General Assembly

Governor's Bill No. 5030

February Session, 2026

LCO No. **498**

Referred to Committee on APPROPRIATIONS

Introduced by:
Request of the Governor Pursuant
to Joint Rule 9

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR GENERAL GOVERNMENT.

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

Section 1. (NEW) (*Effective July 1, 2026*) (a) On and after July 1, 2026, the Commissioner of Motor Vehicles shall issue Pizza State commemorative number plates of a design to enhance public awareness of the state's pizza-making tradition and to provide funding to Connecticut Foodshare. The design shall be determined by the commissioner. No use shall be made of such plates except as official registration marker plates.

(b) The Commissioner of Motor Vehicles shall charge a fee of sixty-five dollars for Pizza State commemorative number plates, in addition to the regular fee or fees prescribed for the registration of a motor vehicle. The commissioner shall deposit fifteen dollars of such fee into an account controlled by the Department of Motor Vehicles to be used for the cost of producing, issuing, renewing and replacing such number plates, and fifty dollars of such fee into the Pizza State commemorative

account established under subsection (d) of this section. Except as provided in subsection (f) of this section, no additional fee shall be charged in connection with the renewal of such number plates. No transfer fee shall be charged for transfer of an existing registration to or from a registration with Pizza State commemorative number plates. Such number plates shall have letters and numbers selected by the Commissioner of Motor Vehicles. The commissioner may establish a higher fee for number plates: (1) That contain the numbers and letters from a previously issued number plate; (2) that contain letters in place of numbers, as authorized by section 14-49 of the general statutes, in addition to the fee or fees prescribed for registration under said section; and (3) that are low number plates issued in accordance with section 14-160 of the general statutes, in addition to the fee or fees prescribed for registration under said section. All fees established and collected pursuant to this section, except moneys designated for administrative costs of the Department of Motor Vehicles, shall be deposited in the Pizza State commemorative account.

(c) The Commissioner of Motor Vehicles may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish standards and procedures for the issuance, renewal and replacement of Pizza State commemorative number plates.

(d) There is established an account to be known as the "Pizza State commemorative account", which shall be a separate, nonlapsing account. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be distributed annually by the Department of Motor Vehicles to Connecticut Foodshare. The commissioner may receive private donations to the account and any such receipts shall be deposited in the account.

(e) The Commissioner of Motor Vehicles may provide for the reproduction and marking of the Pizza State commemorative number plates image for use on clothing, recreational equipment, posters, mementoes or other products or programs deemed by the commissioner

to be suitable as a means of supporting the Pizza State commemorative account. Any moneys received by the commissioner from such marketing shall be deposited in the account.

(f) The Commissioner of Motor Vehicles may allow a registrant to make an additional voluntary donation of fifteen dollars at the time of registration renewal for any motor vehicle bearing a Pizza State commemorative number plate. Any such donation shall be deposited in the Pizza State commemorative account.

Sec. 2. Subsection (a) of section 29-1r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a Department of Emergency Services and Public Protection. Said department shall be the designated emergency management and homeland security agency for the state. The department head shall be the Commissioner of Emergency Services and Public Protection, who shall be appointed by the Governor in accordance with sections 4-5 to 4-8, inclusive, as amended by this act, with the powers and duties prescribed in said sections. The commissioner shall be responsible for providing a coordinated, integrated program for the protection of life and property and for state-wide emergency management and homeland security. The commissioner shall appoint not more than **[**two**]** three deputy commissioners who shall, under the direction of the commissioner, assist in the administration of the department. The commissioner may do all things necessary to apply for, qualify for and accept any federal funds made available or allotted under any federal act for emergency management or homeland security.

Sec. 3. Subsection (d) of section 14-21cc of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(d) The funds in the account shall be distributed **[**quarterly**]** annually

by the Secretary of the Office of Policy and Management to Hispanic-American Veterans of Connecticut, Inc.

Sec. 4. Subsection (a) of section 4-65a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be an Office of Policy and Management which shall be responsible for all aspects of state staff planning and analysis in the areas of budgeting, management, planning, **[**energy policy determination and evaluation,**]** intergovernmental policy, criminal and juvenile justice planning and program evaluation. The department head shall be the Secretary of the Office of Policy and Management, who shall be appointed by the Governor in accordance with the provisions of sections 4-5, as amended by this act, 4-6, 4-7 and 4-8, with all the powers and duties therein prescribed. The Secretary of the Office of Policy and Management shall be the employer representative (1) in collective bargaining negotiations concerning changes to the state employees retirement system and health and welfare benefits, and (2) in all other matters involving collective bargaining, including negotiation and administration of all collective bargaining agreements and supplemental understandings between the state and the state employee unions concerning all executive branch employees except (A) employees of the Division of Criminal Justice, and (B) faculty and professional employees of boards of trustees of constituent units of the state system of higher education. The secretary may designate a member of the secretary's staff to act as the employer representative in the secretary's place.

Sec. 5. Subsection (b) of section 7-74 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) (1) The fee for a certified copy of a certificate of marriage or death shall be twenty dollars. Such fees shall not be required of the department.

(2) Any fee received by the Department of Public Health for a certificate of death shall be deposited in the neglected cemetery account, established in accordance with section 19a-308b.

(3) On or before October 31, 2026, and quarterly thereafter, the Commissioner of Public Health shall certify to the Secretary of the Office of Policy and Management the amount of fees collected in accordance with subdivision (1) of this subsection during the immediately preceding calendar quarter and the balance in the neglected cemetery account, established in accordance with section 19a-308b, as of the last day of the immediately preceding calendar quarter.

Sec. 6. Section 46a-52 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The commission shall consist of nine persons. On and after October 1, 2000, such persons shall be appointed with the advice and consent of both houses of the General Assembly. (1) On or before July 15, 1990, the Governor shall appoint five members of the commission, three of whom shall serve for terms of five years and two of whom shall serve for terms of three years. Upon the expiration of such terms, and thereafter, the Governor shall appoint either two or three members, as appropriate, to serve for terms of five years. On or before July 14, 1990, the president pro tempore of the Senate, the minority leader of the Senate, the speaker of the House of Representatives and the minority leader of the House of Representatives shall each appoint one member to serve for a term of three years. Upon the expiration of such terms, and thereafter, members so appointed shall serve for terms of three years. (2) If any vacancy occurs, the appointing authority making the initial appointment shall appoint a person to serve for the remainder of the unexpired term. The Governor shall select one of the members of the commission to serve as chairperson for a term of one year. The commission shall meet at least once during each two-month period and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the members of

the commission after notice in accordance with the provisions of section 1-225.

(b) Except as provided in section 46a-57, the members of the commission shall serve without pay, but their reasonable expenses, including educational training expenses and expenses for necessary stenographic and clerical help, shall be paid by the state upon approval of the Commissioner of Administrative Services. Not later than two months after appointment to the commission, each member of the commission shall receive a minimum of ten hours of introductory training prior to voting on any commission matter. Each year following such introductory training, each member shall receive five hours of follow-up training. Such introductory and follow-up training shall consist of instruction on the laws governing discrimination in employment, housing, public accommodation and credit, affirmative action and the procedures of the commission. Such training shall be organized by the managing director of the legal division of the commission. Any member who fails to complete such training shall not vote on any commission matter. Any member who fails to comply with such introductory training requirement within six months of appointment shall be deemed to have resigned from office. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office.

(c) On or before July 15, 1989, the commission shall appoint an executive director who shall be the chief executive officer of the Commission on Human Rights and Opportunities to serve for a term expiring on July 14, 1990. Upon the expiration of such term and thereafter, the executive director shall be appointed for a term of four years. The executive director shall be supervised and annually evaluated by the commission. The executive director shall serve at the pleasure of the commission but no longer than four years from July fifteenth in the year of his or her appointment unless reappointed pursuant to the provisions of this subsection. The executive director

shall receive an annual salary within the salary range of a salary group established by the Commissioner of Administrative Services for the position. The executive director (1) shall conduct comprehensive planning with respect to the functions of the commission; (2) shall coordinate the activities of the commission; and (3) shall cause the administrative organization of the commission to be examined with a view to promoting economy and efficiency. In accordance with established procedures, the executive director may enter into such contractual agreements as may be necessary for the discharge of the director's duties.

(d) The executive director may appoint no more than two deputy directors with the approval of a majority of the members of the commission. The deputy directors shall be supervised by the executive director and shall assist the executive director in the administration of the commission, the effectuation of its statutory responsibilities and such other duties as may be assigned by the executive director. Deputy directors shall serve at the pleasure of the executive director and without tenure. The executive director may remove a deputy director with the approval of a majority of the members of the commission.

[(e) The commission shall be within the Labor Department for administrative purposes only.**]**

Sec. 7. Section 10-76ooo of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Department of Education shall conduct a study concerning the disproportionate or over-identification of minority students for special education and related services. Such study shall include, but need not be limited to, an examination of the rates of identification for special education and related services, disaggregated by race and gender for each school district. Not later than January 1, 2027, the department shall submit a report on its findings and recommendations to the **[**Office of

the Educational Ombudsperson, established pursuant to section 10-15o, and to the**]** joint standing committee of the General Assembly having cognizance of matters relating to education, in accordance with the provisions of section 11-4a.

