



General Assembly

**Amendment**

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LCO No. 9990



Offered by:

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SEN. ANWAR, 3<sup>rd</sup> Dist.

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To: Subst. House Bill No. 6669

File No. 453

Cal. No. 290

**"AN ACT PROTECTING PATIENTS AND PROHIBITING UNNECESSARY HEALTH CARE COSTS."**

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

3 "Section 1. (NEW) (*Effective October 1, 2023*) (a) The Comptroller shall  
4 establish the Drug Discount Card Program to be made available to all  
5 residents of this state. To further the purpose of such program, the  
6 Comptroller may cooperate with other states and territories of the  
7 United States, or regional consortia to pool prescription drug  
8 purchasing power to (1) lower prescription drug costs, (2) negotiate  
9 discounts with prescription drug manufacturers, (3) centralize the  
10 purchasing of prescription drugs, and (4) establish volume discount  
11 contracting. As used in this subsection, "volume discount contracting"  
12 means a negotiated purchase of a prescription drug in a large quantity  
13 for a decreased cost.

14 (b) The Comptroller shall study the feasibility of centralizing state-  
15 wide contracts to consolidate the purchasing of prescription and  
16 physician-administered drugs by state agencies, state hospitals, state-  
17 operated local mental health authorities and other public entities, as  
18 necessary. The study shall include an evaluation of (1) the potential cost  
19 savings, administrative feasibility and other benefits and risks of  
20 centralizing and consolidating contracts, and (2) any additional staff and  
21 resources required by the Comptroller to centrally procure and  
22 administer such contracts. Not later than November 1, 2023, each state  
23 agency, state hospital, state-operated local mental health authority and  
24 other public entity, as necessary, that procures prescription or  
25 physician-administered drugs shall provide information regarding the  
26 types, amount and cost of such drugs to the Comptroller, in a form and  
27 manner prescribed by the Comptroller. Not later than February 1, 2024,  
28 the Comptroller shall submit a report regarding the findings of such  
29 study to the Governor and, in accordance with the provisions of section  
30 11-4a of the general statutes, to the General Assembly.

31 Sec. 2. (*Effective from passage*) Not later than January 1, 2025, the  
32 Commissioner of Consumer Protection, in consultation with The  
33 University of Connecticut School of Pharmacy, shall report, in  
34 accordance with the provisions of section 11-4a of the general statutes,  
35 to the joint standing committee of the General Assembly having  
36 cognizance of matters relating to public health regarding  
37 recommendations on a framework for establishing an outreach and  
38 education program to inform physicians licensed pursuant to chapter  
39 370 of the general statutes (1) when a drug patent will expire and  
40 become available in generic form, and (2) when generic alternatives exist  
41 for drugs whose patent recently expired.

42 Sec. 3. (NEW) (*Effective October 1, 2023*) For the purposes of this  
43 section and sections 4 to 6, inclusive, of this act:

44 (1) "Commissioner" means the Commissioner of Consumer  
45 Protection;

46 (2) "Contact" means any communication transmitted in person or by  
47 telephone, electronic mail, text message or other electronic means  
48 between a pharmaceutical representative and a prescribing practitioner  
49 or pharmacist, to promote or provide information relating to a legend  
50 drug;

51 (3) "Department" means the Department of Consumer Protection;

52 (4) "Legend drug" has the same meaning as provided in section 20-  
53 571 of the general statutes;

54 (5) "Pharmaceutical manufacturer" means a (A) person, whether  
55 within or without the boundaries of the state of Connecticut, that  
56 produces, prepares, cultivates, grows, propagates, compounds,  
57 converts or processes a drug, device or cosmetic, directly or indirectly,  
58 by extraction from substances of natural origin, by means of chemical  
59 synthesis or by a combination of extraction and chemical synthesis, or  
60 that packages, repackages, labels or relabels a container under such  
61 manufacturer's own trademark or label or any other trademark or label,  
62 or a drug, device or cosmetic for the purpose of selling the drug, device  
63 or cosmetic, or (B) sterile compounding pharmacy, as defined in section  
64 20-633b of the general statutes that dispenses sterile pharmaceuticals  
65 without a prescription or a patient-specific medical order intended for  
66 use in humans;

67 (6) "Pharmaceutical manufacturer" includes a virtual manufacturer,  
68 as defined in section 20-571 of the general statutes;

69 (7) "Pharmaceutical marketing firm" means a pharmaceutical  
70 manufacturer that employs pharmaceutical representatives;

71 (8) "Pharmaceutical representative" means any person, including, but  
72 not limited to, a sales representative, who markets, promotes or  
73 provides information regarding a legend drug for human use to a  
74 prescribing practitioner and is employed or compensated by a  
75 pharmaceutical manufacturer;

76 (9) "Pharmacist" has the same meaning as provided in section 20-571  
77 of the general statutes; and

78 (10) "Prescribing practitioner" has the same meaning as provided in  
79 section 20-571 of the general statutes.

80 Sec. 4. (NEW) (*Effective October 1, 2023*) (a) On and after October 1,  
81 2023, a pharmaceutical manufacturer that employs an individual to  
82 perform the duties of a pharmaceutical sales representative shall  
83 register annually with the department as a pharmaceutical marketing  
84 firm, in a form and manner prescribed by the commissioner. No  
85 pharmaceutical manufacturer shall authorize an individual to perform  
86 such duties on such manufacturer's behalf unless such manufacturer has  
87 obtained a registration from the department pursuant to this section.  
88 Registrations issued pursuant to this section shall expire annually on  
89 June thirtieth.

90 (b) The nonrefundable fee for registration as a pharmaceutical  
91 marketing firm and for annual renewal of such registration shall be one  
92 hundred fifty dollars. Any pharmaceutical marketing firm that fails to  
93 renew its registration on or before June thirtieth shall pay a late fee of  
94 one hundred dollars for each year that such firm did not renew, in  
95 addition to the annual renewal fee required under this section.

96 (c) On the date of its initial registration, and annually thereafter, each  
97 pharmaceutical marketing firm shall provide to the department a list of  
98 all individuals employed by such firm as a pharmaceutical sales  
99 representative. Each pharmaceutical marketing firm shall notify the  
100 department, in a form and manner prescribed by the commissioner, of  
101 each individual who is no longer employed as a pharmaceutical sales  
102 representative or who was hired after the date on which such firm  
103 provided such annual list, not later than two weeks after such individual  
104 leaves employment or was hired.

105 (d) The department shall prominently post on its Internet web site the  
106 most recent list provided by each pharmaceutical marketing firm  
107 pursuant to subsection (c) of this section.

108 (e) Any person who is not identified to the department pursuant to  
109 subsection (c) of this section shall not perform the duties of a  
110 pharmaceutical sales representative on behalf of the pharmaceutical  
111 marketing firm for any prescribing practitioner in this state.

112 (f) Not later than July 1, 2024, and annually thereafter, each  
113 pharmaceutical marketing firm shall provide the commissioner with the  
114 following information regarding the performance for the previous  
115 calendar year of each of its pharmaceutical sales representatives  
116 identified to the department pursuant to subsection (c) of this section at  
117 any time during the previous calendar year, in a form and manner  
118 prescribed by the commissioner:

119 (1) The aggregate number of contacts such pharmaceutical sales  
120 representative had with prescribing practitioners and pharmacists;

121 (2) The specialty of each prescribing practitioner and pharmacist with  
122 whom such pharmaceutical sales representative made contact;

123 (3) Whether product samples, materials or gifts of any value were  
124 provided to a prescribing practitioner or such practitioner's staff in a  
125 prescribing practitioner's office or to a pharmacist; and

126 (4) An aggregate report of all free samples, by drug name and  
127 strength, in a form and manner prescribed by the commissioner.

128 (g) The department shall annually analyze the information submitted  
129 pursuant to this section and compile a report on the activities of  
130 pharmaceutical sales representatives in the state. Not later than  
131 December 1, 2024, and annually thereafter, the department shall post  
132 such report on its Internet web site and submit such report to the  
133 Secretary of the Office of Policy and Management.

134 Sec. 5. (NEW) (*Effective October 1, 2023*) Each pharmaceutical  
135 representative engaged in legend drug marketing in this state shall  
136 disclose, in writing, to a prescribing practitioner or pharmacist, at the  
137 time of each contact with such prescribing practitioner or pharmacist,

138 the following information:

139 (1) The list price of a legend drug when such pharmaceutical  
140 representative provides information concerning such legend drug to the  
141 prescribing practitioner or pharmacist based on the dose and quantity  
142 of such legend drug as described in the medication package insert; and

143 (2) Information on the variation efficacy of the legend drug marketed  
144 to different racial and ethnic groups, if such information is available.

145 Sec. 6. (NEW) (*Effective October 1, 2023*) (a) The commissioner may (1)  
146 refuse to authorize the issuance or renewal of a registration to operate  
147 as a pharmaceutical marketing firm, (2) revoke, suspend or place  
148 conditions on a registration to operate as a pharmaceutical marketing  
149 firm, and (3) assess a penalty of up to one thousand dollars for each  
150 violation of any provision of section 4 or 5 of this act, or take other action  
151 permitted by subdivision (7) of subsection (a) of section 21a-7 of the  
152 general statutes, if the applicant or holder of the registration fails to  
153 comply with the requirements set forth in section 4 or 5 of this act.

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

157 Sec. 7. (*Effective from passage*) Not later than January 1, 2025, the Office  
158 of Health Strategy, in consultation with the Insurance Department, shall  
159 report, in accordance with the provisions of section 11-4a of the general  
160 statutes, to the joint standing committee of the General Assembly  
161 having cognizance of matters relating to insurance regarding its analysis  
162 of pharmacy benefits managers' practices of prescription drug  
163 distribution, including, but not limited to, spread pricing arrangements,  
164 manufacturing rebates and transparency, fees charged, financial  
165 incentives for adding drugs to health plan formularies and an  
166 evaluation of prescription drug distribution practices conducted by  
167 pharmacy benefits managers in other states. Such report shall provide  
168 recommendations (1) to reduce prescription drug costs for consumers,  
169 and (2) for the regulation of pharmacy benefits managers in this state.

