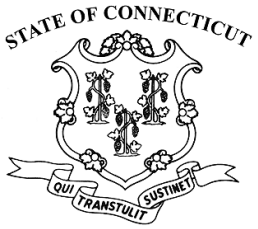

Substitute House Bill No. 6669

Public Act No. 23-171

AN ACT PROTECTING PATIENTS AND PROHIBITING UNNECESSARY HEALTH CARE COSTS.

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

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

(b) The Comptroller shall study the feasibility of centralizing state-wide contracts to consolidate the purchasing of prescription and physician-administered drugs by state agencies, state hospitals, state-operated local mental health authorities and other public entities, as necessary. The study shall include an evaluation of (1) the potential cost savings, administrative feasibility and other benefits and risks of centralizing and consolidating contracts, and (2) any additional staff and

resources required by the Comptroller to centrally procure and administer such contracts. Not later than November 1, 2023, each state agency, state hospital, state-operated local mental health authority and other public entity, as necessary, that procures prescription or physician-administered drugs shall provide information regarding the types, amount and cost of such drugs to the Comptroller, in a form and manner prescribed by the Comptroller. Not later than February 1, 2024, the Comptroller shall submit a report regarding the findings of such study to the Governor and, in accordance with the provisions of section 11-4a of the general statutes, to the General Assembly.

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

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

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

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

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

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

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

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

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

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

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

(10) "Prescribing practitioner" has the same meaning as provided in

section 20-571 of the general statutes.

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. (NEW) (*Effective October 1, 2023*) Each pharmaceutical representative engaged in legend drug marketing in this state shall

disclose, in writing, to a prescribing practitioner or pharmacist, at the time of each contact with such prescribing practitioner or pharmacist, the following information:

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

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

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

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

Sec. 7. (*Effective from passage*) Not later than January 1, 2025, the Office of Health Strategy, in consultation with the Insurance Department, shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance regarding its analysis of pharmacy benefits managers' practices of prescription drug distribution, including, but not limited to, spread pricing arrangements, manufacturing rebates and transparency, fees charged, financial

incentives for adding drugs to health plan formularies and an evaluation of prescription drug distribution practices conducted by pharmacy benefits managers in other states. Such report shall provide recommendations (1) to reduce prescription drug costs for consumers, and (2) for the regulation of pharmacy benefits managers in this state.

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

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

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

(2) Prior to publishing the annual list pursuant to subdivision (1) of this subsection, the executive director shall prepare a preliminary list that includes outpatient prescription drugs that the executive director

plans to include on such annual list. The executive director shall make such preliminary list available for public comment for not less than thirty days. During the public comment period, any manufacturer of an outpatient prescription drug included on the preliminary list may produce documentation, as permitted by federal law, to the executive director to establish that the wholesale acquisition cost of such drug, less all rebates paid to the state for such outpatient prescription drug during the immediately preceding calendar year, does not exceed the limits established in subdivision (3) of this subsection. If such documentation establishes, to the satisfaction of the executive director, that the wholesale acquisition cost of the drug, less all rebates paid to the state for such drug during the immediately preceding calendar year, does not exceed the limits established in subdivision (3) of this subsection, the executive director shall, not later than fifteen days after the closing of the public comment period, remove such drug from the preliminary list before publishing the annual list pursuant to subdivision (1) of this subsection.

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

[(3)**]** (4) (A) The pharmaceutical manufacturer of an outpatient prescription drug included on a list prepared by the executive director pursuant to subdivision (1) of this subsection shall provide to the office, in a form and manner specified by the executive director, (i) a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed outpatient prescription drug, and (ii) aggregate, company-level research and development costs and such other capital expenditures that the

executive director, in the executive director's discretion, deems relevant for the most recent year for which final audited data are available.

