subsection.

2452 (k) Any employee of the office who directly oversees or assists in
2453 conducting a cost and market impact review shall not take part in
2454 factual deliberations or the issuance of a preliminary or final decision
2455 on the certificate of need application concerning the transfer of
2456 ownership of a hospital that is the subject of such cost and market
2457 impact review.

2458 (l) The Commissioner of Public Health shall adopt regulations, in
2459 accordance with the provisions of chapter 54 of the general statutes,
2460 concerning cost and market impact reviews and to administer the
2461 provisions of this section. Such regulations shall include definitions of
2462 the following terms: "Dispersed service area", "health status adjusted
2463 total medical expense", "major service category", "relative prices", "total
2464 health care spending" and "health care services". The commissioner
2465 may implement policies and procedures necessary to administer the
2466 provisions of this section while in the process of adopting such policies
2467 and procedures in regulation form, provided the commissioner
2468 publishes notice of intention to adopt the regulations on the
2469 Department of Public Health's Internet web site and the eRegulations

2470 System not later than twenty days after implementing such policies
2471 and procedures. Policies and procedures implemented pursuant to this
2472 subsection shall be valid until the time such regulations are effective.

2473 Sec. 35. Subsections (d) to (g), inclusive, of section 19a-639a of the
2474 general statutes are repealed and the following is substituted in lieu
2475 thereof (*Effective July 1, 2015*):

2476 (d) Upon determining that an application is complete, the office
2477 shall provide notice of this determination to the applicant and to the
2478 public in accordance with regulations adopted by the department. In
2479 addition, the office shall post such notice on its web site. The date on
2480 which the office posts such notice on its web site shall begin the review
2481 period. Except as provided in this subsection, (1) the review period for
2482 a completed application shall be ninety days from the date on which
2483 the office posts such notice on its web site; and (2) the office shall issue
2484 a decision on a completed application prior to the expiration of the
2485 ninety-day review period. The review period for a completed
2486 application that involves a transfer of a large group practice, as
2487 described in subdivision (3) of subsection (a) of section 19a-638, as
2488 amended by this act, when the offer was made in response to a request
2489 for proposal or similar voluntary offer for sale shall be sixty days from
2490 the date on which the office posts notice on its web site. Upon request
2491 or for good cause shown, the office may extend the review period for a
2492 period of time not to exceed sixty days. If the review period is
2493 extended, the office shall issue a decision on the completed application
2494 prior to the expiration of the extended review period. If the office
2495 holds a public hearing concerning a completed application in
2496 accordance with subsection (e) or (f) of this section, the office shall
2497 issue a decision on the completed application not later than sixty days
2498 after the date the office closes the public hearing record.

2499 (e) Except as provided in this subsection, the office shall hold a
2500 public hearing on a properly filed and completed certificate of need
2501 application if three or more individuals or an individual representing
2502 an entity with five or more people submits a request, in writing, that a

2503 public hearing be held on the application. For a properly filed and
2504 completed certificate of need application involving a transfer of
2505 ownership of a large group practice, as described in subdivision (3) of
2506 subsection (a) of section 19a-638, as amended by this act, when an offer
2507 was made in response to a request for proposal or similar voluntary
2508 offer for sale, a public hearing shall be held if twenty-five or more
2509 individuals or an individual representing twenty-five or more people
2510 submits a request, in writing, that a public hearing be held on the
2511 application. Any request for a public hearing shall be made to the
2512 office not later than thirty days after the date the office determines the
2513 application to be complete.

2514 (f) (1) The office shall hold a public hearing with respect to each
2515 certificate of need application submitted under this chapter that
2516 involves the transfer of ownership of a hospital, as defined in
2517 subsection (d) of section 19a-639, as amended by this act. Such hearing
2518 shall be held in the municipality in which the hospital that is the
2519 subject of the application is located.

2520 ~~[(f)]~~ (2) The office may hold a public hearing with respect to any
2521 certificate of need application submitted under this chapter. The office
2522 shall provide not less than two weeks' advance notice to the applicant,
2523 in writing, and to the public by publication in a newspaper having a
2524 substantial circulation in the area served by the health care facility or
2525 provider. In conducting its activities under this chapter, the office may
2526 hold hearing on applications of a similar nature at the same time.