Sec. 8. Section 10-15o of the 2026 supplement to the general statutes is repealed. (*Effective from passage*)

Sec. 9. Subsection (d) of section 1-84 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(d) No public official or state employee or employee of such public official or state employee shall agree to accept, or be a member or employee of a partnership, association, professional corporation or sole proprietorship which partnership, association, professional corporation or sole proprietorship agrees to accept any employment, fee or other thing of value, or portion thereof, for appearing, agreeing to appear, or taking any other action on behalf of another person before the Department of Banking, the Office of the Claims Commissioner, the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health, the Insurance Department, the Department of Consumer Protection, the Department of Motor Vehicles, the State Insurance and Risk Management Board, the Department of Energy and Environmental Protection, the Public Utilities Regulatory Authority, the Connecticut Siting Council or the Connecticut Real Estate Commission; provided this shall not prohibit any such person from making inquiry for information on behalf of another before any of said commissions or commissioners if no fee or reward is given or promised in consequence thereof. For the purpose of this subsection, partnerships, associations, professional corporations or sole proprietorships refer only to such partnerships, associations, professional corporations or sole proprietorships which have been formed to carry on the business or profession directly relating to the employment, appearing, agreeing to appear or taking of action provided for in this subsection. Nothing in

this subsection shall prohibit any employment, appearing, agreeing to appear or taking action before any municipal board, commission or council. Nothing in this subsection shall be construed as applying (1) to the actions of any teaching or research professional employee of a public institution of higher education if such actions are not in violation of any other provision of this chapter, (2) to the actions of any other professional employee of a public institution of higher education if such actions are not compensated and are not in violation of any other provision of this chapter, (3) to any member of a board or commission who receives no compensation other than per diem payments or reimbursement for actual or necessary expenses, or both, incurred in the performance of the member's duties, or (4) to any member or director of a quasi-public agency. Notwithstanding the provisions of this subsection to the contrary, a legislator, an officer of the General Assembly or part-time legislative employee may be or become a member or employee of a firm, partnership, association or professional corporation which represents clients for compensation before agencies listed in this subsection, provided the legislator, officer of the General Assembly or part-time legislative employee shall take no part in any matter involving the agency listed in this subsection and shall not receive compensation from any such matter. Receipt of a previously established salary, not based on the current or anticipated business of the firm, partnership, association or professional corporation involving the agencies listed in this subsection, shall be permitted.

Sec. 10. Subsection (c) of section 1-84b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(c) The provisions of this subsection apply to present or former executive branch public officials or state employees of an agency who hold or formerly held positions which involve significant decision-making or supervisory responsibility. Such positions shall be designated as such by the agency concerned, in consultation with the Office of State Ethics, except that such provisions shall not apply to

members or former members of the boards or commissions who serve ex officio, who are required by statute to represent the regulated industry or who are permitted by statute to have a past or present affiliation with the regulated industry. On or before November **[**1, 2021, and not less than**]** first annually, **[**thereafter,**]** the head of each agency concerned, or his or her designee, shall submit the designation of all positions in existence on such date that are subject to the provisions of this subsection to the office electronically, in a manner prescribed by the Citizen's Ethics Advisory Board. If an agency creates such a position after its annual submission under this subsection, the head of such agency, or his or her designee, shall submit the designation of the newly created position not later than thirty days after the creation of such position. As used in this subsection, "agency" means the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health, the Connecticut Siting Council, the Department of Banking, the Insurance Department, the Department of Emergency Services and Public Protection, the office within the Department of Consumer Protection that carries out the duties and responsibilities of sections 30-2 to 30-68m, inclusive, the Public Utilities Regulatory Authority, including the Office of Consumer Counsel, and the Department of Consumer Protection and the term "employment" means professional services or other services rendered as an employee or as an independent contractor.

(1) No public official or state employee in an executive branch position designated pursuant to the provisions of this subsection shall negotiate for, seek or accept employment with any business subject to regulation by his agency.

(2) No former public official or state employee who held such a position in the executive branch shall, within one year after leaving an agency, accept employment with a business subject to regulation by that agency.

(3) No business shall employ a present or former public official or

state employee in violation of this subsection.

Sec. 11. Subsection (b) of section 2-137 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) The committee shall consist of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, children and appropriations and the budgets of state agencies, or their designees;

(2) Three appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly and two of whom shall be providers of behavioral health services for children in the state;

(3) Three appointed by the president pro tempore of the Senate, one of whom shall be a member of the General Assembly and two of whom shall be representatives of private advocacy groups that provide services for children and families in the state;

(4) (A) Two appointed by the chairperson of the committee selected by the speaker of the House of Representatives pursuant to subsection (e) of this section, one of whom shall be a child or youth advocate; (B) two appointed by the chairperson of the committee selected by the president pro tempore of the Senate pursuant to subsection (e) of this section, one of whom shall be a child or youth advocate; and (C) two jointly appointed by the three chairpersons of the committee, as described in subsection (e) of this section, who shall be providers of substance use treatment services to young adults;

(5) Two appointed by the majority leader of the House of Representatives, who shall be representatives of children's hospitals;

(6) One appointed by the majority leader of the Senate, who shall be

a representative of public school superintendents in the state;

(7) Two appointed by the minority leader of the House of Representatives, who shall be representatives of families with children who have been diagnosed with behavioral health disorders;

(8) Two appointed by the minority leader of the Senate, who shall be providers of behavioral health services;

(9) Two jointly appointed by the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, each of whom shall be a representative of one of the two federally recognized Indian tribes in the state;

(10) The Commissioners of Children and Families, Correction, Developmental Services, Early Childhood, Education, Insurance, Mental Health and Addiction Services, Public Health and Social Services, or their designees;

[(11) The Commissioner of Health Strategy, or the commissioner's designee;**]**

[(12)**]** (11) The Child Advocate, or the Child Advocate's designee;

[(13)**]** (12) The Healthcare Advocate and the Behavioral Health Advocate, or their designees;

[(14)**]** (13) The executive director of the Court Support Services Division of the Judicial Branch, or the executive director's designee;

[(15)**]** (14) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

[(16)**]** (15) The Secretary of the Office of Policy and Management, or the secretary's designee; and

[(17)**]** (16) One representative from each administrative services organization under contract with the Department of Social Services to provide such services for recipients of assistance under the HUSKY Health program, who shall be ex-officio, nonvoting members.

Sec. 12. Section 4-5 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means the Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Aging and Disability Services, Commissioner of Early Childhood, **[**Commissioner of Health Strategy,**]** executive director of the Office of Military Affairs, executive director of the Technical Education and Career System, Chief Workforce Officer and Commissioner of Higher Education. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 13. Subsection (b) of section 4-101a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Grants, technical assistance or consultation services, or any combination thereof, provided under this section may be made to assist

a nongovernmental acute care general hospital to develop and implement a plan to achieve financial stability and assure the delivery of appropriate health care services in the service area of such hospital, or to assist a nongovernmental acute care general hospital in determining strategies, goals and plans to ensure its financial viability or stability. Any such hospital seeking such grants, technical assistance or consultation services shall prepare and submit to the Office of Policy and Management and the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health a plan that includes at least the following: (1) A statement of the hospital's current projections of its finances for the current and the next three fiscal years; (2) identification of the major financial issues which effect the financial stability of the hospital; (3) the steps proposed to study or improve the financial status of the hospital and eliminate ongoing operating losses; (4) plans to study or change the mix of services provided by the hospital, which may include transition to an alternative licensure category; and (5) other related elements as determined by the Office of Policy and Management. Such plan shall clearly identify the amount, value or type of the grant, technical assistance or consultation services, or combination thereof, requested. Any grants, technical assistance or consultation services, or any combination thereof, provided under this section shall be determined by the Secretary of the Office of Policy and Management not to jeopardize the federal matching payments under the medical assistance program and the emergency assistance to families program as determined by the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health or the Department of Social Services in consultation with the Office of Policy and Management.

Sec. 14. Subsection (b) of section 8-37vvv of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) The council shall consist of the following regular members:

(1) Two appointed by the president pro tempore of the Senate, one of whom is an individual who is experiencing or has experienced homelessness and one of whom is a representative of a continuum of care organization;

(2) Two appointed by the speaker of the House of Representatives, one of whom is a representative of an organization that advocates for victims of domestic violence or domestic violence prevention and one of whom is a representative of an organization that provides shelters or housing for individuals experiencing homelessness;

(3) One appointed by the majority leader of the Senate, who is a representative of a public housing authority;

(4) One appointed by the majority leader of the House of Representatives, who has expertise in mental health or addiction treatment;

(5) Two appointed by the minority leader of the Senate, one of whom is a representative of local government and one of whom is a representative of a philanthropic organization;

(6) Two appointed by the minority leader of the House of Representatives, one of whom is a representative of a faith-based organization and one of whom is a representative of a group that advocates for housing developers;

(7) Two appointed by the Commissioner of Housing;

(8) The Commissioner of Housing, or the commissioner's designee;

(9) The Commissioner of Aging and Disability Services, or the commissioner's designee;

(10) The Commissioner of Children and Families, or the commissioner's designee;

(11) The Commissioner of Correction, or the commissioner's designee;

(12) The Labor Commissioner, or the commissioner's designee;

(13) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(14) The Commissioner of Social Services, or the commissioner's designee;

(15) The Commissioner of Veterans Affairs, or the commissioner's designee;

(16) The Secretary of the Office of Policy and Management, or the secretary's designee;

(17) The executive director of the Court Support Services Division of the Judicial Department, or the executive director's designee;

[(18) The Commissioner of Health Strategy, or the commissioner's designee;**]**

[(19)**]** (18) The chief executive officer of the Connecticut Housing Finance Authority, or the chief executive officer's designee; and

[(20)**]** (19) The Long-Term Care Ombudsman.

Sec. 15. Subdivision (8) of subsection (c) of section 10-222tt of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(8) The commission, in consultation with the **[**Office of Health Strategy,**]** Office of the Healthcare Advocate and Department of Social Services, shall conduct a study to determine if certain special education services can be billed to Medicaid or other private insurance.