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

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

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

(a) As used in this section:

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

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

and Medicaid Services to be part of a hospital's campus;

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

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

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

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

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

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

(9) "Observation" means services furnished by a hospital on the hospital's campus, regardless of length of stay, including use of a bed and periodic monitoring by the hospital's nursing or other staff to

evaluate an outpatient's condition or determine the need for admission to the hospital as an inpatient;

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

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

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

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

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

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

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional

medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility, and (D) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

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

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

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

(2) (A) A statement that the patient's actual financial liability will

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

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

(d) Each initial billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the corresponding Medicare facility fee reimbursement rate for the same service as a comparison or, if there is no corresponding Medicare facility fee for such service, (A) the approximate amount Medicare would have paid the hospital for the facility fee on the billing statement, or (B) the percentage of the hospital's charges that Medicare would have paid the hospital for the facility fee; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction. Not later than October 15, 2022, and annually thereafter, each hospital, health system and hospital-based facility shall submit to the Health Systems Planning Unit of the Office of Health Strategy a sample of a billing statement

issued by such hospital, health system or hospital-based facility that complies with the provisions of this subsection and which represents the format of billing statements received by patients. Such billing statement shall not contain patient identifying information.

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

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

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

act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

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

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

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

(j) A hospital-based facility shall, when scheduling services for which

a facility fee may be charged, inform the patient (1) that the hospital-based facility is part of a hospital or health system, (2) of the name of the hospital or health system, (3) that the hospital or health system may charge a facility fee in addition to and separate from the professional fee charged by the provider, and (4) of the telephone number the patient may call for additional information regarding such patient's potential financial liability.

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

(2) Such notice shall include the following information:

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

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

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

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial

liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

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

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

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

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

(5) Not later than July 1, 2023, and annually thereafter, each hospital-based facility that was the subject of a transaction, as described in subsection (c) of section 19a-486i, during the preceding calendar year shall report to the Health Systems Planning Unit of the Office of Health Strategy the number of patients served by such hospital-based facility in the preceding three years.

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

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

(3) Notwithstanding the provisions of subdivisions (1) and (2) of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of subdivision (1) of this **[**section**]** subsection, and in circumstances when an insurance contract that is in effect on July 1, 2024, provides reimbursement for facility fees prohibited under the provisions of subdivision (2) of this subsection, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the applicable date of expiration, renewal or amendment of such contract, whichever such date is the earliest. **[**A violation of this subsection shall be considered an unfair trade practice

pursuant to chapter 735a.**]**

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

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

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

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

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

(m) (1) Each hospital and health system shall report not later than **[**July 1, 2023**]** October 1, 2023, and thereafter not later than July 1, 2024, and annually thereafter, to the executive director of the Office of Health Strategy, on a form prescribed by the executive director, concerning facility fees charged or billed during the preceding calendar year. Such report shall include, but need not be limited to, (A) the name and address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, and an indication as to whether each facility is located on or outside of the hospital or health system campus, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility disaggregated by payer mix, (D) for each facility, the total amount of facility fees charged and the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of facility fees charged and the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee gross revenue, disaggregated by current procedural terminology category (CPT) code for each such

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

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

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

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

and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

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

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

(d) If the unit finds, by a preponderance of the evidence, following a hearing held under subsection (c) of this section that such person, health

care facility or institution has violated or is violating any provision of this chapter, or any regulation or order of the unit, the unit shall issue a cease and desist order to such person, health care facility or institution that shall be considered a final decision subject to appeal to the Superior Court in accordance with section 4-183.

(e) Any cease and desist order issued under this section may be enforced by the Attorney General pursuant to section 19a-642.

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

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

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

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

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

(4) The establishment of a freestanding emergency department;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

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

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

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

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

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

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described

in section 19a-241;

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

(18) Replacement of existing **[**imaging equipment**]** computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners, positron emission tomography-computed tomography scanners, or nonhospital based linear accelerators, if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the unit of the date on which the equipment is replaced and the disposition of the replaced equipment, including if a replacement scanner has dual modalities or functionalities and the applicant already offers similar imaging services for each of the equipment's modalities or functionalities that will be utilized;

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

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

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

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

(23) On or before June 30, 2026, an increase in the licensed bed

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

(c) (1) Any person, health care facility or institution that is unsure whether a certificate of need is required under this section, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c, as amended by this act, shall send a letter to the unit that describes the project and requests that the unit make a determination as to whether a certificate of need is required. In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c, as amended by this act. A person, health care facility or institution making such request shall provide the unit with any information the unit requests as part of its determination process. The unit shall provide a determination within thirty days of receipt of such request.

