



General Assembly

Amendment

January Session, 2025

LCO No. 8638



Offered by:

SEN. LOONEY, 11th Dist.

SEN. DUFF, 25th Dist.

SEN. CABRERA, 17th Dist.

To: Subst. Senate Bill No. 10

File No. 419

Cal. No. 241

"AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION."

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

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

4 (1) "Health carrier" has the same meaning as provided in section 38a-
5 1080 of the general statutes; and

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

9 (b) (1) Not later than March 1, 2026, and annually thereafter, each
10 health carrier shall file a certification with the Insurance Commissioner
11 for the immediately preceding calendar year, certifying that such health
12 carrier completed a review of such health carrier's administrative

13 practices for compliance with the state and federal mental health and
14 substance use disorder benefit reporting requirements pursuant to
15 sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c,
16 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-
17 544 of the general statutes, as amended by this act, and the provisions
18 of the federal Paul Wellstone and Pete Domenici Mental Health Parity
19 and Addiction Equity Act of 2008, P.L. 110-343, as amended from time
20 to time, and regulations adopted thereunder.

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

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

39 Sec. 2. Subsection (c) of section 38a-477ee of the general statutes is
40 repealed and the following is substituted in lieu thereof (*Effective October*
41 *1, 2025*):

42 (c) [(1)] Not later than April 15, 2021, and annually thereafter, the
43 Insurance Commissioner shall submit each report that the
44 commissioner received pursuant to subsection (b) of this section for the

45 calendar year immediately preceding to:

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

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

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

56 Sec. 3. (NEW) (*Effective October 1, 2025*) (a) (1) The commissioner, after
57 providing an opportunity for a hearing in accordance with chapter 54 of
58 the general statutes, may impose a civil penalty on any health carrier of
59 not more than one hundred dollars with respect to each participant or
60 beneficiary covered under a health insurance policy of such health
61 carrier, provided such penalty shall not exceed an aggregate amount of
62 one million dollars annually, for such health carrier's failure to comply
63 with (A) the certification requirements pursuant to the provisions of
64 section 1 of this act, (B) the state and federal mental health and substance
65 use disorder benefit reporting requirements identified in subdivision (1)
66 of subsection (b) of section 1 of this act, or (C) any other requirement
67 pursuant to sections 38a-477ee, as amended by this act, 38a-488c, 38a-
68 488d, 38a-514c, 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this
69 act, and 38a-544 of the general statutes, as amended by this act, and the
70 provisions of the federal Paul Wellstone and Pete Domenici Mental
71 Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as
72 amended from time to time, and regulations adopted thereunder.

73 (2) The commissioner may order the payment of such reasonable
74 expenses as may be necessary to compensate the commissioner in
75 conjunction with any proceedings under this section, which shall be

76 dedicated to the enforcement and implementation of the state and
77 federal mental health parity laws and regulations adopted thereunder.

78 (b) (1) If any health carrier fails to file any data, report, certification or
79 other information required by the provisions of section 38a-477ee of the
80 general statutes, as amended by this act, or section 1 of this act, the
81 commissioner shall impose a late fee on such health carrier of one
82 hundred dollars per day from the due date of such filing of data, report,
83 certification or information to the date such health carrier submits such
84 filing to the commissioner.

85 (2) For any health carrier that files any incomplete data, report,
86 certification or other information required by the provisions of section
87 38a-477ee of the general statutes, as amended by this act, and section 1
88 of this act, the commissioner shall provide notice to such health carrier
89 of such incomplete filing that includes (A) a description of such data,
90 report, certification or other information that is incomplete and any
91 additional data that is needed to consider such filing complete, and (B)
92 the date by which such health carrier is required to provide such data.
93 The commissioner shall impose a late fee on such health carrier of one
94 hundred dollars per day, commencing from the date identified by the
95 commissioner pursuant to subparagraph (B) of this subdivision.

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

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

104 (e) The commissioner may engage the services of any health policy
105 research organization or any other independent expert as the
106 commissioner deems necessary to assist the commissioner in the review

107 of any violation of the nonquantitative treatment limitations
108 requirements pursuant to section 38a-477ee of the general statutes, as
109 amended by this act, and the provisions of the federal Paul Wellstone
110 and Pete Domenici Mental Health Parity and Addiction Equity Act of
111 2008, P.L. 110-343, as amended from time to time, and regulations
112 adopted thereunder.