Sec. 16. Subsections (b) to (d), inclusive, of section 10-532 of the

general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) The Commissioner of Early Childhood, in collaboration with the Commissioners of Social Services **[**,**]** and Public Health, **[**and Health Strategy,**]** shall, within available appropriations, develop a state-wide program to offer universal nurse home visiting services to all families with newborns residing in the state to support parental health, healthy child development and strengthen families.

(c) When developing the program, said commissioners shall (1) consult with insurers that offer health benefit plans in the state, hospitals, local public health authorities, existing early childhood home visiting programs, community-based organizations and social service providers; and (2) maximize the use of available federal funding.

(d) The program shall provide universal nurse home visiting services that are (1) evidence-based, and (2) designed to improve outcomes in one or more of the following areas: (A) Child safety; (B) child health and development; (C) family economic self-sufficiency; (D) maternal and parental health; (E) positive parenting; (F) reducing child mistreatment; (G) reducing family violence; (H) parent-infant bonding; and (I) any other appropriate area established, in writing, by the Commissioners of Early Childhood, Social Services **[**,**]** and Public Health. **[**and Health Strategy.**]**

Sec. 17. Subsection (b) of section 12-34h of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Any pharmaceutical manufacturer or wholesale distributor that intends to withdraw an identified prescription drug from sale in this state shall, at least one hundred eighty days before such withdrawal, send advance written notice to the **[**Office of Health Strategy**]** commissioner disclosing such pharmaceutical manufacturer's or wholesale distributor's intention.

Sec. 18. Subparagraph (B) of subdivision (1) of subsection (c) of section 12-263q of the 2026 supplement to the general statutes, as amended by section 360 of public act 25-168, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(B) For purposes of this subdivision, "financially distressed hospital" means a hospital that has experienced over the five-year period from October 1, 2011, through September 30, 2016, an average net loss of more than five per cent of aggregate revenue. A hospital has an average net loss of more than five per cent of aggregate revenue if such a loss is reflected in the applicable years of financial reporting that have been made available by the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health for such hospital in accordance with section 19a-670. Upon said commissioner's receipt of a determination by the Centers for Medicare and Medicaid Services that a hospital is not exempt, the total audited net revenue from the provision of outpatient hospital services for fiscal year 2016 shall be increased by such hospital's audited net revenue from the provision of outpatient hospital services for fiscal year 2016 and the effective rate of the tax due under this section shall be adjusted to ensure that the total amount of such tax to be collected under subsection (a) of this section is redistributed, commencing with the calendar quarter next succeeding the date of the determination by the Centers for Medicare and Medicaid Services.

Sec. 19. Section 17b-59a of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) As used in this section:

(1) "Electronic health information system" means an information processing system, involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data and knowledge for communication and decision

making, and includes: (A) An electronic health record that provides access in real time to a patient's complete medical record; (B) a personal health record through which an individual, and anyone authorized by such individual, can maintain and manage such individual's health information; (C) computerized order entry technology that permits a health care provider to order diagnostic and treatment services, including prescription drugs electronically; (D) electronic alerts and reminders to health care providers to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments; (E) error notification procedures that generate a warning if an order is entered that is likely to lead to a significant adverse outcome for a patient; and (F) tools to allow for the collection, analysis and reporting of data on adverse events, near misses, the quality and efficiency of care, patient satisfaction and other healthcare-related performance measures.

(2) "Interoperability" means the ability of two or more systems or components to exchange information and to use the information that has been exchanged and includes: (A) The capacity to physically connect to a network for the purpose of exchanging data with other users; and (B) the capacity of a connected user to access, transmit, receive and exchange usable information with other users.

(3) "Standard electronic format" means a format using open electronic standards that: (A) Enable health information technology to be used for the collection of clinically specific data; (B) promote the interoperability of health care information across health care settings, including reporting to local, state and federal agencies; and (C) facilitate clinical decision support.

(b) The Commissioner of Social Services, in consultation with the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management, shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families, Veterans Affairs and Mental Health and Addiction Services,

uniform management information, uniform statistical information, uniform terminology for similar facilities and uniform electronic health information technology standards, (2) plan for increased participation of the private sector in the delivery of human services, and (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to facilitate shared services and eliminate duplication.

(c) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall, in consultation with the Commissioner of Social Services and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, implement and periodically revise the state-wide health information technology plan established pursuant to this section and shall establish electronic data standards to facilitate the development of integrated electronic health information systems for use by health care providers and institutions that receive state funding. Such electronic data standards shall: (1) Include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) limit the use and dissemination of an individual's Social Security number and require the encryption of any Social Security number provided by an individual; (3) require privacy standards no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and contained in 45 CFR 160, 164; (4) require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail; (5) be compatible with any national data standards in order to allow for interstate interoperability; (6) permit the collection of health information in a standard electronic format; and (7) be compatible with the requirements for an electronic health information system.

(d) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall, within existing resources and in consultation with the State Health Information Technology Advisory Council: (1) Oversee the development and implementation of the State-wide Health Information Exchange in conformance with section 17b-59d, as amended by this act; (2) coordinate the state's health information technology and health information exchange efforts to ensure consistent and collaborative cross-agency planning and implementation; and (3) serve as the state liaison to, and work collaboratively with, the State-wide Health Information Exchange established pursuant to section 17b-59d, as amended by this act, to ensure consistency between the state-wide health information technology plan and the State-wide Health Information Exchange and to support the state's health information technology and exchange goals.

(e) The state-wide health information technology plan, implemented and periodically revised pursuant to subsection (c) of this section, shall enhance interoperability to support optimal health outcomes and include, but not be limited to (1) general standards and protocols for health information exchange, and (2) national data standards to support secure data exchange data standards to facilitate the development of a state-wide, integrated electronic health information system for use by health care providers and institutions that are licensed by the state. Such electronic data standards shall (A) include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols, (B) be compatible with any national data standards in order to allow for interstate interoperability, (C) permit the collection of health information in a standard electronic format, and (D) be compatible with the requirements for an electronic health information system.

(f) Not later than February **[**1, 2017, and annually thereafter**]** first annually, the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management, in consultation with the State Health Information Technology Advisory Council, shall report in accordance

with the provisions of section 11-4a to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health concerning: (1) The development and implementation of the state-wide health information technology plan and data standards, established and implemented by the **[**Commissioner of Health Strategy**]** secretary pursuant to this section; (2) the establishment of the State-wide Health Information Exchange; and (3) recommendations for policy, regulatory and legislative changes and other initiatives to promote the state's health information technology and exchange goals.

Sec. 20. Subsections (d) to (g), inclusive, of section 17b-59d of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(d) (1) The **[**Commissioner of Health Strategy, in consultation with the**]** Secretary of the Office of Policy and Management, **[**and**]** in consultation with the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, shall, upon the approval by the State Bond Commission of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, develop and issue a request for proposals for the development, management and operation of the State-wide Health Information Exchange. Such request shall promote the reuse of any and all enterprise health information technology assets, such as the existing Provider Directory, Enterprise Master Person Index, Direct Secure Messaging Health Information Service provider infrastructure, analytic capabilities and tools that exist in the state or are in the process of being deployed. Any enterprise health information exchange technology assets purchased after June 2, 2016, and prior to the implementation of the State-wide Health Information Exchange shall be capable of interoperability with a State-wide Health Information Exchange.

(2) Such request for proposals may require an eligible organization

responding to the request to: (A) Have not less than three years of experience operating either a state-wide health information exchange in any state or a regional exchange serving a population of not less than one million that (i) enables the exchange of patient health information among health care providers, patients and other authorized users without regard to location, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time health care provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing or medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and operations; (C) be capable of providing consulting to ensure effective governance; (D) be regulated or administratively overseen by a state government agency; and (E) have sufficient staff and appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the State-wide Health Information Exchange.

(e) Notwithstanding the provisions of subsection (d) of this section, if, on or before January 1, 2016, the Commissioner of Social Services, in consultation with the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, submits a plan to the Secretary of the Office of Policy and Management for the establishment of a State-wide Health Information Exchange consistent with subsections (a), (b) and (c) of this section, **[**and such plan is approved by the secretary, the commissioner**]** the secretary may implement such plan and enter into any contracts or agreements to implement such plan.

(f) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall have administrative authority over the State-wide Health Information Exchange. The **[**commissioner**]** secretary

shall be responsible for designating, and posting on **[**its**]** the Office of Policy and Management's Internet web site, the list of systems, technologies, entities and programs that shall constitute the State-wide Health Information Exchange. Systems, technologies, entities, and programs that have not been so designated shall not be considered part of said exchange.

(g) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall adopt regulations in accordance with the provisions of chapter 54 that set forth requirements necessary to implement the provisions of this section. The **[**commissioner**]** secretary may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the **[**commissioner**]** secretary holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes notice of intention to adopt the regulations on the Office of **[**Health Strategy's**]** Policy and Management's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 21. Subsection (f) of section 17b-59e of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(f) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall adopt regulations in accordance with the provisions of chapter 54 that set forth requirements necessary to implement the provisions of this section. The **[**commissioner**]** secretary may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the **[**commissioner**]** secretary holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes notice of

intention to adopt the regulations on the Office of **[**Health Strategy's**]** Policy and Management's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 22. Section 17b-59f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) There shall be a State Health Information Technology Advisory Council to advise the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management and the health information technology officer, designated in accordance with section **[**19a-754a**]** 4-66, as amended by this act, in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts and goals and to advise the **[**commissioner**]** secretary and officer in the development and implementation of the state-wide health information technology plan and standards and the State-wide Health Information Exchange, established pursuant to section 17b-59d, as amended by this act. The advisory council shall also advise the **[**commissioner**]** secretary and officer regarding the development of appropriate governance, oversight and accountability measures to ensure success in achieving the state's health information technology and exchange goals.