2527 (g) The Commissioner of Public Health may implement policies and
2528 procedures necessary to administer the provisions of this section while
2529 in the process of adopting such policies and procedures as regulation,
2530 provided the commissioner holds a public hearing prior to
2531 implementing the policies and procedures and prints notice of intent to
2532 adopt regulations [in the Connecticut Law Journal] on the
2533 department's Internet web site and the eRegulations System not later
2534 than twenty days after the date of implementation. Policies and
2535 procedures implemented pursuant to this section shall be valid until

2536 the time final regulations are adopted. [Final regulations shall be
2537 adopted by December 31, 2011.]

2538 Sec. 36. Subsection (c) of section 19a-486a of the general statutes is
2539 repealed and the following is substituted in lieu thereof (*Effective July*
2540 *1, 2015*):

2541 (c) Not later than thirty days after receipt of the certificate of need
2542 determination letter by the commissioner and the Attorney General,
2543 the purchaser and the nonprofit hospital shall hold a hearing on the
2544 contents of the certificate of need determination letter in the
2545 municipality in which the new hospital is proposed to be located. The
2546 nonprofit hospital shall provide not less than two weeks' advance
2547 notice of the hearing to the public by publication in a newspaper
2548 having a substantial circulation in the affected community for not less
2549 than three consecutive days. Such notice shall contain substantially the
2550 same information as in the certificate of need determination letter. The
2551 purchaser and the nonprofit hospital shall record and transcribe the
2552 hearing and make such recording or transcription available to the
2553 commissioner, the Attorney General or members of the public upon
2554 request. A public hearing held in accordance with the provisions of
2555 section 19a-639a, as amended by this act, shall satisfy the requirements
2556 of this subsection.

2557 Sec. 37. Subsection (a) of section 19a-486d of the general statutes is
2558 repealed and the following is substituted in lieu thereof (*Effective July*
2559 *1, 2015*):

2560 (a) The commissioner shall deny an application filed pursuant to
2561 subsection (d) of section 19a-486a, as amended by this act, unless the
2562 commissioner finds that: (1) [The affected community will be assured
2563 of continued access to high quality and affordable health care after
2564 accounting for any proposed change impacting hospital staffing; (2)] in
2565 a situation where the asset or operation to be transferred provides or
2566 has provided health care services to the uninsured or underinsured,
2567 the purchaser has made a commitment to provide health care to the

2568 uninsured and the underinsured; ~~[(3)]~~ (2) in a situation where health
2569 care providers or insurers will be offered the opportunity to invest or
2570 own an interest in the purchaser or an entity related to the purchaser
2571 safeguard procedures are in place to avoid a conflict of interest in
2572 patient referral; and ~~[(4)]~~ (3) certificate of need authorization is justified
2573 in accordance with chapter 368z. The commissioner may contract with
2574 any person, including, but not limited to, financial or actuarial experts
2575 or consultants, or legal experts with the approval of the Attorney
2576 General, to assist in reviewing the completed application. The
2577 commissioner shall submit any bills for such contracts to the
2578 purchaser. Such bills shall not exceed one hundred fifty thousand
2579 dollars. The purchaser shall pay such bills no later than thirty days
2580 after the date of receipt of such bills.

2581 Sec. 38. Subsection (a) of section 19a-644 of the general statutes is
2582 repealed and the following is substituted in lieu thereof (*Effective July*
2583 *1, 2015*):

2584 (a) On or before February twenty-eighth annually, for the fiscal year
2585 ending on September thirtieth of the immediately preceding year, each
2586 short-term acute care general, ~~or~~ children's hospital and health
2587 system shall report to the office with respect to its operations in such
2588 fiscal year, in such form as the office may by regulation require. Such
2589 report shall include: (1) Salaries and fringe benefits for the ten highest
2590 paid positions; (2) the name of each joint venture, partnership,
2591 subsidiary and corporation related to the hospital; and (3) the salaries
2592 paid to hospital and health system employees by each such joint
2593 venture, partnership, subsidiary and related corporation and by the
2594 hospital to the employees of related corporations. For purposes of this
2595 subsection, "health system" has the same meaning as provided in
2596 section 33-182aa.