(d) The executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the executive director holds a public hearing prior to implementing the policies and procedures and

posts notice of intent to adopt regulations on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

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

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

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

(a) An application for a certificate of need shall be filed with the unit in accordance with the provisions of this section and any regulations adopted by the Office of Health Strategy. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee based on the cost of the project. The amount of the fee shall be as follows: (A) One thousand dollars for a project that will cost not greater than fifty thousand dollars; (B) two thousand dollars for a project that will cost

greater than fifty thousand dollars but not greater than one hundred thousand dollars; (C) three thousand dollars for a project that will cost greater than one hundred thousand dollars but not greater than five hundred thousand dollars; (D) four thousand dollars for a project that will cost greater than five hundred thousand dollars but not greater than one million dollars; (E) five thousand dollars for a project that will cost greater than one million dollars but not greater than five million dollars; (F) eight thousand dollars for a project that will cost greater than five million dollars but not greater than ten million dollars; and (G) ten thousand dollars for a project that will cost greater than ten million dollars.

(b) Prior to the filing of a certificate of need application, the applicant shall (1) publish notice that an application is to be submitted to the unit (A) in a newspaper having a substantial circulation in the area where the project is to be located, and (B) on the applicant's Internet web site in a clear and conspicuous location that is easily accessible by members of the public, (2) request the publication of notice (A) in at least two sites within the affected community that are commonly accessed by the public, such as a town hall or library, and (B) on any existing Internet web site of the municipality or local health department, and (3) submit such notice to the unit for posting on such unit's Internet web site. Such newspaper notice shall **[**(1)**]** be published **[**(A) not later than twenty days prior to the date of filing of the certificate of need application, and (B) for not less than three consecutive days**]** for not less than three consecutive days, with the final date of consecutive publication occurring not later than twenty days prior to the date of filing of the certificate of need application, and **[**(2)**]** contain a brief description of the nature of the project and the street address where the project is to be located. Postings in the affected community and on the applicant's Internet web site shall remain until the decision on the application is rendered. The unit shall not invalidate any notice due to changes or removal of the notice from a community Internet web site of which the

applicant has no control. An applicant shall file the certificate of need application with the unit not later than ninety days after publishing notice of the application in a newspaper in accordance with the provisions of this subsection. The unit shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

(c) (1) Not later than five business days after receipt of a properly filed certificate of need application, the unit shall publish notice of the application on its Internet web site. Not later than thirty days after the date of filing of the application, the unit may request such additional information as the unit determines necessary to complete the application. In addition to any information requested by the unit, if the application involves the transfer of ownership of a hospital, as defined in section 19a-639, the applicant shall submit to the unit (A) a plan demonstrating how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services, and (B) the names of persons currently holding a position with the hospital to be purchased or the purchaser, as defined in section 19a-639, as an officer, director, board member or senior manager, whether or not such person is expected to hold a position with the hospital after completion of the transfer of ownership of the hospital and any salary, severance, stock offering or any financial gain, current or deferred, such person is expected to receive as a result of, or in relation to, the transfer of ownership of the hospital.

(2) The applicant shall, not later than sixty days after the date of the unit's request, submit any requested information and any information required under this subsection to the unit. If an applicant fails to submit

such information to the unit within the sixty-day period, the unit shall consider the application to have been withdrawn.