(b) The council shall consist of the following members:

(1) One member appointed by the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management, who shall be an expert in state health care reform initiatives;

(2) The health information technology officer, designated in accordance with section **[**19a-754a**]** 4-66, as amended by this act, or the health information technology officer's designee;

(3) The Commissioners of Social Services, Mental Health and

Addiction Services, Children and Families, Correction, Public Health and Developmental Services, or the commissioners' designees;

(4) The Chief Information Officer of the state, or the Chief Information Officer's designee;

(5) The chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee;

(6) The chief information officer of The University of Connecticut Health Center, or the chief information officer's designee;

(7) The Healthcare Advocate, or the Healthcare Advocate's designee;

(8) The Comptroller, or the Comptroller's designee;

(9) The Attorney General, or the Attorney General's designee;

(10) Five members appointed by the Governor, one each who shall be (A) a representative of a health system that includes more than one hospital, (B) a representative of the health insurance industry, (C) an expert in health information technology, (D) a health care consumer or consumer advocate, and (E) a current or former employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186;

(11) Three members appointed by the president pro tempore of the Senate, one each who shall be (A) a representative of a federally qualified health center, (B) a provider of behavioral health services, and (C) a physician licensed under chapter 370;

(12) Three members appointed by the speaker of the House of Representatives, one each who shall be (A) a technology expert who represents a hospital system, as defined in section 19a-486i, as amended by this act, (B) a provider of home health care services, and (C) a health care consumer or a health care consumer advocate;

(13) One member appointed by the majority leader of the Senate, who shall be a representative of an independent community hospital;

(14) One member appointed by the majority leader of the House of Representatives, who shall be a physician who provides services in a multispecialty group and who is not employed by a hospital;

(15) One member appointed by the minority leader of the Senate, who shall be a primary care physician who provides services in a small independent practice;

(16) One member appointed by the minority leader of the House of Representatives, who shall be an expert in health care analytics and quality analysis;

(17) The president pro tempore of the Senate, or the president's designee;

(18) The speaker of the House of Representatives, or the speaker's designee;

(19) The minority leader of the Senate, or the minority leader's designee; and

(20) The minority leader of the House of Representatives, or the minority leader's designee.

(c) Any member appointed or designated under subdivisions (11) to (20), inclusive, of subsection (b) of this section may be a member of the General Assembly.

(d) (1) The health information technology officer, designated in accordance with section **[**19a-754a**]** 4-66, as amended by this act, shall serve as a chairperson of the council. The council shall elect a second chairperson from among its members, who shall not be a state official. The chairpersons of the council may establish subcommittees and working groups and may appoint individuals other than members of

the council to serve as members of the subcommittees or working groups. The terms of the members shall be coterminous with the terms of the appointing authority for each member and subject to the provisions of section 4-1a. If any vacancy occurs on the council, the appointing authority having the power to make the appointment under the provisions of this section shall appoint a person in accordance with the provisions of this section. A majority of the members of the council shall constitute a quorum. Members of the council shall serve without compensation, but shall be reimbursed for all reasonable expenses incurred in the performance of their duties.

(2) The chairpersons of the council may appoint up to four additional members to the council, who shall serve at the pleasure of the chairpersons.

(e) (1) The council shall establish a working group to be known as the All-Payer Claims Database Advisory Group. Said group shall include, but need not be limited to, (A) the Secretary of the Office of Policy and Management, the Comptroller, the Commissioners of Public Health, Social Services and Mental Health and Addiction Services, the Insurance Commissioner, the Healthcare Advocate and the Chief Information Officer, or their designees; (B) a representative of the Connecticut State Medical Society; and (C) representatives of health insurance companies, health insurance purchasers, hospitals, consumer advocates and health care providers. The health information technology officer may appoint additional members to said group.

(2) The All-Payer Claims Database Advisory Group shall develop a plan to implement a state-wide multipayer data initiative to enhance the state's use of health care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors.

(f) Prior to submitting any application, proposal, planning document or other request seeking federal grants, matching funds or other federal

support for health information technology or health information exchange, the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management or the Commissioner of Social Services shall present such application, proposal, document or other request to the council for review and comment.

Sec. 23. Subsections (a) and (b) of section 17b-59g of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The state, acting by and through the Secretary of the Office of Policy and Management, **[**in collaboration with the Commissioner of Health Strategy,**]** shall establish a program to expedite the development of the State-wide Health Information Exchange, established under section 17b-59d, as amended by this act, to assist the state, health care providers, insurance carriers, physicians and all stakeholders in empowering consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health goals. The purposes of the program shall be to (1) assist the State-wide Health Information Exchange in establishing and maintaining itself as a neutral and trusted entity that serves the public good for the benefit of all Connecticut residents, including, but not limited to, Connecticut health care consumers and Connecticut health care providers and carriers, and (2) perform, on behalf of the state, the role of intermediary between public and private stakeholders and customers of the State-wide Health Information Exchange. **[**, and (3) fulfill the responsibilities of the Office of Health Strategy, as described in section 19a-754a.**]**

(b) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management, in consultation with the health information technology officer, designated in accordance with section **[**19a-754**]** 4-66 as amended by this act, shall design **[**, and the Secretary of the Office of

Policy and Management, in collaboration with said commissioner,**]** and may establish or incorporate an entity to implement the program established under subsection (a) of this section. Such entity shall, without limitation, be owned and governed, in whole or in part, by a party or parties other than the state and may be organized as a nonprofit entity.

Sec. 24. Section 17b-312 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of Social Services shall seek, in accordance with the provisions of section 17b-8, **[**and in consultation with the Insurance Commissioner and the Office of Health Strategy established under section 19a-754a,**]** a waiver under Section 1115 of the Social Security Act, as amended from time to time, to seek federal funds to support the Covered Connecticut program established under section 19a-754c, as amended by this act. Upon approval by the Centers for Medicare and Medicaid Services, the Commissioner of Social Services shall implement the waiver.

Sec. 25. Subsection (c) of section 17b-337 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) one member from the Department of Public Health appointed by the Commissioner of Public Health; (5) one member from the Department of Housing appointed by the Commissioner of Housing; (6) one member from the Department of Developmental Services appointed by the Commissioner

of Developmental Services; (7) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (8) one member from the Department of Transportation appointed by the Commissioner of Transportation; (9) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; **[**(10) one member from the Health Systems Planning Unit of the Office of Health Strategy appointed by the Commissioner of Health Strategy; and (11)**]** and (10) one member from the Department of Aging and Disability Services appointed by the Commissioner of Aging and Disability Services. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

Sec. 26. Subdivision (3) of subsection (f) of section 17b-340 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(3) For the fiscal year ending June 30, 1992, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred thirty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the **[**Office of Health Care Access**]** Health Systems Planning Unit of the Department of Public Health pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1993, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one

hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the **[**Office of Health Care Access**]** Health Systems Planning Unit pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1994, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the **[**Office of Health Care Access**]** Health Systems Planning Unit pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred ten per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1995, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the **[**Office of Health Care Access**]** Health Systems Planning Unit pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, except for the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component

shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to the state-wide median allowable cost. For the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to the state-wide median allowable cost and such medians shall be based upon the same cost year used to set rates for facilities with prospective rates. Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the Commissioner of Social Services (A) may allow costs in excess of maximum amounts for any facility with patient days covered by Medicare, including days requiring coinsurance, in excess of twelve per cent of annual patient days which also has patient days covered by Medicaid in excess of fifty per cent of annual patient days; (B) may establish a pilot program whereby costs in excess of maximum amounts shall be allowed for beds in a nursing home which has a managed care program and is affiliated with a hospital licensed under chapter 368v; and (C) may establish rates whereby allowable costs may exceed such maximum amounts for beds approved on or after July 1, 1991, which are restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury.

Sec. 27. Section 17b-356 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

Any health care facility or institution, as defined in subsection (a) of section 19a-490, except a nursing home, rest home, residential care home or residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities, proposing to expand its services by adding nursing home beds shall obtain the approval of the Commissioner of Social Services in accordance with the procedures established pursuant to sections 17b-352, 17b-353 and 17b-354 for a facility, as defined in section 17b-352, prior to obtaining the approval of the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health pursuant to section 19a-639, as amended by this act.

Sec. 28. Section 19a-6q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of Public Health, in consultation with the **[**Commissioner of Health Strategy and**]** local and regional health departments, shall, within available resources, develop a plan that is consistent with the Department of Public Health's Healthy Connecticut 2020 health improvement plan and the state healthcare innovation plan developed pursuant to the State Innovation Model Initiative by the Centers for Medicare and Medicaid Services Innovation Center. The Commissioner of Public Health shall develop and implement such plan to: (1) Reduce the incidence of tobacco use, high blood pressure, health care associated infections, asthma, unintended pregnancy and diabetes; (2) improve chronic disease care coordination in the state; and (3) reduce the incidence and effects of chronic disease and improve outcomes for conditions associated with chronic disease in the state. The Commissioner of Public Health shall post such plan on the Department of Public Health's Internet web site.

Sec. 29. Subsection (b) of section 19a-7 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) For the purposes of establishing a state health plan as required by subsection (a) of this section and consistent with state and federal law on patient records, the department is entitled to access hospital discharge data, emergency room and ambulatory surgery encounter data, data on home health care agency client encounters and services, data from community health centers on client encounters and services and all data collected or compiled by the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health pursuant to section 19a-613, as amended by this act.