2597 Sec. 39. (*Effective July 1, 2015*) Not later than January 1, 2016, the
2598 Commissioner of Public Health shall report, in accordance with the
2599 provisions of section 11-4a of the general statutes, to the joint standing
2600 committee of the General Assembly having cognizance of matters

2601 relating to public health concerning certificate of need requirements
2602 under chapter 368z of the general statutes. Such report shall include,
2603 but need not be limited to, recommendations (1) to eliminate the
2604 requirements to obtain certificate of need approval or to create an
2605 expedited approval process for certain services, equipment purchases
2606 and ownership transfers or other matters for which such approval is
2607 currently required under section 19a-638 of the general statutes, as
2608 amended by this act, such as, for example: (A) Ancillary capital
2609 expenditures not related to direct patient care or services; (B)
2610 replacement of outdated or damaged equipment, the purchase of
2611 which was previously approved by the office; (C) repairs to facilities
2612 damaged by floods, storms or other unexpected occurrences; and (D)
2613 facility improvements necessary to comply with building codes or
2614 other legal requirements, and (2) concerning an expedited automatic
2615 approval of certain certificate of need applications in circumstances
2616 where the Department of Public Health does not notify the applicant
2617 within thirty days of its intent to review such application.

2618 Sec. 40. Section 19a-486b of the general statutes is repealed and the
2619 following is substituted in lieu thereof (*Effective October 1, 2015*):

2620 (a) Not later than one hundred twenty days after the date of receipt
2621 of the completed application pursuant to subsection (d) of section 19a-
2622 486a, the Attorney General and the commissioner shall approve the
2623 application, with or without modification, or deny the application. The
2624 commissioner shall also determine, in accordance with the provisions
2625 of chapter 368z, whether to approve, with or without modification, or
2626 deny the application for a certificate of need that is part of the
2627 completed application. Notwithstanding the provisions of section 19a-
2628 639a, as amended by this act, the commissioner shall complete the
2629 decision on the application for a certificate of need within the same
2630 time period as the completed application. Such one-hundred-twenty-
2631 day period may be extended by (1) agreement of the Attorney General,
2632 the commissioner, the nonprofit hospital and the purchaser, or (2) the
2633 commissioner pending completion of a cost and market impact review

2634 conducted pursuant to section 34 of this act. If the Attorney General
2635 initiates a proceeding to enforce a subpoena pursuant to section 19a-
2636 486c or 19a-486d, as amended by this act, the one-hundred-twenty-day
2637 period shall be tolled until the final court decision on the last pending
2638 enforcement proceeding, including any appeal or time for the filing of
2639 such appeal. Unless the one-hundred-twenty-day period is extended
2640 pursuant to this section, if the commissioner and Attorney General fail
2641 to take action on an agreement prior to the one hundred twenty-first
2642 day after the date of the filing of the completed application, the
2643 application shall be deemed approved.

2644 (b) The commissioner and the Attorney General may place any
2645 conditions on the approval of an application that relate to the purposes
2646 of sections 19a-486a to 19a-486h, inclusive, as amended by this act. In
2647 placing any such conditions the commissioner shall follow the
2648 guidelines and criteria described in subdivision (4) of subsection (d) of
2649 section 19a-639, as amended by this act. Any such conditions may be in
2650 addition to any conditions placed by the commissioner pursuant to
2651 subdivision (4) of subsection (d) of section 19a-639, as amended by this
2652 act.