170 Sec. 8. Subsection (d) of section 19a-754b of the general statutes is  
171 repealed and the following is substituted in lieu thereof (*Effective October*  
172 *1, 2023*):

173 (d) (1) On or before March 1, 2020, and annually thereafter, the  
174 executive director of the Office of Health Strategy, in consultation with  
175 the Comptroller, Commissioner of Social Services and Commissioner of  
176 Public Health, shall prepare a list of not more than ten outpatient  
177 prescription drugs that the executive director, in the executive director's  
178 discretion, determines are (A) provided at substantial cost to the state,  
179 considering the net cost of such drugs, or (B) critical to public health.  
180 The list shall include outpatient prescription drugs from different  
181 therapeutic classes of outpatient prescription drugs and [at least] not  
182 less than one generic outpatient prescription drug.

183 [(2) The executive director shall not list any outpatient prescription  
184 drug under subdivision (1) of this subsection unless the wholesale  
185 acquisition cost of the drug, less all rebates paid to the state for such  
186 drug during the immediately preceding calendar year, (A) increased by  
187 at least (i) twenty per cent during the immediately preceding calendar  
188 year, or (ii) fifty per cent during the immediately preceding three  
189 calendar years, and (B) was not less than sixty dollars for (i) a thirty-day  
190 supply of such drug, or (ii) a course of treatment of such drug lasting  
191 less than thirty days.]

192 (2) Prior to publishing the annual list pursuant to subdivision (1) of  
193 this subsection, the executive director shall prepare a preliminary list  
194 that includes outpatient prescription drugs that the executive director  
195 plans to include on such annual list. The executive director shall make  
196 such preliminary list available for public comment for not less than  
197 thirty days. During the public comment period, any manufacturer of an  
198 outpatient prescription drug included on the preliminary list may  
199 produce documentation, as permitted by federal law, to the executive  
200 director to establish that the wholesale acquisition cost of such drug, less  
201 all rebates paid to the state for such outpatient prescription drug during  
202 the immediately preceding calendar year, does not exceed the limits

203 established in subdivision (3) of this subsection. If such documentation  
204 establishes, to the satisfaction of the executive director, that the  
205 wholesale acquisition cost of the drug, less all rebates paid to the state  
206 for such drug during the immediately preceding calendar year, does not  
207 exceed the limits established in subdivision (3) of this subsection, the  
208 executive director shall, not later than fifteen days after the closing of  
209 the public comment period, remove such drug from the preliminary list  
210 before publishing the annual list pursuant to subdivision (1) of this  
211 subsection.

212 (3) The executive director shall not list any outpatient prescription  
213 drugs under subdivision (1) or (2) of this subsection unless the  
214 wholesale acquisition cost of such outpatient prescription drug (A)  
215 increased by not less than sixteen per cent cumulatively during the  
216 immediately preceding two calendar years, and (B) was not less than  
217 forty dollars for a course of treatment.

218 [(3)] (4) (A) The pharmaceutical manufacturer of an outpatient  
219 prescription drug included on a list prepared by the executive director  
220 pursuant to subdivision (1) of this subsection shall provide to the office,  
221 in a form and manner specified by the executive director, (i) a written,  
222 narrative description, suitable for public release, of all factors that  
223 caused the increase in the wholesale acquisition cost of the listed  
224 outpatient prescription drug, and (ii) aggregate, company-level research  
225 and development costs and such other capital expenditures that the  
226 executive director, in the executive director's discretion, deems relevant  
227 for the most recent year for which final audited data are available.

228 (B) The quality and types of information and data that a  
229 pharmaceutical manufacturer submits to the office under this  
230 subdivision shall be consistent with the quality and types of information  
231 and data that the pharmaceutical manufacturer includes in (i) such  
232 pharmaceutical manufacturer's annual consolidated report on Securities  
233 and Exchange Commission Form 10-K, or (ii) any other public  
234 disclosure.



235        [(4)] (5) The office shall establish a standardized form for reporting  
236 information and data pursuant to this subsection after consulting with  
237 pharmaceutical manufacturers. The form shall be designed to minimize  
238 the administrative burden and cost of reporting on the office and  
239 pharmaceutical manufacturers.

240        Sec. 9. Section 19a-508c of the general statutes is repealed and the  
241 following is substituted in lieu thereof (*Effective July 1, 2023*):

242        (a) As used in this section:

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

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

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

261        (4) "Health care provider" means an individual, entity, corporation,  
262 person or organization, whether for-profit or nonprofit, that furnishes,  
263 bills or is paid for health care service delivery in the normal course of  
264 business, including, but not limited to, a health system, a hospital, a  
265 hospital-based facility, a freestanding emergency department and an

266 urgent care center;

267 [(4)] (5) "Health system" means: (A) A parent corporation of one or  
268 more hospitals and any entity affiliated with such parent corporation  
269 through ownership, governance, membership or other means, or (B) a  
270 hospital and any entity affiliated with such hospital through ownership,  
271 governance, membership or other means;

272 [(5)] (6) "Hospital" has the same meaning as provided in section 19a-  
273 490;

274 [(6)] (7) "Hospital-based facility" means a facility that is owned or  
275 operated, in whole or in part, by a hospital or health system where  
276 hospital or professional medical services are provided;

277 (8) "Medicaid" means the program operated by the Department of  
278 Social Services pursuant to section 17b-260 and authorized by Title XIX  
279 of the Social Security Act, as amended from time to time;

280 (9) "Observation" means services furnished by a hospital on the  
281 hospital's campus, regardless of length of stay, including use of a bed  
282 and periodic monitoring by the hospital's nursing or other staff to  
283 evaluate an outpatient's condition or determine the need for admission  
284 to the hospital as an inpatient;

285 [(7)] (10) "Payer mix" means the proportion of different sources of  
286 payment received by a hospital or health system, including, but not  
287 limited to, Medicare, Medicaid, other government-provided insurance,  
288 private insurance and self-pay patients;

289 [(8)] (11) "Professional fee" means any fee charged or billed by a  
290 provider for professional medical services provided in a hospital-based  
291 facility;

292 [(9)] (12) "Provider" means an individual, entity, corporation or  
293 health care provider, whether for profit or nonprofit, whose primary  
294 purpose is to provide professional medical services; and

295 [(10)] (13) "Tagline" means a short statement written in a non-English  
296 language that indicates the availability of language assistance services  
297 free of charge.

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

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

309 (2) (A) The amount of the patient's potential financial liability,  
310 including any facility fee likely to be charged, and, where professional  
311 medical services are provided by an affiliated provider, any professional  
312 fee likely to be charged, or, if the exact type and extent of the  
313 professional medical services needed are not known or the terms of a  
314 patient's health insurance coverage are not known with reasonable  
315 certainty, an estimate of the patient's financial liability based on typical  
316 or average charges for visits to the hospital-based facility, including the  
317 facility fee, (B) a statement that the patient's actual financial liability will  
318 depend on the professional medical services actually provided to the  
319 patient, (C) an explanation that the patient may incur financial liability  
320 that is greater than the patient would incur if the professional medical  
321 services were not provided by a hospital-based facility, and (D) a  
322 telephone number the patient may call for additional information  
323 regarding such patient's potential financial liability, including an  
324 estimate of the facility fee likely to be charged based on the scheduled  
325 professional medical services; and

326 (3) That a patient covered by a health insurance policy should contact

327 the health insurer for additional information regarding the hospital's or  
328 health system's charges and fees, including the patient's potential  
329 financial liability, if any, for such charges and fees.

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

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

340 (2) (A) A statement that the patient's actual financial liability will  
341 depend on the professional medical services actually provided to the  
342 patient, (B) an explanation that the patient may incur financial liability  
343 that is greater than the patient would incur if the hospital-based facility  
344 was not hospital-based, and (C) a telephone number the patient may call  
345 for additional information regarding such patient's potential financial  
346 liability, including an estimate of the facility fee likely to be charged  
347 based on the scheduled professional medical services; and

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

352 (d) Each initial billing statement that includes a facility fee shall: (1)  
353 Clearly identify the fee as a facility fee that is billed in addition to, or  
354 separately from, any professional fee billed by the provider; (2) provide  
355 the corresponding Medicare facility fee reimbursement rate for the same  
356 service as a comparison or, if there is no corresponding Medicare facility  
357 fee for such service, (A) the approximate amount Medicare would have  
358 paid the hospital for the facility fee on the billing statement, or (B) the

359 percentage of the hospital's charges that Medicare would have paid the  
360 hospital for the facility fee; (3) include a statement that the facility fee is  
361 intended to cover the hospital's or health system's operational expenses;  
362 (4) inform the patient that the patient's financial liability may have been  
363 less if the services had been provided at a facility not owned or operated  
364 by the hospital or health system; and (5) include written notice of the  
365 patient's right to request a reduction in the facility fee or any other  
366 portion of the bill and a telephone number that the patient may use to  
367 request such a reduction without regard to whether such patient  
368 qualifies for, or is likely to be granted, any reduction. Not later than  
369 October 15, 2022, and annually thereafter, each hospital, health system  
370 and hospital-based facility shall submit to the Health Systems Planning  
371 Unit of the Office of Health Strategy a sample of a billing statement  
372 issued by such hospital, health system or hospital-based facility that  
373 complies with the provisions of this subsection and which represents  
374 the format of billing statements received by patients. Such billing  
375 statement shall not contain patient identifying information.

376 (e) The written notice described in subsections (b) to (d), inclusive,  
377 and (h) to (j), inclusive, of this section shall be in plain language and in  
378 a form that may be reasonably understood by a patient who does not  
379 possess special knowledge regarding hospital or health system facility  
380 fee charges. On and after October 1, 2022, such notices shall include tag  
381 lines in at least the top fifteen languages spoken in the state indicating  
382 that the notice is available in each of those top fifteen languages. The  
383 fifteen languages shall be either the languages in the list published by  
384 the Department of Health and Human Services in connection with  
385 section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-  
386 148, or, as determined by the hospital or health system, the top fifteen  
387 languages in the geographic area of the hospital-based facility.

388 (f) (1) For nonemergency care, if a patient's appointment is scheduled  
389 to occur ten or more days after the appointment is made, such written  
390 notice shall be sent to the patient by first class mail, encrypted electronic  
391 mail or a secure patient Internet portal not less than three days after the  
392 appointment is made. If an appointment is scheduled to occur less than

393 ten days after the appointment is made or if the patient arrives without  
394 an appointment, such notice shall be hand-delivered to the patient when  
395 the patient arrives at the hospital-based facility.

