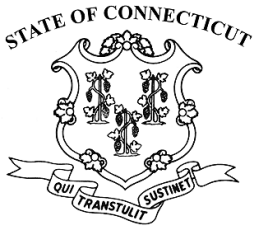

Substitute Senate Bill No. 10

Public Act No. 25-94

AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.

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

Section 1. (NEW) (*Effective October 1, 2025*) (a) As used in this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes; and

(2) "Mental health and substance use disorder benefits" has the same meaning as provided in section 38a-477ee of the general statutes, as amended by this act.

(b) (1) Not later than March 1, 2026, and annually thereafter, each health carrier shall file a certification with the Insurance Commissioner for the immediately preceding calendar year, certifying that such health carrier completed a review of such health carrier's administrative practices for compliance with the state and federal mental health and substance use disorder benefit reporting requirements pursuant to sections 38a-477ee, as amended by this act, 38a-488a, 38a-488c, 38a-488d, 38a-510, as amended by this act, 38a-514, 38a-514c, 38a-514d and 38a-544 of the general statutes, as amended by this act, and the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to

time, and regulations adopted thereunder.

(2) If such health carrier determines that such health carrier's administrative practices for the immediately preceding calendar year comply with the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of this subsection, such certification filed pursuant to subdivision (1) of this subsection shall state such finding.

(3) If such health carrier determines that such health carrier's administrative practices for the immediately preceding calendar year fail to comply with the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of this subsection, such certification filed pursuant to subdivision (1) of this subsection shall state such finding and identify (A) each administrative practice of such health carrier not in compliance with such state and federal mental health and substance use disorder benefit reporting requirements, and (B) action that such health carrier will take to bring such health carrier's administrative practices into compliance with such state and federal mental health and substance use disorder benefit reporting requirements.

Sec. 2. Subsection (c) of section 38a-477ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(c) **[**(1)**]** Not later than April 15, 2021, and annually thereafter, the Insurance Commissioner shall submit each report that the commissioner received pursuant to subsection (b) of this section for the calendar year immediately preceding to:

[(A)**]** (1) The joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with section 11-4a; and

[(B)**]** (2) The Attorney General, Healthcare Advocate and Commissioner of Health Strategy.

[(2) Notwithstanding subdivision (1) of this subsection, the commissioner shall not submit the name or identity of any health carrier or entity that has contracted with such health carrier, and such name or identity shall be given confidential treatment and not be made public by the commissioner.**]**

Sec. 3. (NEW) (*Effective October 1, 2025*) (a) (1) The commissioner, after providing an opportunity for a hearing in accordance with chapter 54 of the general statutes, may impose a civil penalty on any health carrier of not more than one hundred dollars with respect to each participant or beneficiary covered under a health insurance policy of such health carrier, provided such penalty shall not exceed an aggregate amount of six hundred twenty-five thousand dollars annually, for such health carrier's failure to comply with (A) the certification requirements pursuant to the provisions of section 1 of this act, (B) the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of subsection (b) of section 1 of this act, or (C) any other requirement pursuant to sections 38a-477ee, as amended by this act, 38a-488a, 38a-488c, 38a-488d, 38a-510, as amended by this act, 38a-514, 38a-514c, 38a-514d and 38a-544 of the general statutes, as amended by this act, and the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(2) The commissioner may order the payment of such reasonable expenses as may be necessary to compensate the commissioner in conjunction with any proceedings under this section, which shall be dedicated to the enforcement and implementation of the state and federal mental health parity laws and regulations adopted thereunder.

(b) (1) If any health carrier fails to file any data, report, certification or other information required by the provisions of section 38a-477ee of the general statutes, as amended by this act, or section 1 of this act, the commissioner shall impose a late fee on such health carrier of one hundred dollars per day from the due date of such filing of data, report, certification or information to the date such health carrier submits such filing to the commissioner, provided such late fee shall not exceed an aggregate amount of six hundred twenty-five thousand dollars.

(2) For any health carrier that files any incomplete data, report, certification or other information required by the provisions of section 38a-477ee of the general statutes, as amended by this act, and section 1 of this act, the commissioner shall provide notice to such health carrier of such incomplete filing that includes (A) a description of such data, report, certification or other information that is incomplete and any additional data that is needed to consider such filing complete, and (B) the date by which such health carrier is required to provide such data. The commissioner shall impose a late fee on such health carrier of one hundred dollars per day, commencing from the date identified by the commissioner pursuant to subparagraph (B) of this subdivision, provided such late fee shall not exceed an aggregate amount of six hundred twenty-five thousand dollars.

(c) The commissioner may waive any civil penalty imposed pursuant to subsection (a) of this section if the commissioner determines that the violation was due to reasonable cause and was not due to wilful neglect, or if such violation is corrected not more than thirty days after the date that the health carrier filed a certification of noncompliance with the commissioner pursuant to section 1 of this act.

(d) All civil penalties and late fees received by the commissioner pursuant to this section shall be deposited in the General Fund.

