



General Assembly

Amendment

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Offered by:

REP. STEINBERG, 136th Dist.

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To: Subst. Senate Bill No. 445

File No. 519

Cal. No. 591

(As Amended)

**"AN ACT CONCERNING FAIRNESS IN PHARMACY AND
PHARMACY BENEFITS MANAGER CONTRACTS."**

1 Strike section 4 in its entirety and insert the following in lieu thereof:

2 "Sec. 4. Section 19a-904c of the general statutes is repealed and the
3 following is substituted in lieu thereof (*Effective October 1, 2017*):

4 (a) For purposes of this section:

5 (1) "Bidirectional connectivity" means the ability of a hospital's
6 electronic health record system to electronically send and receive
7 electronic health records;

8 ~~[(1)]~~ (2) "Electronic health record" means any computerized, digital
9 or other electronic record of individual health-related information that
10 is created, held, managed or consulted by a health care provider and

11 may include, but need not be limited to, continuity of care documents,
12 admission, discharge [summaries] or transfer records, and other
13 information or data relating to [patient] a patient's medical history or
14 treatment, including, but not limited to, demographics, [medical
15 history,] medication, allergies, immunizations, laboratory test results,
16 radiology or other diagnostic images, vital signs and statistics;

17 [(2)] (3) "Electronic health record system" means a computer-based
18 information system that is used to create, collect, store, manipulate,
19 share, exchange or make available electronic health records for the
20 purpose of the delivery of patient care;

21 [(3)] (4) "Health care provider" means any individual, corporation,
22 facility or institution licensed by the state to provide health care
23 services; [and]

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

25 [(4)] (6) "Secure exchange" means the exchange of patient electronic
26 health records between a hospital and a health care provider in a
27 manner that complies with all state and federal privacy requirements,
28 including, but not limited to, the Health Insurance Portability and
29 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from
30 time to time.

31 (b) Each hospital licensed under chapter 368v shall, to the fullest
32 extent practicable [,] (1) use its electronic health records system to
33 enable bidirectional connectivity and provide for the secure exchange
34 of patient electronic health records between the hospital and any other
35 health care provider who [(1)] maintains an electronic health records
36 system capable of exchanging such records [,] and [(2)] provides health
37 care services to a patient whose records are the subject of the exchange,
38 and (2) send or receive an electronic health record in accordance with
39 the provisions of this subsection upon the request of a patient or, with
40 the consent and authorization of the patient, a patient's health care
41 provider, provided the transfer or receipt of the electronic health
42 record constitutes a secure exchange and does not violate any state or

43 federal law or regulation or constitute an identifiable and legitimate
44 security or privacy risk. If the hospital has reason to believe that the
45 transfer of an electronic health record under subdivision (2) of this
46 subsection would violate a state or federal law or regulation or
47 constitute an identifiable and legitimate security or privacy risk, the
48 hospital shall notify the patient or health care provider who made the
49 request.

50 (c) The requirements of this section apply to [at least the following:
51 (A)] electronic health records that include, but are not limited to: (1)
52 Laboratory and diagnostic tests; [(B)] (2) radiological and other
53 diagnostic imaging; [(C)] (3) continuity of care documents; and [(D)]
54 (4) admission, discharge [notifications and] or transfer documents.

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

60 [(d)] (e) Nothing in this section shall be construed as requiring a
61 hospital to pay for, install, construct or build any new or additional
62 information technology, equipment, hardware or software, including
63 interfaces, where such additional items are necessary to enable such
64 exchange.

65 [(e)] (f) The failure of a hospital to take all reasonable steps to
66 comply with this section shall constitute evidence of health
67 information blocking pursuant to section 19a-904d.

68 [(f)] (g) A hospital that connects to, and actively participates in, the
69 State-wide Health Information Exchange, established pursuant to
70 section 17b-59d shall be deemed to have satisfied the requirements of
71 this section."

72 Strike section 5 in its entirety and insert the following in lieu thereof:

73 "Sec. 5. Section 19a-508c of the general statutes is repealed and the
74 following is substituted in lieu thereof (*Effective October 1, 2017*):

75 (a) As used in this section:

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

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

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

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

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

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

103 hospital or professional medical services are provided;

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

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

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

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

120 (2) (A) The amount of the patient's potential financial liability,
121 including any facility fee likely to be charged, and, where professional
122 medical services are provided by an affiliated provider, any
123 professional fee likely to be charged, or, if the exact type and extent of
124 the professional medical services needed are not known or the terms of
125 a patient's health insurance coverage are not known with reasonable
126 certainty, an estimate of the patient's financial liability based on typical
127 or average charges for visits to the hospital-based facility, including
128 the facility fee, (B) a statement that the patient's actual financial
129 liability will depend on the professional medical services actually
130 provided to the patient, [and] (C) an explanation that the patient may
131 incur financial liability that is greater than the patient would incur if
132 the professional medical services were not provided by a hospital-
133 based facility, and (D) a telephone number the patient may call for
134 additional information regarding such patient's potential financial

135 liability, including an estimate of the facility fee likely to be charged
136 based on the scheduled professional medical services; and

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

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

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

151 (2) (A) A statement that the patient's actual financial liability will
152 depend on the professional medical services actually provided to the
153 patient, [and] (B) an explanation that the patient may incur financial
154 liability that is greater than the patient would incur if the hospital-
155 based facility was not hospital-based, and (C) a telephone number the
156 patient may call for additional information regarding such patient's
157 potential financial liability, including an estimate of the facility fee
158 likely to be charged based on the scheduled professional medical
159 services; and