396 (2) For emergency care, such written notice shall be provided to the  
397 patient as soon as practicable after the patient is stabilized in accordance  
398 with the federal Emergency Medical Treatment and Active Labor Act,  
399 42 USC 1395dd, as amended from time to time, or is determined not to  
400 have an emergency medical condition and before the patient leaves the  
401 hospital-based facility. If the patient is unconscious, under great duress  
402 or for any other reason unable to read the notice and understand and  
403 act on his or her rights, the notice shall be provided to the patient's  
404 representative as soon as practicable.

405 (g) Subsections (b) to (f), inclusive, and (l) of this section shall not  
406 apply if a patient is insured by Medicare or Medicaid or is receiving  
407 services under a workers' compensation plan established to provide  
408 medical services pursuant to chapter 568.

409 (h) A hospital-based facility shall prominently display written notice  
410 in locations that are readily accessible to and visible by patients,  
411 including patient waiting or appointment check-in areas, stating: (1)  
412 That the hospital-based facility is part of a hospital or health system, (2)  
413 the name of the hospital or health system, and (3) that if the hospital-  
414 based facility charges a facility fee, the patient may incur a financial  
415 liability greater than the patient would incur if the hospital-based  
416 facility was not hospital-based. On and after October 1, 2022, such  
417 notices shall include tag lines in at least the top fifteen languages spoken  
418 in the state indicating that the notice is available in each of those top  
419 fifteen languages. The fifteen languages shall be either the languages in  
420 the list published by the Department of Health and Human Services in  
421 connection with section 1557 of the Patient Protection and Affordable  
422 Care Act, P.L. 111-148, or, as determined by the hospital or health  
423 system, the top fifteen languages in the geographic area of the hospital-  
424 based facility. Not later than October 1, 2022, and annually thereafter,  
425 each hospital-based facility shall submit a copy of the written notice

426 required by this subsection to the Health Systems Planning Unit of the  
427 Office of Health Strategy.

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

432 (j) A hospital-based facility shall, when scheduling services for which  
433 a facility fee may be charged, inform the patient (1) that the hospital-  
434 based facility is part of a hospital or health system, (2) of the name of the  
435 hospital or health system, (3) that the hospital or health system may  
436 charge a facility fee in addition to and separate from the professional fee  
437 charged by the provider, and (4) of the telephone number the patient  
438 may call for additional information regarding such patient's potential  
439 financial liability.

440 (k) (1) If any transaction described in subsection (c) of section 19a-  
441 486i, results in the establishment of a hospital-based facility at which  
442 facility fees may be billed, the hospital or health system, that is the  
443 purchaser in such transaction shall, not later than thirty days after such  
444 transaction, provide written notice, by first class mail, of the transaction  
445 to each patient served within the three years preceding the date of the  
446 transaction by the health care facility that has been purchased as part of  
447 such transaction.

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

449 (A) A statement that the health care facility is now a hospital-based  
450 facility and is part of a hospital or health system, the health care facility's  
451 full legal and business name and the date of such facility's acquisition  
452 by a hospital or health system;

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

455 (C) A statement that the hospital-based facility bills, or is likely to bill,

456 patients a facility fee that may be in addition to, and separate from, any  
457 professional fee billed by a health care provider at the hospital-based  
458 facility;

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

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

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

473 (3) A copy of the written notice provided to patients in accordance  
474 with this subsection shall be filed with the Health Systems Planning  
475 Unit of the Office of Health Strategy, established under section 19a-612.  
476 Said unit shall post a link to such notice on its Internet web site.

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

485 (5) Not later than July 1, 2023, and annually thereafter, each hospital-  
486 based facility that was the subject of a transaction, as described in



487 subsection (c) of section 19a-486i, during the preceding calendar year  
488 shall report to the Health Systems Planning Unit of the Office of Health  
489 Strategy the number of patients served by such hospital-based facility  
490 in the preceding three years.

491 (l) (1) Notwithstanding the provisions of this section, no hospital,  
492 health system or hospital-based facility shall collect a facility fee for [(1)]  
493 (A) outpatient health care services that use a current procedural  
494 terminology evaluation and management (CPT E/M) code or  
495 assessment and management (CPT A/M) code and are provided at a  
496 hospital-based facility located off-site from a hospital campus, or [(2)]  
497 (B) outpatient health care services provided at a hospital-based facility  
498 located off-site from a hospital campus [,] received by a patient who is  
499 uninsured of more than the Medicare rate.

500 (2) Notwithstanding the provisions of this section, on and after July  
501 1, 2024, no hospital or health system shall collect a facility fee for  
502 outpatient health care services that use a current procedural  
503 terminology evaluation and management (CPT E/M) code or  
504 assessment and management (CPT A/M) code and are provided on the  
505 hospital campus. The provisions of this subdivision shall not apply to  
506 (A) an emergency department located on a hospital campus, or (B)  
507 observation stays on a hospital campus and (CPT E/M) and (CPT A/M)  
508 codes when billed for the following services: (i) Wound care, (ii)  
509 orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi)  
510 solid organ transplant.

511 (3) Notwithstanding the provisions of subdivisions (1) and (2) of this  
512 subsection, in circumstances when an insurance contract that is in effect  
513 on July 1, 2016, provides reimbursement for facility fees prohibited  
514 under the provisions of subdivision (1) of this [section] subsection, and  
515 in circumstances when an insurance contract that is in effect on July 1,  
516 2024, provides reimbursement for facility fees prohibited under the  
517 provisions of subdivision (2) of this subsection, a hospital or health  
518 system may continue to collect reimbursement from the health insurer  
519 for such facility fees until the applicable date of expiration, renewal or

520 amendment of such contract, whichever such date is the earliest. [A  
521 violation of this subsection shall be considered an unfair trade practice  
522 pursuant to chapter 735a.]

523 (4) The provisions of this subsection shall not apply to a freestanding  
524 emergency department. As used in this [subsection] subdivision,  
525 "freestanding emergency department" means a freestanding facility that  
526 (A) is structurally separate and distinct from a hospital, (B) provides  
527 emergency care, (C) is a department of a hospital licensed under chapter  
528 368v, and (D) has been issued a certificate of need to operate as a  
529 freestanding emergency department pursuant to chapter 368z.

530 (5) (A) On and after July 1, 2024, if the executive director of the Office  
531 of Health Strategy receives information and has a reasonable belief, after  
532 evaluating such information, that any hospital, health system or  
533 hospital-based facility charged facility fees, other than through isolated  
534 clerical or electronic billing errors, in violation of any provision of this  
535 section, or rule or regulation adopted thereunder, such hospital, health  
536 system or hospital-based facility shall be subject to a civil penalty of up  
537 to one thousand dollars. The executive director may issue a notice of  
538 violation and civil penalty by first-class mail or personal service. Such  
539 notice shall include: (i) A reference to the section of the general statutes,  
540 rule or section of the regulations of Connecticut state agencies believed  
541 or alleged to have been violated; (ii) a short and plain language  
542 statement of the matters asserted or charged; (iii) a description of the  
543 activity to cease; (iv) a statement of the amount of the civil penalty or  
544 penalties that may be imposed; (v) a statement concerning the right to a  
545 hearing; and (vi) a statement that such hospital, health system or  
546 hospital-based facility may, not later than ten business days after receipt  
547 of such notice, make a request for a hearing on the matters asserted.

548 (B) The hospital, health system or hospital-based facility to whom  
549 such notice is provided pursuant to subparagraph (A) of this  
550 subdivision may, not later than ten business days after receipt of such  
551 notice, make written application to the Office of Health Strategy to  
552 request a hearing to demonstrate that such violation did not occur. The

553 failure to make a timely request for a hearing shall result in the issuance  
554 of a cease and desist order or civil penalty. All hearings held under this  
555 subsection shall be conducted in accordance with the provisions of  
556 chapter 54.

557 (C) Following any hearing before the Office of Health Strategy  
558 pursuant to this subdivision, if said office finds, by a preponderance of  
559 the evidence, that such hospital, health system or hospital-based facility  
560 violated or is violating any provision of this subsection, any rule or  
561 regulation adopted thereunder or any order issued by said office, said  
562 office shall issue a final cease and desist order in addition to any civil  
563 penalty said office imposes.

564 (m) (1) Each hospital and health system shall report not later than  
565 [July 1, 2023] October 1, 2023, and thereafter not later than July 1, 2024,  
566 and annually thereafter, to the executive director of the Office of Health  
567 Strategy, on a form prescribed by the executive director, concerning  
568 facility fees charged or billed during the preceding calendar year. Such  
569 report shall include, but need not be limited to, (A) the name and  
570 address of each facility owned or operated by the hospital or health  
571 system that provides services for which a facility fee is charged or billed,  
572 and an indication as to whether each facility is located on or outside of  
573 the hospital or health system campus, (B) the number of patient visits at  
574 each such facility for which a facility fee was charged or billed, (C) the  
575 number, total amount and range of allowable facility fees paid at each  
576 such facility disaggregated by payer mix, (D) for each facility, the total  
577 amount of facility fees charged and the total amount of revenue received  
578 by the hospital or health system derived from facility fees, (E) the total  
579 amount of facility fees charged and the total amount of revenue received  
580 by the hospital or health system from all facilities derived from facility  
581 fees, (F) a description of the ten procedures or services that generated  
582 the greatest amount of facility fee gross revenue, disaggregated by  
583 current procedural terminology category (CPT) code for each such  
584 procedure or service and, for each such procedure or service, patient  
585 volume and the total amount of gross and net revenue received by the  
586 hospital or health system derived from facility fees, disaggregated by

587 on-campus and off-campus, and (G) the top ten procedures or services  
588 for which facility fees are charged based on patient volume and the  
589 gross and net revenue received by the hospital or health system for each  
590 such procedure or service, disaggregated by on-campus and off-  
591 campus. For purposes of this subsection, "facility" means a hospital-  
592 based facility that is located on a hospital campus or outside a hospital  
593 campus.

594 (2) The executive director shall publish the information reported  
595 pursuant to subdivision (1) of this subsection, or post a link to such  
596 information, on the Internet web site of the Office of Health Strategy.