Sec. 30. Subsection (l) of section 19a-7h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(l) The commissioner shall, in consultation with the **[**Office of Health Strategy**]** Secretary of the Office of Policy and Management, adopt regulations, in accordance with the provisions of chapter 54, to facilitate interoperability between the immunization information system and the State-wide Health Information Exchange established pursuant to section 17b-59d, as amended by this act. The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the department posts such policies and procedures on the eRegulations System prior to adopting them. Policies and procedures implemented pursuant to this section shall be valid until regulations are adopted in accordance with the provisions of chapter 54.

Sec. 31. Subsection (a) of section 19a-75a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) On or before January 1, 2023, the Department of Public Health shall establish and administer a child and adolescent psychiatrist grant program. The program shall provide incentive grants to employers of child and adolescent psychiatrists for recruiting and hiring new child and adolescent psychiatrists and retaining child and adolescent psychiatrists who are in their employ. The Commissioner of Public Health shall establish eligibility requirements, priority categories, funding limitations and the application process for the grant program. Such priority categories shall include, but need not be limited to, nonhospital employers. The commissioner **[**, in consultation with the Office of Health Strategy,**]** shall distribute incentive grant funds equitably with regard to the type of employer and location of such employer.

Sec. 32. Section 19a-127k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) As used in this section:

(1) "Community benefit partners" means federal, state and municipal government entities and private sector entities, including, but not limited to, faith-based organizations, businesses, educational and academic organizations, health care organizations, health departments, philanthropic organizations, organizations specializing in housing justice, planning and land use organizations, public safety organizations, transportation organizations and tribal organizations, that, in partnership with hospitals, play an essential role with respect to the policy, system, program and financing solutions necessary to achieve community benefit program goals;

(2) "Community benefit program" means any voluntary program or activity to promote preventive health care, protect health and safety, improve health equity and reduce health disparities, reduce the cost and economic burden of poor health and improve the health status for all populations within the geographic service areas of a hospital, regardless

of whether a member of any such population is a patient of such hospital;

(3) "Community benefit program reporting" means the community health needs assessment, implementation strategy and annual report submitted by a hospital to the **[**Office of Health Strategy**]** Department of Social Services pursuant to the provisions of this section;

(4) "Community health needs assessment" means a written assessment, as described in 26 CFR 1.501(r)-(3);

(5) "Health disparities" means health differences that are closely linked with social or economic disadvantages that adversely affect one or more groups of people who have experienced greater systemic social or economic obstacles to health or a safe environment based on race or ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation, gender identity, geographic location or other characteristics historically linked to discrimination or exclusion;

(6) "Health equity" means that every person has a fair and just opportunity to be as healthy as possible, which encompasses removing obstacles to health, such as poverty, racism and the adverse consequences of poverty and racism, including, but not limited to, a lack of equitable opportunities, access to good jobs with fair pay, quality education and housing, safe environments and health care;

(7) "Hospital" means a nonprofit entity licensed as a hospital pursuant to chapter 368v that is required to annually file Internal Revenue Service form 990. "Hospital" includes a for-profit entity licensed as an acute care general hospital;

(8) "Implementation strategy" means a written plan, as described in 26 CFR 1.501(r)-(3), that is adopted by an authorized body of a hospital and documents how such hospital intends to address the needs identified in the community health needs assessment; and

(9) "Meaningful participation" means that (A) residents of a hospital's community, including, but not limited to, residents of such community that experience the greatest health disparities, have an appropriate opportunity to participate in such hospital's planning and decisions, (B) community participation influences a hospital's planning, and (C) participants receive information from a hospital summarizing how their input was or was not used by such hospital.

(b) On and after January 1, 2023, each hospital shall submit community benefit program reporting to the **[**Office of Health Strategy**]** Department of Social Services, or to a designee selected by the Commissioner of **[**Health Strategy**]** Social Services, in the form and manner described in subsections (c) to (e), inclusive, of this section.

(c) Each hospital shall submit its community health needs assessment to the **[**Office of Health Strategy**]** Department of Social Services not later than thirty days after the date on which such assessment is made available to the public pursuant to 26 CFR 1.501(r)-(3)(b), provided the Commissioner of **[**Health Strategy**]** Social Services, or the commissioner's designee, may grant an extension of time to a hospital for the filing of such assessment. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) A definition of the community served by the hospital and a description of how the community was determined;

(B) A description of the process and methods used to conduct the community health needs assessment;

(C) A description of how the hospital solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the community health needs assessment, and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the community health needs assessment;

(F) An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding community health needs assessment, to address the significant health needs identified in the hospital's prior community health needs assessment; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the community health needs assessment;

(B) The demographics of the population within the geographic service area of the hospital and, to the extent feasible, a detailed description of the health disparities, health risks, insurance status, service utilization patterns and health care costs within such geographic service area;

(C) A description of the health status and health disparities affecting the population within the geographic service area of the hospital, including, but not limited to, the health status and health disparities affecting a representative spectrum of age, racial and ethnic groups, incomes and medically underserved populations;

(D) A description of the meaningful participation afforded to community benefit partners and diverse community members in assessing community health needs, priorities and target populations;

(E) A description of the barriers to achieving or maintaining health and to accessing health care, including, but not limited to, social, economic and environmental barriers, lack of access to or availability of sources of health care coverage and services and a lack of access to and availability of prevention and health promotion services and support;

(F) Recommendations regarding the role that the state and other community benefit partners could play in removing the barriers described in subparagraph (E) of this subdivision and enabling effective solutions; and

(G) Any additional information, data or disclosures that the hospital voluntarily chooses to include as may be relevant to its community benefit program.

(d) Each hospital shall submit its implementation strategy to the **[**Office of Health Strategy**]** Department of Social Services not later than thirty days after the date on which such implementation strategy is adopted pursuant to 26 CFR 1.501(r)-(3)(c), provided the Commissioner of **[**Health Strategy**]** Social Services, or the commissioner's designee, may grant an extension to a hospital for the filing of such implementation strategy. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) With respect to each significant health need identified through the community health needs assessment, either (i) a description of how the hospital plans to address the health need, or (ii) identification of the health need as one which the hospital does not intend to address;

(B) For significant health needs described in subparagraph (A)(i) of this subdivision, (i) a description of the actions that the hospital intends to take to address the health need and the anticipated impact of such actions, (ii) identification of the resources that the hospital plans to

commit to address the health need, and (iii) a description of any planned collaboration between the hospital and other facilities or organizations to address the health need;

(C) For significant health needs identified in subparagraph (A)(ii) of this subdivision, an explanation of why the hospital does not intend to address such health need; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the implementation strategy;

(B) A description of the meaningful participation afforded to community benefit partners and diverse community members;

(C) A description of the community health needs and health disparities that were prioritized in developing the implementation strategy with consideration given to the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7, as amended by this act;

(D) Reference-citing evidence, if available, that shows how the implementation strategy is intended to address the corresponding health need or reduction in health disparity;

(E) A description of the planned methods for the ongoing evaluation of proposed actions and corresponding process or outcome measures intended for use in assessing progress or impact;

(F) A description of how the hospital solicited commentary on the implementation strategy from the communities within such hospital's geographic service area and revisions to such strategy based on such commentary; and

(G) Any other information that the hospital voluntarily chooses to include as may be relevant to its implementation strategy, including, but

not limited to, data, disclosures, expected or planned resource outlay, investments or commitments, including, but not limited to, staff, financial or in-kind commitments.

(e) On or before October 1, 2023, and annually thereafter, each hospital shall submit to the **[**Office of Health Strategy**]** Department of Social Services a status report on such hospital's community benefit program, provided the Commissioner of **[**Health Strategy**]** Social Services, or the commissioner's designee, may grant an extension to a hospital for the filing of such report. Such report shall include the following:

(1) A description of major updates regarding community health needs, priorities and target populations, if any;

(2) A description of progress made regarding the hospital's actions in support of its implementation strategy;

(3) A description of any major changes to the proposed implementation strategy and associated hospital actions; and

(4) A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's implementation strategy.

(f) Notwithstanding the provisions of section 19a-755a, as amended by this act, and to the full extent permitted by 45 CFR 164.514(e), the **[**Office of Health Strategy**]** Department of Social Services shall make data in the all-payer claims database available to hospitals for use in their community benefit programs and activities solely for the purposes of (1) preparing the hospital's community health needs assessment, (2) preparing and executing the hospital's implementation strategy, and (3) fulfilling community benefit program reporting, as described in subsections (c) to (e), inclusive, of this section. Any disclosure made by said **[**office**]** department pursuant to this subsection of information other than health information shall be made in a manner to protect the

confidentiality of such information as may be required by state or federal law.

(g) A hospital shall not be responsible for limitations in its ability to fulfill community benefit program reporting requirements, as described in subsections (c) to (e), inclusive, of this section, if the all-payer claims database data is not provided to such hospital, as required by subsection (f) of this section.

(h) **[**On or before**]** Not later than April **[**1, 2024, and**]** first, annually, **[**thereafter,**]** the Commissioner of **[**Health Strategy**]** Social Services shall develop a summary and analysis of the community benefit program reporting submitted by hospitals under this section during the previous calendar year and post such summary and analysis on its Internet web site and solicit stakeholder input through a public comment period. The **[**Office of Health Strategy**]** Department of Social Services shall use such reporting and stakeholder input to:

(1) Identify additional stakeholders that may be engaged to address identified community health needs, including, but not limited to, federal, state and municipal entities, nonhospital private sector health care providers and private sector entities that are not health care providers, including community-based organizations, insurers and charitable organizations;

(2) Determine how each identified stakeholder could assist in addressing identified community health needs or augmenting solutions or approaches reported in the implementation strategies;

(3) Determine whether to make recommendations to the Department of Public Health in the development of its state health plan; and

(4) Inform the state-wide health care facilities and services plan established pursuant to section 19a-634, as amended by this act.