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

164 (d) On and after January 1, 2016, each initial billing statement that
165 includes a facility fee shall: (1) Clearly identify the fee as a facility fee

166 that is billed in addition to, or separately from, any professional fee
167 billed by the provider; (2) provide the corresponding Medicare facility
168 fee reimbursement rate for the same service as a comparison or, if there
169 is no corresponding Medicare facility fee for such service, (A) the
170 approximate amount Medicare would have paid the hospital for the
171 facility fee on the billing statement, or (B) the percentage of the
172 hospital's charges that Medicare would have paid the hospital for the
173 facility fee; (3) include a statement that the facility fee is intended to
174 cover the hospital's or health system's operational expenses; (4) inform
175 the patient that the patient's financial liability may have been less if the
176 services had been provided at a facility not owned or operated by the
177 hospital or health system; and (5) include written notice of the patient's
178 right to request a reduction in the facility fee or any other portion of
179 the bill and a telephone number that the patient may use to request
180 such a reduction without regard to whether such patient qualifies for,
181 or is likely to be granted, any reduction.

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

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

196 (2) For emergency care, such written notice shall be provided to the
197 patient as soon as practicable after the patient is stabilized in
198 accordance with the federal Emergency Medical Treatment and Active

199 Labor Act, 42 USC 1395dd, as amended from time to time, or is
200 determined not to have an emergency medical condition and before
201 the patient leaves the hospital-based facility. If the patient is
202 unconscious, under great duress or for any other reason unable to read
203 the notice and understand and act on his or her rights, the notice shall
204 be provided to the patient's representative as soon as practicable.

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

209 (h) A hospital-based facility shall prominently display written
210 notice in locations that are readily accessible to and visible by patients,
211 including patient waiting areas, stating: ~~[that: (1) The]~~ (1) That the
212 hospital-based facility is part of a hospital or health system, [and] (2)
213 the name of the hospital or health system, and (3) that if the hospital-
214 based facility charges a facility fee, the patient may incur a financial
215 liability greater than the patient would incur if the hospital-based
216 facility was not hospital-based.

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

221 (j) A hospital-based facility shall, when scheduling services for
222 which a facility fee may be charged, inform the patient (1) that the
223 hospital-based facility is part of a hospital or health system, (2) of the
224 name of the hospital or health system, (3) that the hospital or health
225 system may charge a facility fee in addition to and separate from the
226 professional fee charged by the provider, and (4) of the telephone
227 number the patient may call for additional information regarding such
228 patient's potential financial liability.

229 ~~[(j)]~~ (k) (1) On and after January 1, 2016, if any transaction, as
230 described in subsection (c) of section 19a-486i, results in the

231 establishment of a hospital-based facility at which facility fees will
232 likely be billed, the hospital or health system, that is the purchaser in
233 such transaction shall, not later than thirty days after such transaction,
234 provide written notice, by first class mail, of the transaction to each
235 patient served within the previous three years by the health care
236 facility that has been purchased as part of such transaction.

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

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

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

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

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

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

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

260 (3) A copy of the written notice provided to patients in accordance

261 with this subsection shall be filed with the Office of Health Care
262 Access. Said office shall post a link to such notice on its Internet web
263 site.

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

272 ~~[(k)]~~ (l) Notwithstanding the provisions of this section, on and after
273 January 1, 2017, no hospital, health system or hospital-based facility
274 shall collect a facility fee for (1) outpatient health care services that use
275 a current procedural terminology evaluation and management code
276 and are provided at a hospital-based facility, other than a hospital
277 emergency department, located off-site from a hospital campus, or (2)
278 outpatient health care services, other than those provided in an
279 emergency department located off-site from a hospital campus,
280 received by a patient who is uninsured of more than the Medicare rate.
281 Notwithstanding the provisions of this subsection, in circumstances
282 when an insurance contract that is in effect on July 1, 2016, provides
283 reimbursement for facility fees prohibited under the provisions of this
284 section, a hospital or health system may continue to collect
285 reimbursement from the health insurer for such facility fees until the
286 date of expiration of such contract. A violation of this subsection shall
287 be considered an unfair trade practice pursuant to chapter 735a.

288 ~~[(l)]~~ (m) (1) Each hospital and health system shall report not later
289 than July 1, 2016, and annually thereafter to the Commissioner of
290 Public Health concerning facility fees charged or billed during the
291 preceding calendar year. Such report shall include (A) the name and
292 location of each facility owned or operated by the hospital or health
293 system that provides services for which a facility fee is charged or

294 billed, (B) the number of patient visits at each such facility for which a
295 facility fee was charged or billed, (C) the number, total amount and
296 range of allowable facility fees paid at each such facility by Medicare,
297 Medicaid or under private insurance policies, (D) for each facility, the
298 total amount of revenue received by the hospital or health system
299 derived from facility fees, (E) the total amount of revenue received by
300 the hospital or health system from all facilities derived from facility
301 fees, (F) a description of the ten procedures or services that generated
302 the greatest amount of facility fee revenue and, for each such
303 procedure or service, the total amount of revenue received by the
304 hospital or health system derived from facility fees, and (G) the top ten
305 procedures for which facility fees are charged based on patient
306 volume. For purposes of this subsection, "facility" means a hospital-
307 based facility that is located outside a hospital campus.

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

312 Strike section 6 in its entirety and renumber the remaining sections
313 and internal references accordingly