597 Sec. 10. Section 19a-633 of the general statutes is repealed and the  
598 following is substituted in lieu thereof (*Effective October 1, 2023*):

599 (a) The executive director, or any agent authorized by such executive  
600 director to conduct any inquiry, investigation or hearing under the  
601 provisions of this chapter, shall have power to administer oaths and take  
602 testimony under oath relative to the matter of inquiry or investigation.  
603 At any hearing ordered by the unit, the executive director or such agent  
604 having authority by law to issue such process may subpoena witnesses  
605 and require the production of records, papers and documents pertinent  
606 to such inquiry. If any person disobeys such process or, having  
607 appeared in obedience thereto, refuses to answer any pertinent question  
608 put to such person by the executive director or such executive director's  
609 authorized agent or to produce any records and papers pursuant  
610 thereto, the executive director or such executive director's agent may  
611 apply to the superior court for the judicial district of Hartford or for the  
612 judicial district wherein the person resides or wherein the business has  
613 been conducted, or to any judge of said court if the same is not in  
614 session, setting forth such disobedience to process or refusal to answer,  
615 and said court or such judge shall cite such person to appear before said  
616 court or such judge to answer such question or to produce such records  
617 and papers.

618 (b) If the executive director or such agent has received information

619 and has a reasonable belief that any person, health care facility or  
620 institution has violated or is violating any provision of this chapter, or  
621 any regulation or order of the unit, the executive director or such agent  
622 may issue a notice pursuant to this section. The unit shall notify the  
623 person, health care facility or institution against whom such order is  
624 issued by first-class mail or personal service. The notice shall include:  
625 (1) A reference to the sections of the general statutes, regulations of  
626 Connecticut state agencies or orders alleged or believed to have been  
627 violated; (2) a short and plain language statement of the matters asserted  
628 or charged; (3) a description of the activity alleged to have violated a  
629 statute or regulation identified pursuant to subdivision (1) of this  
630 subsection; (4) a statement concerning the right to a hearing of such  
631 person, health care facility or institution; and (5) a statement that such  
632 person, health care facility or institution may, not later than ten business  
633 days after receipt of such notice, make a written request for a hearing on  
634 the matters asserted, to be sent to the executive director or such agent.

635 (c) The person, health care facility or institution to whom such notice  
636 is provided pursuant to subsection (b) of this section may, not later than  
637 ten business days after receipt of the notice, make written application to  
638 the unit to request a hearing to demonstrate that such violation has not  
639 occurred, a certificate of need was not required, or each required  
640 certificate of need was obtained. A failure to make a timely request for  
641 a hearing shall result in the office issuing a cease and desist order. Each  
642 hearing held under this subsection shall be conducted as a contested  
643 case pursuant to chapter 54.

644 (d) If the unit finds, by a preponderance of the evidence, following a  
645 hearing held under subsection (c) of this section that such person, health  
646 care facility or institution has violated or is violating any provision of  
647 this chapter, or any regulation or order of the unit, the unit shall issue a  
648 cease and desist order to such person, health care facility or institution  
649 that shall be considered a final decision subject to appeal to the Superior  
650 Court in accordance with section 4-183.

651 (e) Any cease and desist order issued under this section may be

652 enforced by the Attorney General pursuant to section 19a-642.

653 Sec. 11. Section 19a-638 of the general statutes is repealed and the  
654 following is substituted in lieu thereof (*Effective October 1, 2023*):

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

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

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

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

664 (4) The establishment of a freestanding emergency department;

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

669 (6) The establishment of an outpatient surgical facility, as defined in  
670 section 19a-493b, or as established by a short-term acute care general  
671 hospital;

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

679 (8) The termination of an emergency department by a short-term

680 acute care general hospital;

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

684 (10) The acquisition of computed tomography scanners, magnetic  
685 resonance imaging scanners, positron emission tomography scanners or  
686 positron emission tomography-computed tomography scanners, by any  
687 person, physician, provider, short-term acute care general hospital or  
688 children's hospital, except (A) as provided for in subdivision (22) of  
689 subsection (b) of this section, and (B) a certificate of need issued by the  
690 unit shall not be required where such scanner is a replacement for a  
691 scanner that was previously acquired through certificate of need  
692 approval or a certificate of need determination, including a replacement  
693 scanner that has dual modalities or functionalities if the applicant  
694 already offers similar imaging services for each of the scanner's  
695 modalities or functionalities that will be utilized;

696 (11) The acquisition of nonhospital based linear accelerators, except a  
697 certificate of need issued by the unit shall not be required where such  
698 accelerator is a replacement for an accelerator that was previously  
699 acquired through certificate of need approval or a certificate of need  
700 determination;

701 (12) An increase in the licensed bed capacity of a health care facility,  
702 except as provided in subdivision (23) of subsection (b) of this section;

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

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

709 (15) The termination of inpatient or outpatient services offered by a

710 hospital or other facility or institution operated by the state that  
711 provides services that are eligible for reimbursement under Title XVIII  
712 or XIX of the federal Social Security Act, 42 USC 301, as amended.

713 (b) A certificate of need shall not be required for:

714 (1) Health care facilities owned and operated by the federal  
715 government;

716 (2) The establishment of offices by a licensed private practitioner,  
717 whether for individual or group practice, except when a certificate of  
718 need is required in accordance with the requirements of section 19a-  
719 493b or subdivision (3), (10) or (11) of subsection (a) of this section;

720 (3) A health care facility operated by a religious group that  
721 exclusively relies upon spiritual means through prayer for healing;

722 (4) Residential care homes, as defined in subsection (c) of section 19a-  
723 490, and nursing homes and rest homes, as defined in subsection (o) of  
724 section 19a-490;

725 (5) An assisted living services agency, as defined in section 19a-490;

726 (6) Home health agencies, as defined in section 19a-490;

727 (7) Hospice services, as described in section 19a-122b;

728 (8) Outpatient rehabilitation facilities;

729 (9) Outpatient chronic dialysis services;

730 (10) Transplant services;

731 (11) Free clinics, as defined in section 19a-630;

732 (12) School-based health centers and expanded school health sites, as  
733 such terms are defined in section 19a-6r, community health centers, as  
734 defined in section 19a-490a, not-for-profit outpatient clinics licensed in  
735 accordance with the provisions of chapter 368v and federally qualified



736 health centers;

737 (13) A program licensed or funded by the Department of Children  
738 and Families, provided such program is not a psychiatric residential  
739 treatment facility;

740 (14) Any nonprofit facility, institution or provider that has a contract  
741 with, or is certified or licensed to provide a service for, a state agency or  
742 department for a service that would otherwise require a certificate of  
743 need. The provisions of this subdivision shall not apply to a short-term  
744 acute care general hospital or children's hospital, or a hospital or other  
745 facility or institution operated by the state that provides services that are  
746 eligible for reimbursement under Title XVIII or XIX of the federal Social  
747 Security Act, 42 USC 301, as amended;

748 (15) A health care facility operated by a nonprofit educational  
749 institution exclusively for students, faculty and staff of such institution  
750 and their dependents;

751 (16) An outpatient clinic or program operated exclusively by or  
752 contracted to be operated exclusively by a municipality, municipal  
753 agency, municipal board of education or a health district, as described  
754 in section 19a-241;

755 (17) A residential facility for persons with intellectual disability  
756 licensed pursuant to section 17a-227 and certified to participate in the  
757 Title XIX Medicaid program as an intermediate care facility for  
758 individuals with intellectual disabilities;

759 (18) Replacement of existing [imaging equipment] computed  
760 tomography scanners, magnetic resonance imaging scanners, positron  
761 emission tomography scanners, positron emission tomography-  
762 computed tomography scanners, or nonhospital based linear  
763 accelerators, if such equipment was acquired through certificate of need  
764 approval or a certificate of need determination, provided a health care  
765 facility, provider, physician or person notifies the unit of the date on  
766 which the equipment is replaced and the disposition of the replaced

767 equipment, including if a replacement scanner has dual modalities or  
768 functionalities and the applicant already offers similar imaging services  
769 for each of the equipment's modalities or functionalities that will be  
770 utilized;

771 (19) Acquisition of cone-beam dental imaging equipment that is to be  
772 used exclusively by a dentist licensed pursuant to chapter 379;

773 (20) The partial or total elimination of services provided by an  
774 outpatient surgical facility, as defined in section 19a-493b, except as  
775 provided in subdivision (6) of subsection (a) of this section and section  
776 19a-639e;

777 (21) The termination of services for which the Department of Public  
778 Health has requested the facility to relinquish its license;

779 (22) Acquisition of any equipment by any person that is to be used  
780 exclusively for scientific research that is not conducted on humans; or

781 (23) On or before June 30, 2026, an increase in the licensed bed  
782 capacity of a mental health facility, provided (A) the mental health  
783 facility demonstrates to the unit, in a form and manner prescribed by  
784 the unit, that it accepts reimbursement for any covered benefit provided  
785 to a covered individual under: (i) An individual or group health  
786 insurance policy providing coverage of the type specified in  
787 subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (ii) a self-  
788 insured employee welfare benefit plan established pursuant to the  
789 federal Employee Retirement Income Security Act of 1974, as amended  
790 from time to time; or (iii) HUSKY Health, as defined in section 17b-290,  
791 and (B) if the mental health facility does not accept or stops accepting  
792 reimbursement for any covered benefit provided to a covered  
793 individual under a policy, plan or program described in clause (i), (ii) or  
794 (iii) of subparagraph (A) of this subdivision, a certificate of need for such  
795 increase in the licensed bed capacity shall be required.

796 (c) (1) Any person, health care facility or institution that is unsure  
797 whether a certificate of need is required under this section, or (2) any

798 health care facility that proposes to relocate pursuant to section 19a-  
799 639c, as amended by this act, shall send a letter to the unit that describes  
800 the project and requests that the unit make a determination as to  
801 whether a certificate of need is required. In the case of a relocation of a  
802 health care facility, the letter shall include information described in  
803 section 19a-639c, as amended by this act. A person, health care facility  
804 or institution making such request shall provide the unit with any  
805 information the unit requests as part of its determination process. The  
806 unit shall provide a determination within thirty days of receipt of such  
807 request.

808 (d) The executive director of the Office of Health Strategy may  
809 implement policies and procedures necessary to administer the  
810 provisions of this section while in the process of adopting such policies  
811 and procedures as regulation, provided the executive director holds a  
812 public hearing prior to implementing the policies and procedures and  
813 posts notice of intent to adopt regulations on the office's Internet web  
814 site and the eRegulations System not later than twenty days after the  
815 date of implementation. Policies and procedures implemented pursuant  
816 to this section shall be valid until the time final regulations are adopted.