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

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

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

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

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

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

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

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

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

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

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

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

202 a prescribed drug for the treatment of a mental or behavioral health
203 condition, provided such prescribed drug is in compliance with
204 approved federal Food and Drug Administration indications.

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

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

235 regimen, (C) will cause or will likely cause an adverse reaction by or
236 physical harm to the insured, or (D) is not in the best interest of the
237 insured, based on medical necessity.

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

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

247 Sec. 6. Subsection (b) of section 38a-481 of the general statutes is
248 repealed and the following is substituted in lieu thereof (*Effective January*
249 *1, 2026*):

250 (b) No rate filed under the provisions of subsection (a) of this section
251 shall be effective until it has been approved by the commissioner in
252 accordance with regulations adopted pursuant to this subsection. The
253 commissioner shall adopt regulations, in accordance with the
254 provisions of chapter 54, to prescribe standards to ensure that such rates
255 shall not be excessive, inadequate or unfairly discriminatory. The
256 commissioner may disapprove such rate if it fails to comply with such
257 standards, except that no rate filed under the provisions of subsection
258 (a) of this section for any Medicare supplement policy shall be effective
259 unless approved in accordance with section 38a-474. If the
260 commissioner determines that a health carrier's average premium rate
261 increase, as approved by the commissioner, exceeded the health care
262 cost growth benchmark established pursuant to section 19a-754g for
263 each of the two most recent plan years for which such health care cost
264 growth benchmark data is available, the commissioner may reduce such
265 health carrier's requested rate filed under the provisions of subsection
266 (a) of this section by not more than two percentage points of such

267 premium rate filed in addition to any other rate reductions authorized
268 under this title.

269 Sec. 7. Subsection (a) of section 38a-513 of the general statutes is
270 repealed and the following is substituted in lieu thereof (*Effective January*
271 *1, 2026*):

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

289 (2) No group health insurance policy or certificate for a small
290 employer, as defined in section 38a-564, shall be delivered or issued for
291 delivery in this state unless the premium rates have been submitted to
292 and approved by the commissioner. If the commissioner determines
293 that any small group health insurance carrier's average premium rate
294 increase, as approved by the commissioner, or certificate for a small
295 employer, exceeded the health care cost growth benchmark established
296 pursuant to section 19a-754g for each of the two most recent plan years
297 for which such health care cost growth benchmark data is available, the
298 commissioner may reduce such policy's or certificate's requested
299 premium rate filing under the provisions of subsection (a) of this section

300 by not more than two percentage points of such premium rate filed in
301 addition to any other premium rate reductions authorized under this
302 title. Premium rate filings shall include the information and data
303 required under section 38a-479qqq if the policy is subject to said section,
304 and an actuarial memorandum that includes, but is not limited to,
305 pricing assumptions and claims experience, and premium rates and loss
306 ratios from the inception of the policy. Each premium rate filed on or
307 after January 1, 2021, shall, if the insurer intends to account for rebates,
308 as defined in section 38a-479ooo in the manner specified in section 38a-
309 479rrr, account for such rebates in such manner, if the policy is subject
310 to section 38a-479rrr. As used in this subdivision, "loss ratio" means the
311 ratio of incurred claims to earned premiums by the number of years of
312 policy duration for all combined durations.

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

314 (1) "General anesthesia" has the same meaning as provided in section
315 20-123a of the general statutes; and

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

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

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

329 (1) "General anesthesia" has the same meaning as provided in section
330 20-123a of the general statutes; and

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

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

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

345 (a) As used in this section:

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

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

359 (3) "Facility fee" means any fee charged or billed by a hospital or
360 health system for outpatient services provided in a hospital-based
361 facility that is: (A) Intended to compensate the hospital or health system

362 for the operational expenses of the hospital or health system, and (B)
363 separate and distinct from a professional fee;

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

370 (5) "Health system" means: (A) A parent corporation of one or more
371 hospitals and any entity affiliated with such parent corporation through
372 ownership, governance, membership or other means, or (B) a hospital
373 and any entity affiliated with such hospital through ownership,
374 governance, membership or other means;

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

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

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

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

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

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

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

396 (13) "Tagline" means a short statement written in a non-English
397 language that indicates the availability of language assistance services
398 free of charge.

