General Assembly

Raised Bill No. 289

February Session, 2016

LCO No. **2114**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING HEALTH CARE SERVICES.

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

Section 1. Subsection (e) of section 38a-1084a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) (1) **[**On and after January 1, 2017,**]** On and after one hundred eighty days after the report described in subsection (c) of this section is initially made available to the public on the Insurance Department's and Department of Public Health's Internet web sites, each hospital shall, at the time of scheduling a diagnosis or procedure for nonemergency care that is included in the report submitted to the exchange by the Insurance Commissioner and the Commissioner of Public Health pursuant to subsection (c) of this section, notify the patient of the patient's right to make a request for cost and quality information. Upon the request of a patient for a diagnosis or procedure included in such report, the hospital shall, not later than three business days after scheduling such diagnosis or procedure, provide written notice, electronically or by mail, to the patient who is the subject of the

diagnosis or procedure concerning: (A) If the patient is uninsured, (i) that collection from an uninsured patient whose income is at or below two hundred fifty per cent of the poverty income guidelines, as defined in section 19a-673, is limited to the cost of providing services pursuant to section 19a-673, and (ii) the amount to be charged for the diagnosis or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee; (B) the corresponding Medicare reimbursement amount, if any; (C) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs; (D) The Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

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

(3) A hospital may satisfy the notice requirements of this section by posting the required information on the hospital's Internet web site or through the hospital's Internet portal.

(4) The notice provisions of this subsection shall not apply to (A) unscheduled admissions; (B) unscheduled procedures; (C) unscheduled services; (D) admissions procedures or services scheduled less than three days prior to their occurrence; or (E)

emergency or urgent care services regardless of the location or setting where such services are delivered.

Sec. 2. Section 19a-904a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On and after January 1, 2016, each health care provider shall, prior to any scheduled admission, procedure or service, for nonemergency care, determine whether the patient is covered under a health insurance policy. If the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, such health care provider shall notify the patient, in writing, electronically or by mail, (1) of the charges for the admission, procedure or service and notice that collection from an uninsured patient whose income is at or below two hundred fifty per cent of the poverty income guidelines, as defined in section 19a-673, is limited to the cost of providing services pursuant to section 19a-673, (2) that such patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission, procedure or service, and (3) if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply. Nothing in this subsection shall prevent a health care provider from charging a patient for such unforeseen services. If the patient is determined to have health insurance coverage and the patient's physician or other health care provider is in-network, a hospital is not required to provide notice to the patient as described in this section. A patient's physician or other health care provider shall be responsible for notifying a patient in accordance with the provisions of this section if a service provided by the physician or other health care provider is out-of-network.

(b) Each health care provider and health carrier shall ensure that any notice, billing statement or explanation of benefits submitted to a

patient or insured is written in language that is understandable to an average reader.

(c) The notice provisions of this section shall not apply to (1) unscheduled admissions, (2) unscheduled procedures, (3) unscheduled services, or (4) emergency or urgent care services regardless of the location or setting where such services are delivered.

Sec. 3. Subsections (d) to (k), inclusive, of section 19a-508c of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) On and after January 1, 2016, each initial billing statement that includes a facility fee utilizing a current procedural terminology evaluation and management code for outpatient services shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the Medicare facility fee reimbursement rate for the same service as a comparison, if applicable; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction.

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

(f) (1) For nonemergency care, if a patient's appointment is

scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

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

(g) Subsections (b) to (f), inclusive, <u>and (h) to (k), inclusive,</u> of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

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

(i) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage,

143 marketing materials, Internet web sites and stationery.

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

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

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

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

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

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

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

170 (F) A statement that, prior to seeking services at such hospital-based
171 facility, a patient covered by a health insurance policy should contact

the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

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

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

(k) Notwithstanding the provisions of this section, on and after January 1, 2017, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than <u>for emergency services, as defined in section 38a-477aa, including, but not limited to emergency services provided at</u> a hospital emergency department **[,]** <u>that is</u> located off-site from a hospital campus, or (2) outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract. A violation of this subsection shall be considered an unfair

trade practice pursuant to chapter 735a.

Sec. 4. Section 19a-508d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each health care provider that refers a patient to another health care provider who is not a member of the same partnership, professional corporation, medical foundation or limited liability company formed to render professional services but is affiliated with the referring health care provider shall notify the patient, in writing, that the health care providers are affiliated. Such notice shall also (1) inform the patient that the patient is not required to see the provider to whom he or she is referred and that the patient has a right to seek care from the health care provider chosen by the patient, and (2) provide the patient with the Internet web site and toll-free telephone number of the patient's health carrier to obtain information regarding in-network health care providers and estimated out-of-pocket costs for the referred service. A health care provider is not required to provide notice to a patient pursuant to this section if the health care provider otherwise provides substantially similar notice to patients pursuant to federal law. For purposes of this section, "affiliated" means a relationship between two or more health care providers that permits the health care providers to negotiate jointly or as a member of the same group of health care providers with third parties over rates for professional medical services. "Affiliated" does not include participation in an accountable care organization or similar value-based collaborative care model.