817 (e) On or before June 30, 2026, a mental health facility seeking to  
818 increase licensed bed capacity without applying for a certificate of need,  
819 as permitted pursuant to subdivision (23) of subsection (b) of this  
820 section, shall notify the Office of Health Strategy, in a form and manner  
821 prescribed by the executive director of said office, regarding (1) such  
822 facility's intent to increase licensed bed capacity, (2) the address of such  
823 facility, and (3) a description of all services that are being or will be  
824 provided at such facility.

825 (f) Not later than January 1, 2025, the executive director of the Office  
826 of Health Strategy shall report to the Governor and, in accordance with  
827 the provisions of section 11-4a, to the joint standing committee of the  
828 General Assembly having cognizance of matters relating to public  
829 health concerning the executive director's recommendations, if any,  
830 regarding the establishment of an expedited certificate of need process

831 for mental health facilities.

832 Sec. 12. Section 19a-639a of the general statutes is repealed and the  
833 following is substituted in lieu thereof (*Effective October 1, 2023*):

834 (a) An application for a certificate of need shall be filed with the unit  
835 in accordance with the provisions of this section and any regulations  
836 adopted by the Office of Health Strategy. The application shall address  
837 the guidelines and principles set forth in (1) subsection (a) of section 19a-  
838 639, and (2) regulations adopted by the department. The applicant shall  
839 include with the application a nonrefundable application fee based on  
840 the cost of the project. The amount of the fee shall be as follows: (A) One  
841 thousand dollars for a project that will cost not greater than fifty  
842 thousand dollars; (B) two thousand dollars for a project that will cost  
843 greater than fifty thousand dollars but not greater than one hundred  
844 thousand dollars; (C) three thousand dollars for a project that will cost  
845 greater than one hundred thousand dollars but not greater than five  
846 hundred thousand dollars; (D) four thousand dollars for a project that  
847 will cost greater than five hundred thousand dollars but not greater than  
848 one million dollars; (E) five thousand dollars for a project that will cost  
849 greater than one million dollars but not greater than five million dollars;  
850 (F) eight thousand dollars for a project that will cost greater than five  
851 million dollars but not greater than ten million dollars; and (G) ten  
852 thousand dollars for a project that will cost greater than ten million  
853 dollars.

854 (b) Prior to the filing of a certificate of need application, the applicant  
855 shall (1) publish notice that an application is to be submitted to the unit  
856 (A) in a newspaper having a substantial circulation in the area where  
857 the project is to be located, and (B) on the applicant's Internet web site  
858 in a clear and conspicuous location that is easily accessible by members  
859 of the public, (2) request the publication of notice (A) in at least two sites  
860 within the affected community that are commonly accessed by the  
861 public, such as a town hall or library, and (B) on any existing Internet  
862 web site of the municipality or local health department, and (3) submit  
863 such notice to the unit for posting on such unit's Internet web site. Such

864 newspaper notice shall [(1)] be published [(A) not later than twenty days  
865 prior to the date of filing of the certificate of need application, and (B)  
866 for not less than three consecutive days] for not less than three  
867 consecutive days, with the final date of consecutive publication  
868 occurring not later than twenty days prior to the date of filing of the  
869 certificate of need application, and [(2)] contain a brief description of the  
870 nature of the project and the street address where the project is to be  
871 located. Postings in the affected community and on the applicant's  
872 Internet web site shall remain until the decision on the application is  
873 rendered. The unit shall not invalidate any notice due to changes or  
874 removal of the notice from a community Internet web site of which the  
875 applicant has no control. An applicant shall file the certificate of need  
876 application with the unit not later than ninety days after publishing  
877 notice of the application in a newspaper in accordance with the  
878 provisions of this subsection. The unit shall not accept the applicant's  
879 certificate of need application for filing unless the application is  
880 accompanied by the application fee prescribed in subsection (a) of this  
881 section and proof of compliance with the publication requirements  
882 prescribed in this subsection.

883 (c) (1) Not later than five business days after receipt of a properly filed  
884 certificate of need application, the unit shall publish notice of the  
885 application on its Internet web site. Not later than thirty days after the  
886 date of filing of the application, the unit may request such additional  
887 information as the unit determines necessary to complete the  
888 application. In addition to any information requested by the unit, if the  
889 application involves the transfer of ownership of a hospital, as defined  
890 in section 19a-639, the applicant shall submit to the unit (A) a plan  
891 demonstrating how health care services will be provided by the new  
892 hospital for the first three years following the transfer of ownership of  
893 the hospital, including any consolidation, reduction, elimination or  
894 expansion of existing services or introduction of new services, and (B)  
895 the names of persons currently holding a position with the hospital to  
896 be purchased or the purchaser, as defined in section 19a-639, as an  
897 officer, director, board member or senior manager, whether or not such

898 person is expected to hold a position with the hospital after completion  
899 of the transfer of ownership of the hospital and any salary, severance,  
900 stock offering or any financial gain, current or deferred, such person is  
901 expected to receive as a result of, or in relation to, the transfer of  
902 ownership of the hospital.

903 (2) The applicant shall, not later than sixty days after the date of the  
904 unit's request, submit any requested information and any information  
905 required under this subsection to the unit. If an applicant fails to submit  
906 such information to the unit within the sixty-day period, the unit shall  
907 consider the application to have been withdrawn.

908 (3) The unit shall make reasonable efforts to limit the requests for  
909 additional information to two such requests and, in all cases, cease all  
910 requests for additional information not later than six months after  
911 receiving the application.

912 (d) Upon [determining that] deeming an application [is] complete,  
913 the unit shall provide notice of this determination to the applicant and  
914 to the public in accordance with regulations adopted by the department.  
915 In addition, the unit shall post such notice on its Internet web site and  
916 notify the applicant not later than five days after deeming the  
917 application complete. The date on which the unit posts such notice on  
918 its Internet web site shall begin the review period. Except as provided  
919 in this subsection, (1) the review period for [a completed] an application  
920 deemed complete shall be ninety days from the date on which the unit  
921 posts such notice on its Internet web site; and (2) the unit shall issue a  
922 decision on [a completed] an application deemed complete prior to the  
923 expiration of the ninety-day review period in matters without a public  
924 hearing. The review period for [a completed] an application deemed  
925 complete that involves a transfer of a large group practice, as described  
926 in subdivision (3) of subsection (a) of section 19a-638, as amended by  
927 this act, when the offer was made in response to a request for proposal  
928 or similar voluntary offer for sale, shall be sixty days from the date on  
929 which the unit posts notice on its Internet web site. Upon request or for  
930 good cause shown, the unit may extend the review period for a period

931 of time not to exceed sixty days. If the review period is extended, the  
932 unit shall issue a decision on the completed application prior to the  
933 expiration of the extended review period. If the unit holds a public  
934 hearing concerning a completed application in accordance with  
935 subsection (e) or (f) of this section, the unit shall issue a decision on the  
936 completed application not later than sixty days after the date the unit  
937 closes the public hearing record.

938 (e) Except as provided in this subsection, the unit shall hold a public  
939 hearing on a properly filed and completed certificate of need application  
940 if three or more individuals or an individual representing an entity with  
941 five or more people submits a request, in writing, that a public hearing  
942 be held on the application. For a properly filed and completed certificate  
943 of need application involving a transfer of ownership of a large group  
944 practice, as described in subdivision (3) of subsection (a) of section 19a-  
945 638, as amended by this act, when an offer was made in response to a  
946 request for proposal or similar voluntary offer for sale, a public hearing  
947 shall be held if twenty-five or more individuals or an individual  
948 representing twenty-five or more people submits a request, in writing,  
949 that a public hearing be held on the application. Any request for a public  
950 hearing shall be made to the unit not later than thirty days after the date  
951 the unit [determines] deems the application to be complete.

952 (f) (1) The unit shall hold a public hearing with respect to each  
953 certificate of need application filed pursuant to section 19a-638, as  
954 amended by this act, after December 1, 2015, that concerns any transfer  
955 of ownership involving a hospital. Such hearing shall be held in the  
956 municipality in which the hospital that is the subject of the application  
957 is located.

958 (2) The unit may hold a public hearing with respect to any certificate  
959 of need application submitted under this chapter. The unit shall provide  
960 not less than two weeks' advance notice to the applicant, in writing, and  
961 to the public by publication in a newspaper having a substantial  
962 circulation in the area served by the health care facility or provider. In  
963 conducting its activities under this chapter, the unit may hold hearings

964 with respect to applications of a similar nature at the same time. The  
965 applicant shall post a copy of the unit's hearing notice on the applicant's  
966 Internet web site in a clear and conspicuous location that is easily  
967 accessible by members of the public. Such applicant shall request the  
968 publication of notice in at least two sites within the affected community  
969 that are commonly accessed by the public, such as a town hall or library,  
970 as well as on any existing Internet web site of the municipality or local  
971 health department. The unit shall not invalidate any notice due to  
972 changes or removal of the notice from a community Internet web site of  
973 which the applicant has no control.

974 (g) For applications submitted on or after October 1, 2023, the unit  
975 may retain an independent consultant with expertise in the specific area  
976 of health care that is the subject of the application filed by an applicant  
977 if the review and analysis of an application cannot reasonably be  
978 conducted by the unit without the expertise of an industry analyst or  
979 other actuarial consultant. The unit shall submit bills for independent  
980 consultant services to the applicant. Such applicant shall pay such bills  
981 not later than thirty days after receipt of such bills. Such bills shall be a  
982 reasonable amount per application. The provisions of chapter 57 and  
983 sections 4-212 to 4-219, inclusive, and 4e-19 shall not apply to any  
984 retainer agreement executed pursuant to this subsection.

985 [(g)] (h) The executive director of the Office of Health Strategy may  
986 implement policies and procedures necessary to administer the  
987 provisions of this section while in the process of adopting such policies  
988 and procedures as regulation, provided the executive director holds a  
989 public hearing prior to implementing the policies and procedures and  
990 posts notice of intent to adopt regulations on the office's Internet web  
991 site and the eRegulations System not later than twenty days after the  
992 date of implementation. Policies and procedures implemented pursuant  
993 to this section shall be valid until the time final regulations are adopted.