(i) Each for-profit entity licensed as an acute care general hospital

shall submit community benefit program reporting consistent with the reporting schedules of subsections (c) to (e), inclusive, of this section, and reasonably similar to what would be included on such hospital's federal filings to the Internal Revenue Service, where applicable.

Sec. 33. Section 19a-486 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

For purposes of sections 19a-486 to 19a-486h, inclusive, as amended by this act:

(1) "Nonprofit hospital" means a nonprofit entity licensed as a hospital pursuant to this chapter and any entity affiliated with such a hospital through governance or membership, including, but not limited to, a holding company or subsidiary.

(2) "Purchaser" means a person acquiring any assets of a nonprofit hospital through a transfer.

(3) "Person" means any individual, firm, partnership, corporation, limited liability company, association or other entity.

(4) "Transfer" means to sell, transfer, lease, exchange, option, convey, give or otherwise dispose of or transfer control over, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business.

(5) "Control" has the meaning assigned to it in section 36b-41.

(6) "Commissioner" means the Commissioner of **[**Health Strategy**]** Public Health, or the commissioner's designee.

Sec. 34. Section 19a-486g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of Public Health shall refuse to issue a license to, or if issued shall suspend or revoke the license of, a hospital if the

commissioner finds, after a hearing and opportunity to be heard, that:

(1) There was a transaction described in section 19a-486a that occurred without the commissioner's approval, **[**of the Commissioner of Health Strategy,**]** if such approval was required by sections 19a-486 to 19a-486h, inclusive, as amended by this act;

(2) There was a transaction described in section 19a-486a without the approval of the Attorney General, if such approval was required by sections 19a-486 to 19a-486h, inclusive, as amended by this act, and the Attorney General certifies to the **[**Commissioner of Health Strategy**]** commissioner that such transaction involved a material amount of the nonprofit hospital's assets or operations or a change in control of operations; or

(3) The hospital is not complying with the terms of an agreement approved by the Attorney General and **[**Commissioner of Health Strategy**]** commissioner pursuant to sections 19a-486 to 19a-486h, inclusive, as amended by this act.

Sec. 35. Section 19a-486h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by this act, shall be construed to limit: (1) The common law or statutory authority of the Attorney General; (2) the statutory authority of the Commissioner of Public Health including, but not limited to, licensing **[**; (3) the statutory authority of the Commissioner of Health Strategy, including, but not limited to, certificate of need authority; or (4)**]** and certificate of need authority; or (3) the application of the doctrine of cy pres or approximation.

Sec. 36. Subsections (d) to (i), inclusive, of section 19a-486i of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(d) (1) The written notice required under subsection (c) of this section shall identify each party to the transaction and describe the material change as of the date of such notice to the business or corporate structure of the group practice, including: (A) A description of the nature of the proposed relationship among the parties to the proposed transaction; (B) the names and specialties of each physician that is a member of the group practice that is the subject of the proposed transaction and who will practice medicine with the resulting group practice, hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by, or otherwise affiliated with such hospital or hospital system following the effective date of the transaction; (C) the names of the business entities that are to provide services following the effective date of the transaction; (D) the address for each location where such services are to be provided; (E) a description of the services to be provided at each such location; and (F) the primary service area to be served by each such location.

(2) Not later than thirty days after the effective date of any transaction described in subsection (c) of this section, the parties to the transaction shall submit written notice to the Commissioner of **[**Health Strategy**]** Public Health. Such written notice shall include, but need not be limited to, the same information described in subdivision (1) of this subsection. The commissioner shall post a link to such notice on the **[**Office of Health Strategy's**]** Department of Public Health's Internet web site.

(e) Not less than thirty days prior to the effective date of any transaction that results in an affiliation between one hospital or hospital system and another hospital or hospital system, the parties to the affiliation shall submit written notice to the Attorney General of such affiliation. Such written notice shall identify each party to the affiliation and describe the affiliation as of the date of such notice, including: (1) A description of the nature of the proposed relationship among the parties to the affiliation; (2) the names of the business entities that are to provide services following the effective date of the affiliation; (3) the address for each location where such services are to be provided; (4) a description

of the services to be provided at each such location; and (5) the primary service area to be served by each such location.

(f) Written information submitted to the Attorney General pursuant to subsections (b) to (e), inclusive, of this section shall be maintained and used by the Attorney General in the same manner as provided in section 35-42.

(g) Not later than January **[**15, 2018, and**]** fifteenth annually, **[**thereafter,**]** each hospital and hospital system shall file with the Attorney General and the Commissioner of **[**Health Strategy**]** Public Health a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

(h) Not later than January **[**15, 2018, and**]** fifteenth annually, **[**thereafter,**]** each group practice comprised of thirty or more physicians that is not the subject of a report filed under subsection (g) of this section shall file with the Attorney General and the Commissioner of **[**Health Strategy**]** Public Health a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

(i) Not later than January **[**15, 2018, and**]** fifteenth annually, **[**thereafter,**]** each hospital and hospital system shall file with the Attorney General and the Commissioner of **[**Health Strategy**]** Public Health a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

Sec. 37. Section 19a-486j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) On or before October 31, **[**2024**]** 2026, and semiannually thereafter, each hospital, as defined in section 12-263p, shall submit a semiannual report to the Commissioner of **[**Health Strategy**]** Social Services that identifies, for each of the two prior calendar quarters, (1) the number of days of cash on hand, or days cash and cash equivalents otherwise available to the hospital, and (2) the dollar amount of (A) invoices that are at least ninety days past due in the reporting period, (B) utility bills that are at least ninety days past due in the reporting period, (C) fees, taxes or assessments owed to public entities that are at least ninety days past due in the reporting period, and (D) unpaid employee health insurance premiums, including unpaid contributions, claims or other obligations supporting employees under a self-funded insurance plan or fully insured plan, that are at least ninety days past due in the reporting period. The commissioner shall develop a uniform template, including, but not limited to, definitions of terms used in such template, to be used by hospitals for the purposes of complying with the provisions of this subsection and post such template on the **[**Office of Health Strategy's**]** Department of Social Services' Internet web site. A hospital may request an extension of time to comply with the requirements of this subsection in a form and manner prescribed by the

commissioner. The commissioner may grant such request for good cause, as determined by the commissioner. Such template shall be based on generally accepted accounting principles as prescribed by the Financial Accounting Standards Board.

(b) If a hospital submits a report pursuant to the provisions of subsection (a) of this section reflecting two consecutive quarters of sixty days or less of days of cash on hand, or days cash and cash equivalents otherwise available to the hospital, the commissioner may require the hospital to provide the **[**Office of Health Strategy**]** Department of Social Services with additional information that the commissioner deems relevant to understanding the financial health of the hospital.

(c) If a hospital submits a report pursuant to the provisions of subsection (a) of this section reflecting two consecutive quarters of forty-five days or less of cash on hand, or days cash and cash equivalents otherwise available to the hospital, the **[**Office of Health Strategy**]** Department of Social Services shall contact the hospital to offer assistance.

(d) If a hospital has multiple consecutive quarters of one hundred or more days of cash on hand, or days cash and cash equivalents otherwise available to the hospital, the commissioner may waive one of the hospital's two semiannual reports required pursuant to the provisions of subsection (a) of this section.

Sec. 38. Subsection (b) of section 19a-490ii of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Not later than March **[**1, 2025, and**]** first annually, **[**thereafter**]** until March 1, 2029, each hospital that conducts an analysis pursuant to subsection (a) of this section shall submit a report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health and, not later than March **[**1, 2026, and**]** first annually **[**thereafter**]**

until March 1, 2029, shall also submit such report to the **[**Commissioners**]** Commissioner of Public Health **[**and Health Strategy**]** and the Healthcare Advocate, regarding its findings and any recommendations for achieving the goals described in subparagraphs (A) to (C), inclusive, of subdivision (4) of subsection (a) of this section.

Sec. 39. Subsections (b) and (c) of section 19a-493b of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) No entity, individual, firm, partnership, corporation, limited liability company or association, other than a hospital, shall individually or jointly establish or operate an outpatient surgical facility in this state without complying with chapter 368z, except as otherwise provided by this section, and obtaining a license within the time specified in this subsection from the Department of Public Health for such facility pursuant to the provisions of this chapter, unless such entity, individual, firm, partnership, corporation, limited liability company or association: (1) Provides to the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health satisfactory evidence that it was in operation on or before July 1, 2003, or (2) obtained, on or before July 1, 2003, from the Office of Health Care Access, a determination that a certificate of need is not required. An entity, individual, firm, partnership, corporation, limited liability company or association otherwise in compliance with this section may operate an outpatient surgical facility without a license through March 30, 2007, and shall have until March 30, 2007, to obtain a license from the Department of Public Health.

(c) Notwithstanding the provisions of this section, no outpatient surgical facility shall be required to comply with section 19a-631, as amended by this act, 19a-632, 19a-644, as amended by this act, 19a-645, as amended by this act, 19a-646, as amended by this act, 19a-649, 19a-664 to 19a-666, inclusive, 19a-673 to 19a-676, inclusive, 19a-678, 19a-681, as amended by this act, or 19a-683. Each outpatient surgical facility shall

continue to be subject to the obligations and requirements applicable to such facility, including, but not limited to, any applicable provision of this chapter and those provisions of chapter 368z not specified in this subsection, except that a request for permission to undertake a transfer or change of ownership or control shall not be required pursuant to subsection (a) of section 19a-638 if the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health determines that the following conditions are satisfied: (1) Prior to any such transfer or change of ownership or control, the outpatient surgical facility shall be owned and controlled exclusively by persons licensed pursuant to section 20-13 or chapter 375, either directly or through a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, or is under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a person licensed under section 20-13 or chapter 375, and (2) after any such transfer or change of ownership or control, persons licensed pursuant to section 20-13 or chapter 375, a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, shall own and control no less than a sixty per cent interest in the outpatient surgical facility.