399 (b) If a hospital or health system charges a facility fee utilizing a
400 current procedural terminology evaluation and management (CPT
401 E/M) code, [or] assessment and management (CPT A/M) code,
402 injection and infusion (CPT) code or drug administration (CPT) code for
403 outpatient services provided at a hospital-based facility where a
404 professional fee is also expected to be charged, the hospital or health
405 system shall provide the patient with a written notice that includes the
406 following information:

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

411 (2) (A) The amount of the patient's potential financial liability,
412 including any facility fee likely to be charged, and, where professional
413 medical services are provided by an affiliated provider, any professional
414 fee likely to be charged, or, if the exact type and extent of the
415 professional medical services needed are not known or the terms of a
416 patient's health insurance coverage are not known with reasonable
417 certainty, an estimate of the patient's financial liability based on typical
418 or average charges for visits to the hospital-based facility, including the
419 facility fee, (B) a statement that the patient's actual financial liability will
420 depend on the professional medical services actually provided to the
421 patient, (C) an explanation that the patient may incur financial liability

422 that is greater than the patient would incur if the professional medical
423 services were not provided by a hospital-based facility, and (D) a
424 telephone number the patient may call for additional information
425 regarding such patient's potential financial liability, including an
426 estimate of the facility fee likely to be charged based on the scheduled
427 professional medical services; and

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

432 (c) If a hospital or health system charges a facility fee without
433 utilizing a current procedural terminology evaluation and management
434 (CPT E/M) code, assessment and management (CPT A/M) code,
435 injection and infusion (CPT) code or drug administration (CPT) code for
436 outpatient services provided at a hospital-based facility, located outside
437 the hospital campus, the hospital or health system shall provide the
438 patient with a written notice that includes the following information:

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

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

451 (3) That a patient covered by a health insurance policy should contact
452 the health insurer for additional information regarding the hospital's or

453 health system's charges and fees, including the patient's potential
454 financial liability, if any, for such charges and fees.

455 (d) Each initial billing statement that includes a facility fee shall: (1)
456 Clearly identify the fee as a facility fee that is billed in addition to, or
457 separately from, any professional fee billed by the provider; (2) provide
458 the corresponding Medicare facility fee reimbursement rate for the same
459 service as a comparison or, if there is no corresponding Medicare facility
460 fee for such service, (A) the approximate amount Medicare would have
461 paid the hospital for the facility fee on the billing statement, or (B) the
462 percentage of the hospital's charges that Medicare would have paid the
463 hospital for the facility fee; (3) include a statement that the facility fee is
464 intended to cover the hospital's or health system's operational expenses;
465 (4) inform the patient that the patient's financial liability may have been
466 less if the services had been provided at a facility not owned or operated
467 by the hospital or health system; and (5) include written notice of the
468 patient's right to request a reduction in the facility fee or any other
469 portion of the bill and a telephone number that the patient may use to
470 request such a reduction without regard to whether such patient
471 qualifies for, or is likely to be granted, any reduction. Not later than
472 October 15, 2022, and annually thereafter, each hospital, health system
473 and hospital-based facility shall submit to the Health Systems Planning
474 Unit of the Office of Health Strategy a sample of a billing statement
475 issued by such hospital, health system or hospital-based facility that
476 complies with the provisions of this subsection and which represents
477 the format of billing statements received by patients. Such billing
478 statement shall not contain patient identifying information.

479 (e) The written notice described in subsections (b) to (d), inclusive,
480 and (h) to (j), inclusive, of this section shall be in plain language and in
481 a form that may be reasonably understood by a patient who does not
482 possess special knowledge regarding hospital or health system facility
483 fee charges. On and after October 1, 2022, such notices shall include tag
484 lines in at least the top fifteen languages spoken in the state indicating
485 that the notice is available in each of those top fifteen languages. The

486 fifteen languages shall be either the languages in the list published by
487 the Department of Health and Human Services in connection with
488 section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-
489 148, or, as determined by the hospital or health system, the top fifteen
490 languages in the geographic area of the hospital-based facility.