994 Sec. 13. Section 19a-639c of the general statutes is repealed and the  
995 following is substituted in lieu thereof (*Effective October 1, 2023*):



996 (a) Any health care facility that proposes to relocate a facility shall  
997 submit a letter to the unit, as described in subsection (c) of section 19a-  
998 638, as amended by this act. In addition to the requirements prescribed  
999 in said subsection (c), in such letter the health care facility shall  
1000 demonstrate to the satisfaction of the unit that the population served by  
1001 the health care facility and the payer mix will not substantially change  
1002 as a result of the facility's proposed relocation. If the facility is unable to  
1003 demonstrate to the satisfaction of the unit that the population served  
1004 and the payer mix will not substantially change as a result of the  
1005 proposed relocation, the health care facility shall apply for certificate of  
1006 need approval pursuant to subdivision (1) of subsection (a) of section  
1007 19a-638, as amended by this act, in order to effectuate the proposed  
1008 relocation. The unit shall provide a determination not later than thirty  
1009 days after receipt of such letter.

1010 (b) The executive director of the Office of Health Strategy may  
1011 implement policies and procedures necessary to administer the  
1012 provisions of this section while in the process of adopting such policies  
1013 and procedures as regulation, provided the executive director holds a  
1014 public hearing prior to implementing the policies and procedures and  
1015 posts notice of intent to adopt regulations on the office's Internet web  
1016 site and the eRegulations System not later than twenty days after the  
1017 date of implementation. Policies and procedures implemented pursuant  
1018 to this section shall be valid until the time final regulations are adopted.

1019 Sec. 14. Section 19a-653 of the general statutes is repealed and the  
1020 following is substituted in lieu thereof (*Effective October 1, 2023*):

1021 (a) Any person or health care facility or institution that is required to  
1022 file a certificate of need for any of the activities described in section 19a-  
1023 638, as amended by this act, and any person or health care facility or  
1024 institution that is required to file data or information under any public  
1025 or special act or under this chapter or sections 19a-486 to 19a-486h,  
1026 inclusive, or any regulation adopted or order issued under this chapter  
1027 or said sections, [which wilfully] and negligently fails to seek certificate  
1028 of need approval for any of the activities described in section 19a-638, as

1029 amended by this act, or to so file within prescribed time periods, and  
1030 any person or health care facility or institution that has agreed to fully  
1031 resolve a certificate of need application through settlement and  
1032 negligently fails to comply with any term or condition enumerated in  
1033 the settlement agreement, shall be subject to a civil penalty of up to one  
1034 thousand dollars a day for each day such person or health care facility  
1035 or institution conducts any of the described activities without certificate  
1036 of need approval as required by section 19a-638, as amended by this act,  
1037 [or] for each day such information is missing, incomplete or inaccurate  
1038 or for each day any condition of a settlement agreement is not met. Any  
1039 civil penalty authorized by this section shall be imposed by the Office of  
1040 Health Strategy in accordance with subsections (b) to (e), inclusive, of  
1041 this section.

1042 (b) If the Office of Health Strategy has reason to believe that a  
1043 violation has occurred for which a civil penalty is authorized by  
1044 subsection (a) of this section or subsection (e) of section 19a-632, it shall  
1045 notify the person or health care facility or institution by first-class mail  
1046 or personal service. The notice shall include: (1) A reference to the  
1047 sections of the statute, [or] regulation or settlement agreement involved;  
1048 (2) a short and plain statement of the matters asserted or charged; (3) a  
1049 statement of the amount of the civil penalty or penalties to be imposed;  
1050 (4) the initial date of the imposition of the penalty; and (5) a statement  
1051 of the party's right to a hearing.

1052 (c) The person or health care facility or institution to whom the notice  
1053 is addressed shall have fifteen business days from the date of mailing of  
1054 the notice to make written application to the unit to (1) request [(1)] a  
1055 hearing to contest the imposition of the penalty, [or] (2) request an  
1056 extension of time to file the required data, or (3) comply with  
1057 enumerated conditions of an agreed settlement. A failure to make a  
1058 timely request for a hearing or an extension of time to file the required  
1059 data or a denial of a request for an extension of time shall result in a final  
1060 order for the imposition of the penalty. All hearings under this section  
1061 shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The  
1062 Office of Health Strategy may grant an extension of time for filing the

1063 required data or mitigate or waive the penalty upon such terms and  
1064 conditions as, in its discretion, it deems proper or necessary upon  
1065 consideration of any extenuating factors or circumstances.

1066 (d) A final order of the Office of Health Strategy assessing a civil  
1067 penalty shall be subject to appeal as set forth in section 4-183 after a  
1068 hearing before the unit pursuant to subsection (c) of this section, except  
1069 that any such appeal shall be taken to the superior court for the judicial  
1070 district of New Britain. Such final order shall not be subject to appeal  
1071 under any other provision of the general statutes. No challenge to any  
1072 such final order shall be allowed as to any issue which could have been  
1073 raised by an appeal of an earlier order, denial or other final decision by  
1074 the office.

1075 (e) If any person or health care facility or institution fails to pay any  
1076 civil penalty under this section, after the assessment of such penalty has  
1077 become final the amount of such penalty may be deducted from  
1078 payments to such person or health care facility or institution from the  
1079 Medicaid account.

1080 Sec. 15. (NEW) (*Effective October 1, 2023*) (a) For purposes of this  
1081 section and section 19a-649 of the general statutes:

1082 (1) "340B covered entity" means an entity authorized to participate in  
1083 the federal 340B Drug Pricing Program under 42 USC 256b(a)(4), as  
1084 amended from time to time, and includes any pharmacy under contract  
1085 with the entity to dispense drugs on behalf of the entity; and

1086 (2) "Pharmacy benefits manager" has the same meaning as provided  
1087 in section 38a-479aaa of the general statutes and includes a wholly or  
1088 partially owned or controlled subsidiary of a pharmacy benefits  
1089 manager.

1090 (b) On and after January 1, 2024, a contract entered into between a  
1091 pharmacy benefit manager and a 340B covered entity shall not contain  
1092 any of the following provisions:

1093 (1) A reimbursement rate for a prescription drug that is less than the  
1094 reimbursement rate paid to pharmacies that are not 340B covered  
1095 entities;

1096 (2) A fee or adjustment that is not imposed on providers or  
1097 pharmacies that are not 340B covered entities;

1098 (3) A fee or adjustment amount that exceeds the fee or adjustment  
1099 amount imposed on providers or pharmacies that are not 340B covered  
1100 entities;

1101 (4) Any provision that prevents or interferes with a patient's choice  
1102 to receive a prescription drug from a 340B covered entity, including the  
1103 administration of the drug; and

1104 (5) Any provision that excludes a 340B covered entity from pharmacy  
1105 benefit manager networks based on the 340B covered entity's  
1106 participation in the federal 340B Drug Pricing Program.

1107 (c) Except to the extent permitted by law, a pharmacy benefits  
1108 manager may not consider whether an entity is a 340B covered entity  
1109 when determining reimbursement rates.

1110 (d) A pharmacy benefits manager may not retaliate against a 340B  
1111 covered entity based on its exercise or any right or remedy under this  
1112 section.

1113 (e) To the extent that any contract provision contained in a contract  
1114 between a pharmacy benefits manager and a 340B covered entity  
1115 entered into, amended or renewed after January 1, 2024, violates any  
1116 provision of subsection (b) or (c) of this section, such contract provision  
1117 shall be void and unenforceable.

1118 (f) The Insurance Commissioner may adopt regulations, in  
1119 accordance with the provisions of chapter 54 of the general statutes, to  
1120 implement the provisions of this section.

1121 Sec. 16. (*Effective from passage*) (a) The Commissioner of Social Services

1122 shall convene a working group to evaluate (1) the current status of the  
1123 federal 340B drug pricing program authorized by 42 USC 256b, as  
1124 amended from time to time, (2) national efforts to strengthen and  
1125 sustain such program, and (3) opportunities for state action to protect  
1126 340B revenues of federally qualified health centers from unfair  
1127 administrative barriers or unnecessary conditions based on such  
1128 centers' status as a 340B covered entity. Such evaluation shall consider  
1129 (A) the ability of and any legal precedent for states to regulate the  
1130 conduct of drug manufacturers and pharmacy benefits managers, as  
1131 defined in section 38a-479aaa of the general statutes, (B) opportunities  
1132 to facilitate patient access to on-site pharmacies of a federally qualified  
1133 health center, (C) opportunities to establish on-site pharmacies across  
1134 federally qualified health centers, and (D) national trends to sustain  
1135 such program. As used in this subsection, "340B covered entity" means  
1136 a provider participating in the federal 340B drug pricing program  
1137 authorized by 42 USC 256b, as amended from time to time.

1138 (b) Not later than January 31, 2024, the Commissioner of Social  
1139 Services shall report, in accordance with the provisions of section 11-4a  
1140 of the general statutes, on the findings and recommendations of the  
1141 working group to the joint standing committees of the General  
1142 Assembly having cognizance of matters relating to insurance, public  
1143 health and human services.

1144 Sec. 17. (*Effective from passage*) (a) The Commissioner of Social  
1145 Services, in consultation with the executive director of the Office of  
1146 Health Strategy, the Secretary of the Office of Policy and Management  
1147 and other agencies as appropriate, shall develop a strategy to improve  
1148 health care outcomes, community health and health equity to support  
1149 HUSKY Health members. The Department of Social Services shall  
1150 consult with an association of hospitals in the state, Connecticut acute  
1151 care and children's hospitals, and other community health care  
1152 providers and community stakeholders to inform community-based  
1153 prevention policies and wellness, care delivery and financing strategies.

1154 (b) Such strategy shall address improved health equity by identifying

1155 barriers and influences that impact health and health care outcomes for  
1156 HUSKY Health members and articulate options to achieve the following  
1157 goals:

1158 (1) Improve health care access and outcomes;

1159 (2) Increase adoption of interventions to support improved access to  
1160 preventive care services;

1161 (3) Identify and address social, economic and environmental drivers  
1162 of health to advance long-term preventive health and health care  
1163 outcomes;

1164 (4) Explore innovative financing reforms that support high quality  
1165 care, promote integration of primary, preventive and behavioral health  
1166 care and address health-related social needs and long-term preventive  
1167 outcomes;

1168 (5) Improve collaboration and coordination among health care  
1169 providers and cross-sector community partners; and

1170 (6) Improve Medicaid reimbursement and performance to achieve a  
1171 sustainable health care delivery system and improve health care  
1172 affordability for all.