2653 Sec. 41. Subdivisions (10) to (16), inclusive, of section 19a-630 of the
2654 general statutes are repealed and the following is substituted in lieu
2655 thereof (*Effective July 1, 2015*):

2656 (10) ["Group practice"] "Large group practice" means eight or more
2657 full-time equivalent physicians, legally organized in a partnership,
2658 professional corporation, limited liability company formed to render
2659 professional services, medical foundation, not-for-profit corporation,
2660 faculty practice plan or other similar entity (A) in which each physician
2661 who is a member of the group provides substantially the full range of
2662 services that the physician routinely provides, including, but not
2663 limited to, medical care, consultation, diagnosis or treatment, through
2664 the joint use of shared office space, facilities, equipment or personnel;
2665 (B) for which substantially all of the services of the physicians who are
2666 members of the group are provided through the group and are billed

2667 in the name of the group practice and amounts so received are treated
2668 as receipts of the group; or (C) in which the overhead expenses of, and
2669 the income from, the group are distributed in accordance with
2670 methods previously determined by members of the group. An entity
2671 that otherwise meets the definition of group practice under this section
2672 shall be considered a group practice although its shareholders,
2673 partners or owners of the group practice include single-physician
2674 professional corporations, limited liability companies formed to render
2675 professional services or other entities in which beneficial owners are
2676 individual physicians.

2677 (11) "Health care facility" means (A) hospitals licensed by the
2678 Department of Public Health under chapter 368v; (B) specialty
2679 hospitals; (C) freestanding emergency departments; (D) outpatient
2680 surgical facilities, as defined in section 19a-493b and licensed under
2681 chapter 368v; (E) a hospital or other facility or institution operated by
2682 the state that provides services that are eligible for reimbursement
2683 under Title XVIII or XIX of the federal Social Security Act, 42 USC 301,
2684 as amended; (F) a central service facility; (G) mental health facilities;
2685 (H) substance abuse treatment facilities; and (I) any other facility
2686 requiring certificate of need review pursuant to subsection (a) of
2687 section 19a-638, as amended by this act. "Health care facility" includes
2688 any parent company, subsidiary, affiliate or joint venture, or any
2689 combination thereof, of any such facility.

2690 (12) "Nonhospital based" means located at a site other than the main
2691 campus of the hospital.

2692 (13) "Office" means the Office of Health Care Access division within
2693 the Department of Public Health.

2694 (14) "Person" means any individual, partnership, corporation,
2695 limited liability company, association, governmental subdivision,
2696 agency or public or private organization of any character, but does not
2697 include the agency conducting the proceeding.

2698 (15) "Physician" has the same meaning as provided in section 20-
2699 13a.

2700 (16) "Transfer of ownership" means a transfer that impacts or
2701 changes the governance or controlling body of a health care facility,
2702 institution or large group practice, including, but not limited to, all
2703 affiliations, mergers or any sale or transfer of net assets of a health care
2704 facility.

2705 Sec. 42. Subdivision (3) of subsection (a) of section 19a-638 of the
2706 general statutes is repealed and the following is substituted in lieu
2707 thereof (*Effective July 1, 2015*):

2708 (3) A transfer of ownership of a large group practice to any entity
2709 other than a (A) physician, or (B) group of [physicians, except when
2710 the parties have signed a sale agreement to transfer such ownership on
2711 or before September 1, 2014] two or more physicians, legally organized
2712 in a partnership, professional corporation, or limited liability company
2713 formed to render professional services and not employed by or an
2714 affiliate of any hospital, medical foundation, insurance company or
2715 other similar entity;

2716 Sec. 43. (*Effective from passage*) (a) The chairperson of the board of
2717 directors of the State of Connecticut Health and Educational Facilities
2718 Authority, established pursuant to section 10a-179 of the general
2719 statutes, in consultation with the Commissioner of Economic and
2720 Community Development, shall consider financing options to enable
2721 community hospitals to acquire medical equipment, update
2722 information technology, renovate or acquire health care facilities, build
2723 new health care facilities and engage in other activities for the
2724 purposes of: (1) Improving the ability of community hospitals to
2725 effectively serve members of the community, including, but not
2726 limited to, (A) enhancing care coordination, (B) advancing the
2727 integration of health care services, including behavioral health
2728 services, (C) promoting evidence-based care practices and efficient
2729 health care delivery, and (D) providing culturally and linguistically