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

499 (2) For emergency care, such written notice shall be provided to the
500 patient as soon as practicable after the patient is stabilized in accordance
501 with the federal Emergency Medical Treatment and Active Labor Act,
502 42 USC 1395dd, as amended from time to time, or is determined not to
503 have an emergency medical condition and before the patient leaves the
504 hospital-based facility. If the patient is unconscious, under great duress
505 or for any other reason unable to read the notice and understand and
506 act on his or her rights, the notice shall be provided to the patient's
507 representative as soon as practicable.

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

512 (h) A hospital-based facility shall prominently display written notice
513 in locations that are readily accessible to and visible by patients,
514 including patient waiting or appointment check-in areas, stating: (1)
515 That the hospital-based facility is part of a hospital or health system, (2)
516 the name of the hospital or health system, and (3) that if the hospital-
517 based facility charges a facility fee, the patient may incur a financial

518 liability greater than the patient would incur if the hospital-based
519 facility was not hospital-based. On and after October 1, 2022, such
520 notices shall include tag lines in at least the top fifteen languages spoken
521 in the state indicating that the notice is available in each of those top
522 fifteen languages. The fifteen languages shall be either the languages in
523 the list published by the Department of Health and Human Services in
524 connection with section 1557 of the Patient Protection and Affordable
525 Care Act, P.L. 111-148, or, as determined by the hospital or health
526 system, the top fifteen languages in the geographic area of the hospital-
527 based facility. Not later than October 1, 2022, and annually thereafter,
528 each hospital-based facility shall submit a copy of the written notice
529 required by this subsection to the Health Systems Planning Unit of the
530 Office of Health Strategy.

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

535 (j) A hospital-based facility shall, when scheduling services for which
536 a facility fee may be charged, inform the patient (1) that the hospital-
537 based facility is part of a hospital or health system, (2) of the name of the
538 hospital or health system, (3) that the hospital or health system may
539 charge a facility fee in addition to and separate from the professional fee
540 charged by the provider, and (4) of the telephone number the patient
541 may call for additional information regarding such patient's potential
542 financial liability.

543 (k) (1) If any transaction described in subsection (c) of section 19a-
544 486i results in the establishment of a hospital-based facility at which
545 facility fees may be billed, the hospital or health system, that is the
546 purchaser in such transaction shall, not later than thirty days after such
547 transaction, provide written notice, by first class mail, of the transaction
548 to each patient served within the three years preceding the date of the
549 transaction by the health care facility that has been purchased as part of
550 such transaction.

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

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

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

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

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

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

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

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

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

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

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

604 (2) Notwithstanding the provisions of this section, on and after July
605 1, 2024, no hospital or health system shall collect a facility fee for
606 outpatient health care services that use a current procedural
607 terminology evaluation and management (CPT E/M) code or
608 assessment and management (CPT A/M) code and are provided on the
609 hospital campus. The provisions of this subdivision shall not apply to
610 (A) an emergency department located on a hospital campus, or (B)
611 observation stays on a hospital campus and (CPT E/M) and (CPT A/M)
612 codes when billed for the following services: (i) Wound care, (ii)

613 orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi)
614 solid organ transplant.

615 (3) Notwithstanding the provisions of subdivisions (1) and (2) of this
616 subsection, in circumstances when an insurance contract that is in effect
617 on July 1, 2016, provides reimbursement for facility fees prohibited
618 under the provisions of subdivision (1) of this subsection, and in
619 circumstances when an insurance contract that is in effect on July 1,
620 2024, provides reimbursement for facility fees prohibited under the
621 provisions of subdivision (2) of this subsection, a hospital or health
622 system may continue to collect reimbursement from the health insurer
623 for such facility fees until the applicable date of expiration, renewal or
624 amendment of such contract, whichever such date is the earliest.

625 (4) The provisions of this subsection shall not apply to a freestanding
626 emergency department. As used in this subdivision, "freestanding
627 emergency department" means a freestanding facility that (A) is
628 structurally separate and distinct from a hospital, (B) provides
629 emergency care, (C) is a department of a hospital licensed under chapter
630 368v, and (D) has been issued a certificate of need to operate as a
631 freestanding emergency department pursuant to chapter 368z.