Sec. 40. Subsection (a) of section 19a-507 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) Notwithstanding the provisions of chapter 368z, New Horizons, Inc., a nonprofit, nonsectarian organization, or a subsidiary organization controlled by New Horizons, Inc., is authorized to construct and operate an independent living facility for severely physically disabled adults, in the town of Farmington, provided such

facility shall be constructed in accordance with applicable building codes. The Farmington Housing Authority, or any issuer acting on behalf of said authority, subject to the provisions of this section, may issue tax-exempt revenue bonds on a competitive or negotiated basis for the purpose of providing construction and permanent mortgage financing for the facility in accordance with Section 103 of the Internal Revenue Code. Prior to the issuance of such bonds, plans for the construction of the facility shall be submitted to and approved by the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health. The unit shall approve or disapprove such plans within thirty days of receipt thereof. If the plans are disapproved they may be resubmitted. Failure of the unit to act on the plans within such thirty-day period shall be deemed approval thereof. The payments to residents of the facility who are eligible for assistance under the state supplement program for room and board and necessary services, shall be determined annually to be effective July first of each year. Such payments shall be determined on a basis of a reasonable payment for necessary services, which basis shall take into account as a factor the costs of providing those services and such other factors as the commissioner deems reasonable, including anticipated fluctuations in the cost of providing services. Such payments shall be calculated in accordance with the manner in which rates are calculated pursuant to subsection (i) of section 17b-340 and the cost-related reimbursement system pursuant to said section except that efficiency incentives shall not be granted. The commissioner may adjust such rates to account for the availability of personal care services for residents under the Medicaid program. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. The cost basis for such payment shall be subject to audit, and a recomputation of the rate shall be made based upon such audit. The facility shall report on a fiscal year ending on the

thirtieth day of September on forms provided by the commissioner. The required report shall be received by the commissioner no later than December thirty-first of each year. The Department of Social Services may use its existing utilization review procedures to monitor utilization of the facility. If the facility is aggrieved by any decision of the commissioner, the facility may, within ten days, after written notice thereof from the commissioner, obtain by written request to the commissioner, a hearing on all items of aggrievement. If the facility is aggrieved by the decision of the commissioner after such hearing, the facility may appeal to the Superior Court in accordance with the provisions of section 4-183.

Sec. 41. Subsections (d) to (m), inclusive, of section 19a-508c of the 2026 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(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**]** Department of Public Health, established pursuant to section 19a-612, as amended by this act, 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**]** Department of Public Health.

(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**]** Department of Public Health, established under section 19a-612, as amended by this act. 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**]** Department of Public Health, 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**]** first 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**]** Department of Public Health 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**]** Public Health 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**]** Department of Public Health 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**]** Department of Public Health pursuant to this subdivision, if said **[**office**]** department 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**]** department, said **[**office**]** department shall issue a final cease and desist order in addition to any civil penalty said **[**office**]** department 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**]** Public Health, 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 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**]** Department of Public Health.

Sec. 42. Subsection (c) of section 19a-509b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(c) Each hospital that holds or administers one or more hospital bed funds shall make available in a place and manner allowing individual members of the public to easily obtain it, a one-page summary in English and Spanish describing hospital bed funds and how to apply for them. The summary shall also describe any other policies regarding the provision of charity care and reduced cost services for the indigent as reported by the hospital to the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health pursuant to section 19a-649 and shall clearly distinguish hospital bed funds from other sources of financial assistance. The summary shall include notification that the patient is entitled to reapply upon rejection, and that additional funds may become available on an annual basis. The summary shall be available in the patient admissions office, emergency room, social services department and patient accounts or billing office, and from any collection agent. If during the admission process or during its review of the financial resources of the patient, the hospital reasonably believes the patient will have limited funds to pay for any portion of the patient's hospitalization not covered by insurance, the hospital shall provide the summary to each such patient.

Sec. 43. Section 19a-612 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

[(a)**]** There is established, within the **[**Office of Health Strategy, established under section 19a-754a**]** Department of Public Health, a unit to be known as the Health Systems Planning Unit **[**. The unit, under**]** that shall be under the direction of the Commissioner of **[**Health Strategy**]** Public Health. **[**, shall constitute a successor to the former Office of Health Care Access, in accordance with the provisions of sections 4-38d and 4-39.**]**

[(b) Any order, decision, agreed settlement or regulation of the former Office of Health Care Access which is in force on July 1, 2018, shall continue in force and effect as an order or regulation of the Office of Health Strategy until amended, repealed or superseded pursuant to law.

(c) If the words "Office of Health Care Access" are used or referred to in any public or special act of 2009 or in any section of the general statutes which is amended in 2009, such words shall be deemed to mean or refer to the Office of Health Care Access division within the Department of Public Health. If the words "Office of Health Care Access" are used or referred to in any public or special act of 2018 or in any section of the general statutes which is amended in 2018, such words shall be deemed to mean or refer to the Health Systems Planning Unit within the Office of Health Strategy.**]**

Sec. 44. Section 19a-612d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

[(a)**]** The Commissioner of **[**Health Strategy**]** Public Health shall oversee the Health Systems Planning Unit and shall exercise independent decision-making authority over all certificate of need decisions.

[(b) Notwithstanding the provisions of subsection (a) of this section,

the Deputy Commissioner of Public Health shall retain independent decision-making authority over only the certificate of need applications that are pending before the Office of Health Care Access and have been deemed completed by said office on or before May 14, 2018. Following the issuance by the Deputy Commissioner of Public Health of a final decision on any such certificate of need application, the Commissioner of Health Strategy shall exercise independent authority on any further action required on such certificate of need application or the certificate of need issued pursuant to such application.**]**

Sec. 45. Subsection (c) of section 19a-613 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(c) The Commissioner of **[**Health Strategy**]** Public Health, or any person the commissioner designates, may conduct a hearing and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Health Systems Planning Unit.

Sec. 46. Section 19a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of **[**Health Strategy**]** Public Health may employ and pay professional and support staff subject to the provisions of chapter 67 and contract with and engage consultants and other independent professionals as may be necessary or desirable to carry out the functions of the Health Systems Planning Unit.

Sec. 47. Section 19a-630 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

As used in this chapter, unless the context otherwise requires:

(1) "Affiliate" means a person, entity or organization controlling,

controlled by or under common control with another person, entity or organization. Affiliate does not include a medical foundation organized under chapter 594b.

(2) "Applicant" means any person or health care facility that applies for a certificate of need pursuant to section 19a-639a, as amended by this act.

(3) "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive.

(4) "Capital expenditure" means an expenditure that under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation or maintenance and includes acquisition by purchase, transfer, lease or comparable arrangement, or through donation, if the expenditure would have been considered a capital expenditure had the acquisition been by purchase.

(5) "Certificate of need" means a certificate issued by the unit.

(6) "Days" means calendar days.

(7) "Commissioner" means the Commissioner of **[**Health Strategy**]** Public Health.

(8) "Free clinic" means a private, nonprofit community-based organization that provides medical, dental, pharmaceutical or mental health services at reduced cost or no cost to low-income, uninsured and underinsured individuals.

(9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician

routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

(10) "Health care facility" means (A) hospitals licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C) freestanding emergency departments; (D) outpatient surgical facilities, as defined in section 19a-493b, as amended by this act, and licensed under chapter 368v; (E) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; (F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

(11) "Nonhospital based" means located at a site other than the main campus of the hospital.

(12) **[**"Office" means the Office of Health Strategy**]** "Department" means the Department of Public Health.

(13) "Person" means any individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

(14) "Physician" has the same meaning as provided in section 20-13a.

(15) "Termination of services" means the cessation of any services for a combined total of greater than one hundred eighty days within any consecutive two-year period.

(16) "Transfer of ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility, institution or large group practice, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a health care facility.

(17) "Unit" means the Health Systems Planning Unit.

Sec. 48. Subsection (b) of section 19a-631 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Each hospital shall annually pay to the Commissioner of **[**Health Strategy**]** Public Health, for deposit in the General Fund, an amount equal to its share of the actual expenditures made by the unit during each fiscal year including the cost of fringe benefits for unit personnel as estimated by the Comptroller, the amount of expenses for central state services attributable to the unit for the fiscal year as estimated by the Comptroller, plus the expenditures made on behalf of the unit from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year. Payments shall be made by assessment of all hospitals of the costs calculated and collected in accordance with the provisions of this section and section 19a-632. If for any reason a hospital ceases operation, any unpaid assessment for the operations of the unit shall be reapportioned among the remaining hospitals to be paid in addition to any other assessment.

Sec. 49. Section 19a-632a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) For purposes of this section, "electronic funds transfer" has the same meaning as provided in section 12-685.

(b) The **[**Office of Health Strategy**]** Department of Public Health may require a hospital to pay an assessment levied pursuant to section 19a-632 by way of an approved method of electronic funds transfer.

(c) A hospital making an electronic funds transfer pursuant to this section shall initiate such transfer in a timely fashion to ensure that a bank account designated by the department is credited by electronic funds transfer for the amount of the assessment required to be made by such method on or before the date such assessment is due.