2730 appropriate health care services to members of the community served
2731 by the hospital; (2) advancing hospitals' adoption of health information
2732 technology, including the adoption of interoperable electronic health
2733 records systems and clinical support tools; (3) facilitating the ability of
2734 hospitals and other health care providers to exchange health
2735 information electronically to ensure a continuity of care among all
2736 health care providers; (4) supporting infrastructure investments in
2737 health care facilities that are necessary for (A) the transition to
2738 alternative payment methodologies, including investments in data
2739 analysis functions and performance management programs to promote
2740 price transparency for health care services, and (B) aggregation and
2741 analysis of clinical data to facilitate appropriate, evidence-based
2742 intervention and care management practices, especially for vulnerable
2743 populations and persons with complex health care needs; (5)
2744 improving the affordability and quality of health care, by increasing
2745 coordination between hospitals and community-based health care
2746 providers and other community organizations; (6) improving access to
2747 health care services, including behavioral health services; and (7)
2748 ensuring staff-to-patient ratios are sufficient to deliver high quality
2749 health care.

2750 (b) Not later than January 1, 2016, said chairperson shall report, in
2751 accordance with the provisions of section 11-4a of the general statutes,
2752 to the joint standing committees of the General Assembly having
2753 cognizance of matters relating to public health and commerce
2754 concerning such study. Such report shall include, but need not be
2755 limited to, (1) to the extent practicable, a capital needs assessment for
2756 community hospitals; and (2) recommendations concerning (A)
2757 methods to finance improvements currently needed by community
2758 hospitals in the state to fulfill the purposes described in subsection (a)
2759 of this section, including, but not limited to, the use of bond funds,
2760 alternative funding methods and the establishment of a program to
2761 provide low-interest or no-interest loans to community hospitals, (B)
2762 other state programs that may be utilized to support community
2763 hospital improvements, and (C) legislative or regulatory changes that

2764 may be needed to accomplish the purposes described in subsection (a)
 2765 of this section. For purposes of this subsection, "community hospital"
 2766 means: (i) A hospital that is not a teaching hospital and has twenty-five
 2767 or fewer full-time equivalent interns or residents for each one hundred
 2768 inpatient beds; (ii) a hospital that charges less for health care services
 2769 than the state median prices for those health care services; (iii) a
 2770 nonprofit hospital; and (iv) a hospital that is not part of a hospital
 2771 system, as defined in section 19a-486i of the general statutes, as
 2772 amended by this act.

2773 Sec. 44. Section 19a-25d of the general statutes is repealed. (*Effective*
 2774 *October 1, 2015*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2015</i>	38a-1084
Sec. 2	<i>from passage</i>	New section
Sec. 3	<i>October 1, 2015</i>	New section
Sec. 4	<i>October 1, 2015</i>	New section
Sec. 5	<i>October 1, 2015</i>	New section
Sec. 6	<i>October 1, 2015</i>	New section
Sec. 7	<i>October 1, 2015</i>	New section
Sec. 8	<i>January 1, 2016</i>	New section
Sec. 9	<i>January 1, 2016</i>	38a-591
Sec. 10	<i>January 1, 2016</i>	New section
Sec. 11	<i>October 1, 2015</i>	New section
Sec. 12	<i>January 1, 2016</i>	38a-591b(d)
Sec. 13	<i>January 1, 2016</i>	38a-478d
Sec. 14	<i>January 1, 2016</i>	20-7f
Sec. 15	<i>January 1, 2016</i>	38a-193(c)(3)
Sec. 16	<i>from passage</i>	19a-508c
Sec. 17	<i>October 1, 2015</i>	New section
Sec. 18	<i>October 1, 2015</i>	New section
Sec. 19	<i>October 1, 2015</i>	38a-1084
Sec. 20	<i>October 1, 2015</i>	New section
Sec. 21	<i>October 1, 2015</i>	New section
Sec. 22	<i>July 1, 2015</i>	19a-725
Sec. 23	<i>July 1, 2015</i>	New section

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