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

(d) Upon **[**determining that**]** deeming an application **[**is**]** complete, the unit shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the department. In addition, the unit shall post such notice on its Internet web site and notify the applicant not later than five days after deeming the application complete. The date on which the unit posts such notice on its Internet web site shall begin the review period. Except as provided in this subsection, (1) the review period for **[**a completed**]** an application deemed complete shall be ninety days from the date on which the unit posts such notice on its Internet web site; and (2) the unit shall issue a decision on **[**a completed**]** an application deemed complete prior to the expiration of the ninety-day review period in matters without a public hearing. The review period for **[**a completed**]** an application deemed complete that involves a transfer of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when the offer was made in response to a request for proposal or similar voluntary offer for sale, shall be sixty days from the date on which the unit posts notice on its Internet web site. Upon request or for good cause shown, the unit may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the unit shall issue a decision on the completed application prior to the expiration of the extended review period. If the unit holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this section, the unit shall issue a decision on the completed application not later than sixty days after the date the unit

closes the public hearing record.

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

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

(2) The unit may hold a public hearing with respect to any certificate of need application submitted under this chapter. The unit shall provide not less than two weeks' advance notice to the applicant, in writing, and to the public by publication in a newspaper having a substantial circulation in the area served by the health care facility or provider. In conducting its activities under this chapter, the unit may hold hearings with respect to applications of a similar nature at the same time. The applicant shall post a copy of the unit's hearing notice on the applicant's Internet web site in a clear and conspicuous location that is easily accessible by members of the public. Such applicant shall request the

publication of notice in at least two sites within the affected community that are commonly accessed by the public, such as a town hall or library, as well as on any existing Internet web site of the municipality or local health department. The unit shall not invalidate any notice due to changes or removal of the notice from a community Internet web site of which the applicant has no control.

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

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

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

(a) Any health care facility that proposes to relocate a facility shall submit a letter to the unit, as described in subsection (c) of section 19a-

638, as amended by this act. In addition to the requirements prescribed in said subsection (c), in such letter the health care facility shall demonstrate to the satisfaction of the unit that the population served by the health care facility and the payer mix will not substantially change as a result of the facility's proposed relocation. If the facility is unable to demonstrate to the satisfaction of the unit that the population served and the payer mix will not substantially change as a result of the proposed relocation, the health care facility shall apply for certificate of need approval pursuant to subdivision (1) of subsection (a) of section 19a-638, as amended by this act, in order to effectuate the proposed relocation. The unit shall provide a determination not later than thirty days after receipt of such letter.

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

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

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

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

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

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days from the date of mailing of the notice to make written application to the unit to (1) request **[**(1)**]** a hearing to contest the imposition of the penalty, **[**or**]** (2) request an extension of time to file the required data, or (3) comply with enumerated conditions of an agreed settlement. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final

order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The Office of Health Strategy may grant an extension of time for filing the required data or mitigate or waive the penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

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

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

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

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

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

manager.

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

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

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

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

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

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

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

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

(e) To the extent that any contract provision contained in a contract between a pharmacy benefits manager and a 340B covered entity entered into, amended or renewed after January 1, 2024, violates any

provision of subsection (b) or (c) of this section, such contract provision shall be void and unenforceable.

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

Sec. 16. (*Effective from passage*) (a) The Commissioner of Social Services shall convene a working group to evaluate (1) the current status of the federal 340B drug pricing program authorized by 42 USC 256b, as amended from time to time, (2) national efforts to strengthen and sustain such program, and (3) opportunities for state action to protect 340B revenues of federally qualified health centers from unfair administrative barriers or unnecessary conditions based on such centers' status as a 340B covered entity. Such evaluation shall consider (A) the ability of and any legal precedent for states to regulate the conduct of drug manufacturers and pharmacy benefits managers, as defined in section 38a-479aaa of the general statutes, (B) opportunities to facilitate patient access to on-site pharmacies of a federally qualified health center, (C) opportunities to establish on-site pharmacies across federally qualified health centers, and (D) national trends to sustain such program. As used in this subsection, "340B covered entity" means a provider participating in the federal 340B drug pricing program authorized by 42 USC 256b, as amended from time to time.