1173 (c) Such strategy shall include approaches designed to improve  
1174 performance in prevention measures, clinical outcomes, improved  
1175 access to preventative services and health equity measures  
1176 recommended by the Connecticut Medicaid Transparency Advisory  
1177 Board established pursuant to Executive Order Number 6 of Governor  
1178 Ned Lamont in 2020.

1179 (d) Not later than January 1, 2025, the Commissioner of Social  
1180 Services shall submit recommendations for reform to the Medical  
1181 Assistance Program Oversight Council, including, but not limited to,  
1182 recommendations for filing any state plan amendments or federal  
1183 waivers with the federal Centers for Medicare and Medicaid Services to  
1184 achieve the goals identified in subsection (b) of this section and agreed

1185 upon as a result of the strategy developed pursuant to subsection (a) of  
1186 this section. The commissioner may provide updates and other status  
1187 reports to said council on or before December 31, 2024, on the progress  
1188 of the strategic work of the department on such goals.

1189 Sec. 18. (*Effective from passage*) (a) Not later than January 1, 2025, the  
1190 Insurance Department, in consultation with the Office of Health  
1191 Strategy, shall report, in accordance with the provisions of section 11-4a  
1192 of the general statutes, to the joint standing committee of the General  
1193 Assembly having cognizance of matters relating to insurance regarding  
1194 an analysis of the utilization management and provider payment  
1195 practices of Medicare Advantage plans, including, but not limited to, (1)  
1196 the impact of such practices on the delivery of hospital outpatient and  
1197 inpatient services, including patient placement, discharges, transfers  
1198 and other clinical care plans, (2) the costs to hospitals and plan members  
1199 associated with such practices, (3) the effect of such practices on  
1200 commercial, non-Medicare payment rates and access to services,  
1201 including behavioral health services, and (4) a comparison of claims  
1202 denials, modifications and reversals on appeal among Medicare  
1203 Advantage plans and with traditional Medicare, Medicaid and  
1204 commercial non-Medicare product lines. To the extent information and  
1205 data are not available to support specified areas of such analysis, such  
1206 unavailability shall be noted in the report.

1207 (b) Based on the findings of the analysis, such report shall provide  
1208 recommendations on (1) improving the quality of and access to care, (2)  
1209 improving the timely delivery of care, (3) reducing provider  
1210 administrative costs associated with utilization management, (4)  
1211 addressing payment practices that inappropriately reduce provider  
1212 payments, (5) improving any practices identified in the study  
1213 contributing to unwarranted changes to clinical care plans, (6)  
1214 considering quarterly monitoring of prior authorization requests,  
1215 service denials and payment denials by Medicare Advantage plans and  
1216 comparing such data with commercial plans and Medicaid, (7)  
1217 addressing the broad effect of Medicare Advantage plan practices on the  
1218 health care delivery system, including costs borne by non-Medicare

1219 Advantage consumers and plan sponsors, (8) reducing costs for  
1220 consumers, and (9) the extent to which states have the authority to  
1221 regulate Medicare Advantage plans. To the extent such analysis does  
1222 not support recommendations in any of the specified areas, such  
1223 outcome should be noted in the report.

1224 (c) The Insurance Department may engage the services of third-party  
1225 professionals and specialists that the Insurance Commissioner deems  
1226 necessary to assist the commissioner in fulfilling the requirements of  
1227 this section. The costs of such services shall be paid, within available  
1228 appropriations, from the General Fund.

1229 Sec. 19. (NEW) (*Effective July 1, 2024*) (a) As used in this section:

1230 (1) "All-or-nothing clause" means any provision in a health care  
1231 contract that:

1232 (A) Requires the health carrier or health plan administrator to include  
1233 all members of a health care provider in a network plan; or

1234 (B) Requires the health carrier or health plan administrator to enter  
1235 into any additional contract with an affiliate of the health care provider  
1236 as a condition to entering into a contract with such health care provider;

1237 (2) "Anti-steering clause" means any provision in a health care  
1238 contract that restricts the ability of the health carrier or health plan  
1239 administrator from encouraging an enrollee to obtain a health care  
1240 service from a competitor of a hospital or health system, including  
1241 offering incentives to encourage enrollees to utilize specific health care  
1242 providers such as centers of excellence or any other pay-for-  
1243 performance program;

1244 (3) "Anti-tiering clause" means any provision in a health care contract  
1245 that:

1246 (A) Restricts the ability of the health carrier or health plan  
1247 administrator to introduce and modify a tiered network plan or assign  
1248 health care providers into tiers, including a network that tiers providers



1249 by cost or quality; or

1250 (B) Requires the health carrier or health plan administrator to place  
1251 all members of a health care provider in the same tier of a tiered network  
1252 plan;

1253 (4) "Gag clause" means any provision in a health care contract that:

1254 (A) Restricts the ability of the health care provider, health carrier or  
1255 health plan administrator to disclose any price or quality information,  
1256 including, but not limited to, the allowed amount, negotiated rates or  
1257 discounts, any fees for services or any other claim-related financial  
1258 obligations included in the provider contract, to any governmental  
1259 entity as authorized by law or such government entity's contractors or  
1260 agents, any enrollee, any treating health care provider of an enrollee,  
1261 plan sponsor or potential eligible enrollees and plan sponsors; or

1262 (B) Restricts the ability of either any health care provider, health  
1263 carrier or health plan administrator to disclose out-of-pocket costs to  
1264 any enrollee;

1265 (5) "Health benefit plan", "network", "network plan" and "tiered  
1266 network" have the same meanings as provided in section 38a-472f of the  
1267 general statutes, as amended by this act;

1268 (6) "Health care contract" means any contract, agreement or  
1269 understanding, either orally or in writing, entered into, amended,  
1270 restated or renewed between a health care provider and a health carrier,  
1271 health plan administrator, plan sponsor or its contractors or agents for  
1272 delivery of health care services to an enrollee of a health benefit plan;

1273 (7) "Health care provider" means any for-profit or nonprofit entity,  
1274 corporation or organization, parent corporation, member, affiliate,  
1275 subsidiary or entity under common ownership that is or whose  
1276 members are licensed or otherwise authorized by this state to furnish,  
1277 bill for or receive payment for health care service delivery in the normal  
1278 course of business, including, but not limited to, a health system,

1279 hospital, hospital-based facility, freestanding emergency department,  
1280 imaging center, physician group with eight or more physicians, urgent  
1281 care center, as defined in section 19a-493d of the general statutes, and  
1282 any physician or physician group in a practice of fewer than eight  
1283 physicians that is employed by or an affiliate of any hospital, medical  
1284 foundation or insurance company;

1285 (8) "Health carrier" has the same meaning as provided in section 38a-  
1286 591a of the general statutes; and

1287 (9) "Health plan administrator" means any third-party administrator  
1288 who acts on behalf of a plan sponsor to administer a health benefit plan.

1289 (b) No health care provider, health carrier, health plan administrator  
1290 or any agent or other entity that contracts on behalf of a health care  
1291 provider, health carrier, or health plan administrator, may offer, solicit,  
1292 request, amend, renew or enter into a health care contract on or after  
1293 July 1, 2024, that directly or indirectly includes any of the following  
1294 provisions:

1295 (1) An all-or-nothing clause;

1296 (2) An anti-steering clause;

1297 (3) An anti-tiering clause; or

1298 (4) A gag clause.

1299 (c) Any clause in a health care contract, written policy, written  
1300 procedure or agreement entered into, renewed or amended on or after  
1301 July 1, 2024, that is contrary to the provisions set forth in subsection (b)  
1302 of this section shall be null and void. All remaining clauses of such  
1303 health care contract, written policy, written procedure or agreement  
1304 shall remain in effect for the duration of the contract term.

1305 (d) Nothing in this section shall be construed to modify, reduce or  
1306 eliminate the existing privacy protections and standards pursuant to the  
1307 federal Health Insurance Portability and Accountability Act of 1996, P.L.

1308 104-191, as amended from time to time, the federal Genetic Information  
1309 Nondiscrimination Act of 2008, P.L. 110-233, as amended from time to  
1310 time, or the federal Americans with Disabilities Act of 1990, 42 USC  
1311 12101, as amended from time to time.

1312 Sec. 20. Subsection (f) of section 38a-472f of the general statutes is  
1313 repealed and the following is substituted in lieu thereof (*Effective July 1,*  
1314 *2024*):

1315 (f) (1) Each health carrier shall develop standards, to be used by such  
1316 health carrier and its intermediaries, for selecting and tiering, as  
1317 applicable, participating providers and each health care provider  
1318 specialty. Each contract involving a tiered network entered into,  
1319 renewed or amended on or after July 1, 2024, between a health carrier  
1320 and participating provider shall include a provision requiring that such  
1321 health carrier provide to the participating provider, upon request, such  
1322 participating provider's calculated score and related data, as available,  
1323 and a description of the standards used for selecting and tiering such  
1324 participating provider, including:

1325 (A) Definitions and specifications of measures related to quality, cost,  
1326 efficiency, satisfaction and any other factors used to develop such  
1327 standards and measure performance under such standards, with  
1328 delineation of any inclusions or exclusions under each measure;

1329 (B) A defined time period of not less than one year to measure  
1330 performance based on such standards; and

1331 (C) A summary of the grievance process established pursuant to  
1332 subdivision (2) of this subsection for a participating provider to appeal  
1333 the results of such health carrier's tiering decisions and performance  
1334 measures.

1335 (2) The standards developed by each health carrier pursuant to  
1336 subdivision (1) of this subsection shall remain in effect for not less than  
1337 one year. Each health carrier shall (A) provide not less than ninety days'  
1338 written notice to each participating provider before such health carrier

1339 may implement any changes to such standards and measures, and (B)  
1340 establish a grievance process for a participating provider to appeal such  
1341 health carrier's tiering decisions and performance measures for such  
1342 participating provider.

1343 [(2)] (3) No health carrier shall establish selection or tiering criteria in  
1344 a manner that would (A) allow the health carrier to discriminate against  
1345 high-risk populations by excluding or tiering participating providers  
1346 because they are located in a geographic area that contains populations  
1347 or participating providers that present a risk of higher-than-average  
1348 claims, losses or health care services utilization, or (B) exclude  
1349 participating providers because they treat or specialize in treating  
1350 populations that present a risk of higher-than-average claims, losses or  
1351 health care services utilization. Nothing in this subdivision shall be  
1352 construed to prohibit a health carrier from declining to select a health  
1353 care provider or facility for participation in such health carrier's network  
1354 who fails to meet legitimate selection criteria established by such health  
1355 carrier.