(e) The commissioner may engage the services of any health policy

research organization or any other independent expert as the commissioner deems necessary to assist the commissioner in the review of any violation of the nonquantitative treatment limitations requirements pursuant to section 38a-477ee of the general statutes, as amended by this act, and the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

Sec. 4. Section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy (A) for any prescribed drug for longer than thirty days, (B) for a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer, multiple sclerosis or rheumatoid arthritis, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications, or (C) **[**for the period commencing January 1, 2024, and ending January 1, 2027, inclusive,**]** for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) or (C) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

(b) (1) Notwithstanding the **[**sixty-day**]** thirty-day period set forth in subparagraph (A) of subdivision (2) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the

insured, based on medical necessity.

(2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract.

(c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-492i.

Sec. 5. Section 38a-544 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy (A) for any prescribed drug for longer than thirty days, (B) for a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer, multiple sclerosis or rheumatoid arthritis, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications, or (C) **[**for the period commencing January 1, 2024, and ending January 1, 2027, inclusive,**]** for the treatment

of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) or (C) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

(b) (1) Notwithstanding the **[**sixty-day**]** thirty-day period set forth in subparagraph (A) of subdivision (2) of subsection (a) of this section, each insurance company, hospital service corporation, medical service corporation, health care center or other entity that uses step therapy for such prescription drugs shall establish and disclose to its health care providers a process by which an insured's treating health care provider may request at any time an override of the use of any step therapy drug regimen. Any such override process shall be convenient to use by health care providers and an override request shall be expeditiously granted when an insured's treating health care provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected

to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on medical necessity.

(2) Upon the granting of an override request, the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract.

(c) Nothing in this section shall (1) preclude an insured or an insured's treating health care provider from requesting a review under sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of section 38a-518i.

Sec. 6. Subsection (b) of section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until it has been approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474. <u>If the commissioner determines that a health carrier's average premium rate increase, as approved by the commissioner, exceeded the health care cost growth benchmark established pursuant to section 19a-754g for</u>

each of the two most recent plan years for which such health care cost growth benchmark data is available, the commissioner may reduce such health carrier's requested rate filed under the provisions of subsection (a) of this section by not more than two percentage points of such premium rate filed in addition to any other rate reductions authorized under this title.

Sec. 7. Subsection (a) of section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

(a) (1) No group health insurance policy, as defined by the commissioner, or certificate shall be delivered or issued for delivery in this state unless a copy of the form for such policy or certificate has been submitted to and approved by the commissioner under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such order.

(2) No group health insurance policy or certificate for a small employer, as defined in section 38a-564, shall be delivered or issued for delivery in this state unless the premium rates have been submitted to and approved by the commissioner. If the commissioner determines that any small group health insurance carrier's average premium rate

increase, as approved by the commissioner, or certificate for a small employer, exceeded the health care cost growth benchmark established pursuant to section 19a-754g for each of the two most recent plan years for which such health care cost growth benchmark data is available, the commissioner may reduce such policy's or certificate's requested premium rate filing under the provisions of subsection (a) of this section by not more than two percentage points of such premium rate filed in addition to any other premium rate reductions authorized under this title. Premium rate filings shall include the information and data required under section 38a-479qqq if the policy is subject to said section, and an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the policy. Each premium rate filed on or after January 1, 2021, shall, if the insurer intends to account for rebates, as defined in section 38a-479ooo in the manner specified in section 38a-479rrr, account for such rebates in such manner, if the policy is subject to section 38a-479rrr. As used in this subdivision, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

Sec. 8. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "General anesthesia" has the same meaning as provided in section 20-123a of the general statutes; and

(2) "Medically necessary" has the same meaning as provided in section 38a-482a of the general statutes.

(b) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall, if such policy provides coverage for general anesthesia, (1) impose an arbitrary time limit on reimbursement for general anesthesia provided during any

medically necessary procedure, or (2) deny, reduce, terminate or fail to provide such reimbursement, in whole or in part, for general anesthesia solely because the duration of care exceeded a predetermined time limit as determined by the insurer.

Sec. 9. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "General anesthesia" has the same meaning as provided in section 20-123a of the general statutes; and

(2) "Medically necessary" has the same meaning as provided in section 38a-482a of the general statutes.

(b) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall, if such policy provides coverage for general anesthesia, (1) impose an arbitrary time limit on reimbursement for general anesthesia provided during any medically necessary procedure, or (2) deny, reduce, terminate or fail to provide such reimbursement, in whole or in part, for general anesthesia solely because the duration of care exceeded a predetermined time limit as determined by the insurer.

Sec. 10. Section 19a-508c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(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;

(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;

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

(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;

(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;

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

(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

(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 (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 (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 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.

(4) The provisions of this subsection shall not apply to a freestanding emergency department. As used in this 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 Commissioner 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 commissioner 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.

(6) A violation of this subsection shall be considered an unfair trade practice pursuant to section 42-110b.

(m) (1) Each hospital and health system shall report not later than October 1, 2023, and thereafter not later than July 1, 2024, and annually thereafter, to the Commissioner of Health Strategy, on a form prescribed by the commissioner, 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 (CPT) 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 commissioner 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.

Governor's Action:
Approved June 24, 2025