Sec. 5. Section 19a-904d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section:

(1) "Affiliated provider" means a health care provider that is: (A) Employed by a hospital or health system, (B) under a professional

235 services agreement with a hospital or health system that permits such
236 hospital or health system to bill on behalf of such health care provider,
237 or (C) a clinical faculty member of a medical school, as defined in
238 section 33-182aa, that is affiliated with a hospital or health system in a
239 manner that permits such hospital or health system to bill on behalf of
240 such clinical faculty member;

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

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

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

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

259 (6) "Health information blocking" means (A) knowingly interfering
260 with or knowingly engaging in business practices or other conduct that
261 is reasonably likely to interfere with the ability of patients, health care
262 providers or other authorized persons to access, exchange or use
263 electronic health records, or (B) knowingly using an electronic health
264 record system to both (i) steer patient referrals to affiliated providers,
265 and (ii) prevent or unreasonably interfere with patient referrals to

health care providers who are not affiliated providers but shall not include legitimate referrals between providers participating in an accountable care organizations or similar value-based collaborative care models;

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

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

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

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

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

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

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

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

(g) Nothing contained in this section shall be construed as a limitation upon the power or authority of the state, the Attorney

General or the Commissioner of Consumer Protection to seek administrative, legal or equitable relief as provided by any state statute or common law.

(h) Nothing contained in this section shall be construed to (1) be a disclosure required by law as described in 45 CFR 164.512, as amended from time to time, or (2) require a health care provider to disclose patient health information without the patient's consent consistent with federal and state privacy and security laws and regulations.

Sec. 6. Subsection (c) of section 19a-486i of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) Not less than thirty days prior to the effective date of any transaction that results in a material change to the business or corporate structure of a group practice, the parties to the transaction shall submit written notice to the Attorney General of such material change. For purposes of this subsection, a material change to the business or corporate structure of a group practice includes: (1) The merger, consolidation or other affiliation of a group practice with (A) another group practice that results in a group practice comprised of eight or more physicians, **[**or**]** (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system, or (C) any business entity, including, but not limited to, an insurance entity or its affiliate or subsidiary where the management or control of the group practice will be carried out by the business entity after the merger, consolidation or other affiliation; (2) the acquisition of all or substantially all of (A) the properties and assets of a group practice, or (B) the capital stock, membership interests or other equity interests of a group practice by (i) another group practice that results in a group practice comprised of eight or more physicians, or (ii) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital

system; (3) the employment of all or substantially all of the physicians of a group practice by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system; and (4) the acquisition of one or more insolvent group practices by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system.

Sec. 7. Subsection (a) of section 19a-638 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A certificate of need issued by the office shall be required for:

(1) The establishment of a new health care facility;

(2) A transfer of ownership of a health care facility;

(3) A transfer of ownership of a large group practice to any entity other than a (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity;

(4) The establishment of a freestanding emergency department;

(5) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;

(6) The establishment of an outpatient surgical facility, as defined in

section 19a-493b, or as established by a short-term acute care general hospital;

(7) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(8) The termination of an emergency department by a short-term acute care general hospital;

(9) The establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except (A) as provided for in subdivision (22) of subsection (b) of this section, and (B) a certificate of need issued by the office shall not be required where such scanner is a replacement for a scanner<u>, including replacement by a combination scanner that has additional capabilities or modalities,</u> that was previously acquired through certificate of need approval or a certificate of need determination;

(11) The acquisition of nonhospital based linear accelerators;

(12) An increase in the licensed bed capacity of a health care facility;

(13) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(14) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, or by a short-term acute care general hospital; and

(15) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended.

Sec. 8. Subsection (a) of section 38a-477e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On and after **[**July 1, 2016**]** January 1, 2018, each health carrier shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the exchange pursuant to section 38a-1084a, as amended by this act, for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) a list of in-network health care providers, (iv) whether a health care provider is accepting new patients, and (v) languages spoken by health care providers; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

Sec. 9. Section 19a-903b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

A hospital, as defined in section 19a-490b, may designate: [any] (1) Any licensed health care provider; [and] (2) any certified ultrasound or nuclear medicine technologist; or (3) any other person who has been specially trained and determined to be competent to perform the duties by the hospital based on standards set by the appropriate clinical committee of the hospital, to perform the following oxygen-related patient care activities in a hospital: [(1)] (A) Connecting or disconnecting oxygen supply; [(2)] (B) transporting a portable oxygen source; [(3)] (C) connecting, disconnecting or adjusting the mask, tubes and other patient oxygen delivery apparatus; and [(4)] (D) adjusting the rate or flow of oxygen consistent with a medical order. Such provider or technologist may perform such activities only to the extent permitted by hospital policies and procedures, including bylaws, rules and regulations applicable to the medical staff. A hospital shall document that each person designated to perform oxygen-related patient care activities has been properly trained, either through such person's professional education or through training provided by the hospital. In addition, a hospital shall require that such person satisfy annual competency testing. Nothing in this section shall be construed to prohibit a hospital from designating persons who are authorized to transport oxygen equipment or to transport a patient with a portable oxygen source. The provisions of this section shall not apply to any type of ventilator, continuous positive airway pressure or bi-level positive airway pressure units or any other noninvasive positive pressure ventilation.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-1084a(e)
Sec. 2	*from passage*	19a-904a
Sec. 3	*from passage*	19a-508c(d) to (k)
Sec. 4	*from passage*	19a-508d
Sec. 5	*from passage*	19a-904d
Sec. 6	*from passage*	19a-486i(c)
Sec. 7	*from passage*	19a-638(a)

Sec. 8	*from passage*	38a-477e(a)
Sec. 9	*October 1, 2016*	19a-903b

Statement of Purpose:

To make various changes to provisions enacted in public act 15-146 and to allow trained persons to perform oxygen-related patient care activities in a hospital.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]