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

Sec. 17. (*Effective from passage*) (a) The Commissioner of Social Services, in consultation with the executive director of the Office of

Health Strategy, the Secretary of the Office of Policy and Management and other agencies as appropriate, shall develop a strategy to improve health care outcomes, community health and health equity to support HUSKY Health members. The Department of Social Services shall consult with an association of hospitals in the state, Connecticut acute care and children's hospitals, and other community health care providers and community stakeholders to inform community-based prevention policies and wellness, care delivery and financing strategies.

(b) Such strategy shall address improved health equity by identifying barriers and influences that impact health and health care outcomes for HUSKY Health members and articulate options to achieve the following goals:

(1) Improve health care access and outcomes;

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

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

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

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

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

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

(d) Not later than January 1, 2025, the Commissioner of Social Services shall submit recommendations for reform to the Medical Assistance Program Oversight Council, including, but not limited to, recommendations for filing any state plan amendments or federal waivers with the federal Centers for Medicare and Medicaid Services to achieve the goals identified in subsection (b) of this section and agreed upon as a result of the strategy developed pursuant to subsection (a) of this section. The commissioner may provide updates and other status reports to said council on or before December 31, 2024, on the progress of the strategic work of the department on such goals.

Sec. 18. (*Effective from passage*) (a) Not later than January 1, 2025, the Insurance Department, in consultation with the Office of Health Strategy, shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance regarding an analysis of the utilization management and provider payment practices of Medicare Advantage plans, including, but not limited to, (1) the impact of such practices on the delivery of hospital outpatient and inpatient services, including patient placement, discharges, transfers and other clinical care plans, (2) the costs to hospitals and plan members associated with such practices, (3) the effect of such practices on commercial, non-Medicare payment rates and access to services, including behavioral health services, and (4) a comparison of claims denials, modifications and reversals on appeal among Medicare Advantage plans and with traditional Medicare, Medicaid and

commercial non-Medicare product lines. To the extent information and data are not available to support specified areas of such analysis, such unavailability shall be noted in the report.

(b) Based on the findings of the analysis, such report shall provide recommendations on (1) improving the quality of and access to care, (2) improving the timely delivery of care, (3) reducing provider administrative costs associated with utilization management, (4) addressing payment practices that inappropriately reduce provider payments, (5) improving any practices identified in the study contributing to unwarranted changes to clinical care plans, (6) considering quarterly monitoring of prior authorization requests, service denials and payment denials by Medicare Advantage plans and comparing such data with commercial plans and Medicaid, (7) addressing the broad effect of Medicare Advantage plan practices on the health care delivery system, including costs borne by non-Medicare Advantage consumers and plan sponsors, (8) reducing costs for consumers, and (9) the extent to which states have the authority to regulate Medicare Advantage plans. To the extent such analysis does not support recommendations in any of the specified areas, such outcome should be noted in the report.

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

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

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

(A) Requires the health carrier or health plan administrator to include

all members of a health care provider in a network plan; or

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

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

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

(A) Restricts the ability of the health carrier or health plan administrator to introduce and modify a tiered network plan or assign health care providers into tiers, including a network that tiers providers by cost or quality; or

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

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

(A) Restricts the ability of the health care provider, health carrier or health plan administrator to disclose any price or quality information, including, but not limited to, the allowed amount, negotiated rates or discounts, any fees for services or any other claim-related financial obligations included in the provider contract, to any governmental entity as authorized by law or such government entity's contractors or agents, any enrollee, any treating health care provider of an enrollee,

plan sponsor or potential eligible enrollees and plan sponsors; or

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

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

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

(7) "Health care provider" means any for-profit or nonprofit entity, corporation or organization, parent corporation, member, affiliate, subsidiary or entity under common ownership that is or whose members are licensed or otherwise authorized by this state to furnish, bill for or receive payment for health care service delivery in the normal course of business, including, but not limited to, a health system, hospital, hospital-based facility, freestanding emergency department, imaging center, physician group with eight or more physicians, urgent care center, as defined in section 19a-493d of the general statutes, and any physician or physician group in a practice of fewer than eight physicians that is employed by or an affiliate of any hospital, medical foundation or insurance company;

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

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

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

(1) An all-or-nothing clause;

(2) An anti-steering clause;

(3) An anti-tiering clause; or

(4) A gag clause.