1356 [(3)] (4) No health carrier shall establish selection criteria that would  
1357 allow the health carrier to discriminate, with respect to participation in  
1358 a network plan, against any health care provider who is acting within  
1359 the scope of such health care provider's license or certification under  
1360 state law. Nothing in this subdivision shall be construed to require a  
1361 health carrier to contract with any health care provider or facility willing  
1362 to abide by the terms and conditions for participation established by  
1363 such health carrier.

1364 [(4)] (5) Each health carrier shall make the standards required under  
1365 subdivision (1) of this subsection available to the commissioner for  
1366 review and shall post on its Internet web site and make available to the  
1367 public a plain language description of such standards, including all  
1368 measures and corresponding definitions and specifications used to tier  
1369 participating providers and to evaluate participating provider  
1370 performance in each tier. Each health carrier shall post on its Internet  
1371 web site a plain language description of the grievance process

1372 established pursuant to subdivision (2) of this subsection for a  
1373 participating provider to appeal the results of such health carrier's  
1374 tiering decisions and performance measures.

1375 [(5)] (6) Nothing in this subsection shall require a health carrier, its  
1376 intermediaries or health care provider networks with which such health  
1377 carrier or intermediary contracts to (A) employ specific health care  
1378 providers acting within the scope of such health care providers' license  
1379 or certification under state law who meet such health carrier's selection  
1380 criteria, or (B) contract with or retain more health care providers acting  
1381 within the scope of such health care providers' license or certification  
1382 under state law than are necessary to maintain a sufficient network.

1383 Sec. 21. Section 38a-477d of the general statutes is amended by adding  
1384 subsection (j) as follows (*Effective October 1, 2023*):

1385 (NEW) (j) Notwithstanding the provisions with respect to  
1386 explanation of benefits set forth in subsections (d) to (h), inclusive, of  
1387 this section, each insurer, health care center, hospital service  
1388 corporation, medical service corporation, fraternal benefit society or  
1389 other entity that delivers, issues for delivery, renews, amends or  
1390 continues a health insurance policy providing coverage shall permit  
1391 each consumer who is a covered individual under the policy and legally  
1392 capable of consenting to the provision of covered benefits under such  
1393 policy to specify, in writing, that such insurer, health care center,  
1394 hospital service corporation, medical service corporation, fraternal  
1395 benefit society or other entity make all documents pertaining to  
1396 coverage available by electronic means, provided making such  
1397 documents available to such consumer by electronic means complies  
1398 with all applicable federal and state laws and regulations concerning  
1399 data security, including, but not limited to, 45 CFR Part 160, as amended  
1400 from time to time, and 45 CFR Part 164, Subparts A and C, as amended  
1401 from time to time.

1402 Sec. 22. Subsection (g) of section 38a-472f of the general statutes, is  
1403 repealed and the following is substituted in lieu thereof (*Effective from*

1404 *passage*):

1405 (g) (1) (A) A health carrier and participating provider shall provide  
1406 [at least] not less than ninety days' written notice to each other [before  
1407 the health carrier removes a participating provider from the network or  
1408 the participating provider leaves the network. Each participating  
1409 provider that receives a notice of removal or issues a departure notice  
1410 shall provide to the health carrier a list of such participating provider's  
1411 patients who are covered persons under a network plan of such health  
1412 carrier] of any intent to terminate a contract between such health carrier  
1413 and such participating provider prior to the proposed date of  
1414 termination or, in the case of a nonrenewal, from the end of the contract  
1415 period.

1416 (B) A health carrier shall make a good faith effort to provide written  
1417 notice, not [later] less than thirty days [after the health carrier receives  
1418 or issues a written notice under subparagraph (A) of this subdivision]  
1419 before the proposed date of termination of the contract or, in the case of  
1420 a nonrenewal, from the end of the contract period, to all covered persons  
1421 who are patients being treated on a regular basis by or at the  
1422 participating provider. [being removed from or leaving the network,  
1423 irrespective of whether such removal or departure is for cause.] The  
1424 notice requirements set forth in this subparagraph shall not apply if the  
1425 health carrier and participating provider agree, in writing, on an  
1426 extension of such contract for a period not to exceed one year.

1427 (C) For each contract entered into, renewed, amended or continued  
1428 on or after July 1, [2018] 2023, between a health carrier and a  
1429 participating provider that is a hospital, as defined in section 38a-493, or  
1430 a parent corporation of a hospital or an intermediary of a hospital, if the  
1431 contract is not renewed or is terminated by either the health carrier or  
1432 the participating provider, the health carrier and the participating  
1433 provider shall continue to abide by the terms of such contract, including  
1434 reimbursement terms for all health care services and provisions  
1435 provided under such contract, for a period of sixty days from the date  
1436 of termination or, in the case of a nonrenewal, from the end of the

1437 contract period. Except as otherwise agreed between such health carrier  
1438 and such participating provider, the reimbursement terms of any  
1439 contract entered into by such health carrier and such participating  
1440 provider during said sixty-day period shall be retroactive to the date of  
1441 termination or, in the case of a nonrenewal, the end date of the contract  
1442 period. This subparagraph shall not apply if the health carrier and  
1443 participating provider agree, in writing, to the termination or  
1444 nonrenewal of the contract and the health carrier and participating  
1445 provider provide the notices required under subparagraphs (A) and (B)  
1446 of this subdivision.

1447 (2) (A) For the purposes of this subdivision:

1448 (i) "Active course of treatment" means (I) a medically necessary,  
1449 ongoing course of treatment for a life-threatening condition, (II) a  
1450 medically necessary, ongoing course of treatment for a serious  
1451 condition, (III) medically necessary care provided during the second or  
1452 third trimester of pregnancy, or (IV) a medically necessary, ongoing  
1453 course of treatment for a condition for which a treating health care  
1454 provider attests that discontinuing care by such health care provider  
1455 would worsen the covered person's condition or interfere with  
1456 anticipated outcomes;

1457 (ii) "Life-threatening condition" means a disease or condition for  
1458 which the likelihood of death is probable unless the course of such  
1459 disease or condition is interrupted;

1460 (iii) "Serious condition" means a disease or condition that requires  
1461 complex ongoing care such as chemotherapy, radiation therapy or  
1462 postoperative visits, which the covered person is currently receiving;  
1463 and

1464 (iv) "Treating provider" means a covered person's treating health care  
1465 provider or a facility at which a covered person is receiving treatment,  
1466 that is removed from or leaves a health carrier's network pursuant to  
1467 subdivision (1) of this subsection.

1468 (B) (i) Each health carrier shall establish and maintain reasonable  
1469 procedures to transition a covered person, who is in an active course of  
1470 treatment with a participating health care provider or at a participating  
1471 facility that becomes a treating provider, to another participating  
1472 provider in a manner that provides for continuity of care.

1473 (ii) In addition to the notice required under subparagraph (B) of  
1474 subdivision (1) of this subsection, the health carrier shall provide to such  
1475 covered person (I) a list of available participating providers in the same  
1476 geographic area as such covered person who are of the same health care  
1477 provider or facility type, and (II) the procedures for how such covered  
1478 person may request continuity of care as set forth in this subparagraph.

1479 (iii) Such procedures shall provide that:

1480 (I) Any request for a continuity of care period shall be made by the  
1481 covered person or the covered person's authorized representative;

1482 (II) A request for a continuity of care period, made by a covered  
1483 person who meets the requirements under subparagraph (B)(i) of this  
1484 subdivision or such covered person's authorized representative and  
1485 whose treating provider was not removed from or did not leave the  
1486 network for cause, shall be reviewed by the health carrier's medical  
1487 director after consultation with such treating provider; and

1488 (III) For a covered person who is in the second or third trimester of  
1489 pregnancy, the continuity of care period shall extend through the  
1490 postpartum period.

1491 (iv) The continuity of care period for a covered person who is  
1492 undergoing an active course of treatment shall extend to the earliest of  
1493 the following: (I) Termination of the course of treatment by the covered  
1494 person or the treating provider; (II) ninety days after the date the  
1495 participating provider is removed from or leaves the network, unless  
1496 the health carrier's medical director determines that a longer period is  
1497 necessary; (III) the date that care is successfully transitioned to another  
1498 participating provider; (IV) the date benefit limitations under the health



1499 benefit plan are met or exceeded; or (V) the date the health carrier  
 1500 determines care is no longer medically necessary.

1501 (v) The health carrier shall only grant a continuity of care period as  
 1502 provided under subparagraph (B)(iv) of this subdivision if the treating  
 1503 provider agrees, in writing, (I) to accept the same payment from such  
 1504 health carrier and abide by the same terms and conditions as provided  
 1505 in the contract between such health carrier and treating provider when  
 1506 such treating provider was a participating provider, and (II) not to seek  
 1507 any payment from the covered person for any amount for which such  
 1508 covered person would not have been responsible if the treating provider  
 1509 was still a participating provider."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2023</i>	New section
Sec. 2	<i>from passage</i>	New section
Sec. 3	<i>October 1, 2023</i>	New section
Sec. 4	<i>October 1, 2023</i>	New section
Sec. 5	<i>October 1, 2023</i>	New section
Sec. 6	<i>October 1, 2023</i>	New section
Sec. 7	<i>from passage</i>	New section
Sec. 8	<i>October 1, 2023</i>	19a-754b(d)
Sec. 9	<i>July 1, 2023</i>	19a-508c
Sec. 10	<i>October 1, 2023</i>	19a-633
Sec. 11	<i>October 1, 2023</i>	19a-638
Sec. 12	<i>October 1, 2023</i>	19a-639a
Sec. 13	<i>October 1, 2023</i>	19a-639c
Sec. 14	<i>October 1, 2023</i>	19a-653
Sec. 15	<i>October 1, 2023</i>	New section
Sec. 16	<i>from passage</i>	New section
Sec. 17	<i>from passage</i>	New section
Sec. 18	<i>from passage</i>	New section
Sec. 19	<i>July 1, 2024</i>	New section
Sec. 20	<i>July 1, 2024</i>	38a-472f(f)
Sec. 21	<i>October 1, 2023</i>	38a-477d(j)
Sec. 22	<i>from passage</i>	38a-472f(g)