632 (5) (A) On and after July 1, 2024, if the Commissioner of Health
633 Strategy receives information and has a reasonable belief, after
634 evaluating such information, that any hospital, health system or
635 hospital-based facility charged facility fees, other than through isolated
636 clerical or electronic billing errors, in violation of any provision of this
637 section, or rule or regulation adopted thereunder, such hospital, health
638 system or hospital-based facility shall be subject to a civil penalty of up
639 to one thousand dollars. The commissioner may issue a notice of
640 violation and civil penalty by first class mail or personal service. Such
641 notice shall include: (i) A reference to the section of the general statutes,
642 rule or section of the regulations of Connecticut state agencies believed
643 or alleged to have been violated; (ii) a short and plain language
644 statement of the matters asserted or charged; (iii) a description of the
645 activity to cease; (iv) a statement of the amount of the civil penalty or

646 penalties that may be imposed; (v) a statement concerning the right to a
647 hearing; and (vi) a statement that such hospital, health system or
648 hospital-based facility may, not later than ten business days after receipt
649 of such notice, make a request for a hearing on the matters asserted.

650 (B) The hospital, health system or hospital-based facility to whom
651 such notice is provided pursuant to subparagraph (A) of this
652 subdivision may, not later than ten business days after receipt of such
653 notice, make written application to the Office of Health Strategy to
654 request a hearing to demonstrate that such violation did not occur. The
655 failure to make a timely request for a hearing shall result in the issuance
656 of a cease and desist order or civil penalty. All hearings held under this
657 subsection shall be conducted in accordance with the provisions of
658 chapter 54.

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

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

668 (m) (1) Each hospital and health system shall report not later than
669 October 1, 2023, and thereafter not later than July 1, 2024, and annually
670 thereafter, to the Commissioner of Health Strategy, on a form prescribed
671 by the commissioner, concerning facility fees charged or billed during
672 the preceding calendar year. Such report shall include, but need not be
673 limited to, (A) the name and address of each facility owned or operated
674 by the hospital or health system that provides services for which a
675 facility fee is charged or billed, and an indication as to whether each
676 facility is located on or outside of the hospital or health system campus,
677 (B) the number of patient visits at each such facility for which a facility

678 fee was charged or billed, (C) the number, total amount and range of
 679 allowable facility fees paid at each such facility disaggregated by payer
 680 mix, (D) for each facility, the total amount of facility fees charged and
 681 the total amount of revenue received by the hospital or health system
 682 derived from facility fees, (E) the total amount of facility fees charged
 683 and the total amount of revenue received by the hospital or health
 684 system from all facilities derived from facility fees, (F) a description of
 685 the ten procedures or services that generated the greatest amount of
 686 facility fee gross revenue, disaggregated by current procedural
 687 terminology (CPT) category [(CPT)] code for each such procedure or
 688 service and, for each such procedure or service, patient volume and the
 689 total amount of gross and net revenue received by the hospital or health
 690 system derived from facility fees, disaggregated by on-campus and off-
 691 campus, and (G) the top ten procedures or services for which facility
 692 fees are charged based on patient volume and the gross and net revenue
 693 received by the hospital or health system for each such procedure or
 694 service, disaggregated by on-campus and off-campus. For purposes of
 695 this subsection, "facility" means a hospital-based facility that is located
 696 on a hospital campus or outside a hospital campus.

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2025</i>	New section
Sec. 2	<i>October 1, 2025</i>	38a-477ee(c)
Sec. 3	<i>October 1, 2025</i>	New section
Sec. 4	<i>January 1, 2026</i>	38a-510
Sec. 5	<i>January 1, 2026</i>	38a-544
Sec. 6	<i>January 1, 2026</i>	38a-481(b)
Sec. 7	<i>January 1, 2026</i>	38a-513(a)
Sec. 8	<i>January 1, 2026</i>	New section
Sec. 9	<i>January 1, 2026</i>	New section
Sec. 10	<i>January 1, 2026</i>	19a-508c