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

(d) Nothing in this section shall be construed to modify, reduce or eliminate the existing privacy protections and standards pursuant to the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, the federal Genetic Information Nondiscrimination Act of 2008, P.L. 110-233, as amended from time to time, or the federal Americans with Disabilities Act of 1990, 42 USC 12101, as amended from time to time.

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

(f) (1) Each health carrier shall develop standards, to be used by such

health carrier and its intermediaries, for selecting and tiering, as applicable, participating providers and each health care provider specialty. Each contract involving a tiered network entered into, renewed or amended on or after July 1, 2024, between a health carrier and participating provider shall include a provision requiring that such health carrier provide to the participating provider, upon request, such participating provider's calculated score and related data, as available, and a description of the standards used for selecting and tiering such participating provider, including:

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

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

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

(2) The standards developed by each health carrier pursuant to subdivision (1) of this subsection shall remain in effect for not less than one year. Each health carrier shall (A) provide not less than ninety days' written notice to each participating provider before such health carrier may implement any changes to such standards and measures, and (B) establish a grievance process for a participating provider to appeal such health carrier's tiering decisions and performance measures for such participating provider.

[(2)**]** (3) No health carrier shall establish selection or tiering criteria in a manner that would (A) allow the health carrier to discriminate against

high-risk populations by excluding or tiering participating providers because they are located in a geographic area that contains populations or participating providers that present a risk of higher-than-average claims, losses or health care services utilization, or (B) exclude participating providers because they treat or specialize in treating populations that present a risk of higher-than-average claims, losses or health care services utilization. Nothing in this subdivision shall be construed to prohibit a health carrier from declining to select a health care provider or facility for participation in such health carrier's network who fails to meet legitimate selection criteria established by such health carrier.

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

[(4)**]** (5) Each health carrier shall make the standards required under subdivision (1) of this subsection available to the commissioner for review and shall post on its Internet web site and make available to the public a plain language description of such standards, including all measures and corresponding definitions and specifications used to tier participating providers and to evaluate participating provider performance in each tier. Each health carrier shall post on its Internet web site a plain language description of the grievance process established pursuant to subdivision (2) of this subsection for a participating provider to appeal the results of such health carrier's tiering decisions and performance measures.

[(5)**]** (6) Nothing in this subsection shall require a health carrier, its

intermediaries or health care provider networks with which such health carrier or intermediary contracts to (A) employ specific health care providers acting within the scope of such health care providers' license or certification under state law who meet such health carrier's selection criteria, or (B) contract with or retain more health care providers acting within the scope of such health care providers' license or certification under state law than are necessary to maintain a sufficient network.

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

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

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

(g) (1) (A) A health carrier and participating provider shall provide

[at least**]** not less than ninety days' written notice to each other **[**before the health carrier removes a participating provider from the network or the participating provider leaves the network. Each participating provider that receives a notice of removal or issues a departure notice shall provide to the health carrier a list of such participating provider's patients who are covered persons under a network plan of such health carrier**]** of any intent to terminate a contract between such health carrier and such participating provider prior to the proposed date of termination or, in the case of a nonrenewal, from the end of the contract period.

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

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

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

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

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

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

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

(iv) "Treating provider" means a covered person's treating health care provider or a facility at which a covered person is receiving treatment,

that is removed from or leaves a health carrier's network pursuant to subdivision (1) of this subsection.

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

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

(iii) Such procedures shall provide that:

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

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

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

(iv) The continuity of care period for a covered person who is undergoing an active course of treatment shall extend to the earliest of the following: (I) Termination of the course of treatment by the covered

person or the treating provider; (II) ninety days after the date the participating provider is removed from or leaves the network, unless the health carrier's medical director determines that a longer period is necessary; (III) the date that care is successfully transitioned to another participating provider; (IV) the date benefit limitations under the health benefit plan are met or exceeded; or (V) the date the health carrier determines care is no longer medically necessary.

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