(d) Where an assessment is required to be made by electronic funds transfer, any payment made by a method other than electronic funds transfer shall be treated as an assessment not made in a timely manner, and any payment made by electronic funds transfer, where the bank account designated by the department is not credited for the amount of the assessment on or before the date such assessment is due, shall be treated as an assessment not made in a timely manner. Any assessment treated under this subsection as an assessment not made in a timely manner shall be subject to a penalty in accordance with subsection (e) of this section.

(e) Where any assessment is treated under subsection (d) of this section as an assessment not made in a timely manner because it is made by means other than electronic funds transfer, **[**there shall be imposed**]** the department shall impose a penalty equal to ten per cent of the assessment required to be made by electronic funds transfer. Where any assessment made by electronic funds transfer is treated under subsection (d) of this section as an assessment not made in a timely manner because the bank account designated by the department is not credited by electronic funds transfer for the amount of the assessment

on or before the date such assessment is due, **[**there shall be imposed**]** the department shall impose a penalty equal to (1) two per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for not more than five days; (2) five per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than five days but not more than fifteen days; or (3) ten per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than fifteen days.

(f) The **[**office**]** department shall deposit all payments received pursuant to this section with the State Treasurer. The moneys so deposited shall be credited to the General Fund and shall be accounted for as expenses recovered from hospitals.

Sec. 50. Subsection (a) of section 19a-634 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The Health Systems Planning Unit shall conduct, on a biennial basis, within available appropriations, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the unit deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the Commissioner of **[**Health Strategy**]** Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the unit's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access

to health care services.

Sec. 51. Subsections (d) and (e) of section 19a-638 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

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

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

Sec. 52. Subdivision (1) of subsection (a) of section 19a-639 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the **[**Office of Health Strategy**]** Department of Public Health;

Sec. 53. Subsection (a) of section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1,*

2026):

(a) An application for a certificate of need shall be filed with the unit in accordance with the provisions of this section and any regulations adopted by the **[**Office of Health Strategy**]** Department of Public Health. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, as amended by this act, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee based on the cost of the project. The amount of the fee shall be as follows: (A) One thousand dollars for a project that will cost not greater than fifty thousand dollars; (B) two thousand dollars for a project that will cost greater than fifty thousand dollars but not greater than one hundred thousand dollars; (C) three thousand dollars for a project that will cost greater than one hundred thousand dollars but not greater than five hundred thousand dollars; (D) four thousand dollars for a project that will cost greater than five hundred thousand dollars but not greater than one million dollars; (E) five thousand dollars for a project that will cost greater than one million dollars but not greater than five million dollars; (F) eight thousand dollars for a project that will cost greater than five million dollars but not greater than ten million dollars; and (G) ten thousand dollars for a project that will cost greater than ten million dollars.

Sec. 54. Subsection (h) of section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(h) The Commissioner of **[**Health Strategy**]** Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and posts notice of intent to adopt regulations on the **[**office's**]** department's Internet web site and the eRegulations System not later than twenty

days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 55. Subsection (e) of section 19a-639b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

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

Sec. 56. Subsection (b) of section 19a-639c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

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

Sec. 57. Subsection (d) of section 19a-639e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1,*

2026):

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

Sec. 58. Subsection (a) of section 19a-639f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health shall conduct a cost and market impact review in each case where (1) an application for a certificate of need filed pursuant to section 19a-638, as amended by this act, involves the transfer of ownership of a hospital, as defined in section 19a-639, as amended by this act, and (2) the purchaser is a hospital, as defined in section 19a-490, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or a hospital system, as defined in section 19a-486i, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or any person that is organized or operated for profit.

Sec. 59. Subsection (l) of section 19a-639f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(l) The Commissioner of **[**Health Strategy**]** Public Health shall adopt

regulations, in accordance with the provisions of chapter 54, concerning cost and market impact reviews and to administer the provisions of this section. Such regulations shall include definitions of the following terms: "Dispersed service area", "health status adjusted total medical expense", "major service category", "relative prices", "total health care spending" and "health care services". The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner publishes notice of intention to adopt the regulations on the **[**office's**]** department's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 60. Subsections (a) and (b) of section 19a-639g of the 2026 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) Notwithstanding any provision of sections 19a-630 to 19a-639f, inclusive, as amended by this act, any transacting parties involved in any transfer of ownership, as defined in section 19a-630, as amended by this act, of a hospital requiring a certificate of need pursuant to section 19a-638, as amended by this act, in which (1) the hospital subject to the transfer of ownership has filed for bankruptcy protection in any court of competent jurisdiction, and (2) a potential purchaser for such hospital has been or is required to be approved by a bankruptcy court, may, at the discretion of the Commissioner of **[**Health Strategy**]** Public Health, apply for an emergency certificate of need through the emergency certificate of need application process described in this section. An emergency certificate of need issued by the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health pursuant to the provisions of this section and any conditions imposed on such issuance shall apply to the applicant applying for the emergency certificate of need, the hospital subject to the transfer of

ownership and any subsidiary or group practice that would otherwise require a certificate of need pursuant to the provisions of section 19a-638, as amended by this act, and that is also subject to the transfer of ownership as part of the bankruptcy proceeding. The availability of the emergency certificate of need application process described in this section shall not affect any existing certificate of need issued pursuant to the provisions of sections 19a-630 to 19a-639f, inclusive, as amended by this act.

(b) (1) The unit shall develop an emergency certificate of need application, which shall identify any data required to be submitted with such application that the unit deems necessary to analyze the effects of a hospital's transfer of ownership on health care costs, quality and access in the affected market. If a potential purchaser of a hospital, described in subsection (a) of this section, is a for-profit entity, the unit's emergency certificate of need application may require additional information or data intended to ensure that the ongoing operation of the hospital after the transfer of ownership will be maintained in the public interest. The commissioner shall post any emergency certificate of need application developed pursuant to the provisions of this subdivision on the **[**Office of Health Strategy's**]** Department of Public Health's Internet web site and may modify any data required to be submitted with an emergency certificate of need application, provided the commissioner posts any such modification to the **[**office's**]** department's Internet web site not later than fifteen days before such a modification becomes effective.

(2) An applicant seeking an emergency certificate of need shall submit an emergency certificate of need application to the unit in a form and manner prescribed by the commissioner.

(3) An emergency certificate of need application shall be deemed complete on the date the unit determines that an applicant has submitted a complete application, including data required by the unit pursuant to subdivision (1) of this subsection. The unit shall determine

whether an application is complete not later than three business days after an applicant submits an application. If, after making such a determination, the unit deems an application incomplete, the unit shall, not more than three business days after deeming such application incomplete, notify the applicant that such application is incomplete and identify any application or data elements that were not adequately addressed by the applicant. The unit shall not review such an application until the applicant submits any such application or data elements to the unit.

(4) The unit may hold a public hearing on an emergency certificate of need application, provided (A) the unit holds such public hearing not later than thirty days after such application is deemed complete, and (B) the unit notifies the applicant of such public hearing not less than five days before the date of the public hearing. Any such public hearing or any other proceeding related to the emergency certificate of need application process described in this section shall not be considered a contested case pursuant to the provisions of chapter 54. Members of the public may submit public comments at any time during the emergency certificate of need application process and may request the unit to exercise its discretion to hold a public hearing pursuant to the provisions of this subdivision.

(5) When evaluating an emergency certificate of need application, the unit may consult any person and consider any relevant information, provided, unless prohibited by federal or state law, the unit includes any opinion or information gathered from consulting any such person and any such relevant information considered in the record relating to the emergency certificate of need application and cites any such opinion or information and any such relevant information considered in its final decision on the emergency certificate of need application. The unit may contract with one or more third-party consultants, at the expense of the applicant, to analyze (A) the anticipated effect of the hospital's transfer of ownership on access, cost and quality of health care in the affected community, and (B) any other issue arising from the application review

process. The aggregate cost of any such third-party consultations shall not exceed two hundred thousand dollars. Any reports or analyses generated by any such third-party consultant that the unit considers in issuing its final decision on an emergency certificate of need application shall, unless otherwise prohibited by federal or state law, be included in the record relating to the emergency certificate of need application. The provisions of chapter 57 and sections 4-212 to 4-219, inclusive, and 4e-19 shall not apply to any retainer agreement executed pursuant to this subsection.

Sec. 61. Section 19a-643 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The **[**Office of Health Strategy**]** Department of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as amended by this act, and sections 19a-644, as amended by this act, and 19a-645, as amended by this act, concerning the submission of data by health care facilities and institutions, including data on dealings between health care facilities and institutions and their affiliates, and, with regard to requests or proposals pursuant to sections 19a-638 to 19a-639e, inclusive, as amended by this act, by state health care facilities and institutions, the ongoing inspections by the unit of operating budgets that have been approved by the health care facilities and institutions, standard reporting forms and standard accounting procedures to be utilized by health care facilities and institutions and the transferability of line items in the approved operating budgets of the health care facilities and institutions, except that any health care facility or institution may transfer any amounts among items in its operating budget. All such transfers shall be reported to the unit not later than thirty days after the transfer or transfers.

(b) The **[**Office of Health Strategy**]** Department of Public Health may adopt such regulations, in accordance with the provisions of chapter 54, as are necessary to implement this chapter.

Sec. 62. Subsections (a) and (b) of section 19a-644 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general or children's hospital shall report to the unit with respect to its operations in such fiscal year, in such form as the unit may by regulation require. Such report shall include: (1) Salaries and fringe benefits for the ten highest paid hospital and health system employees; (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; (3) the salaries paid to hospital and health system employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations; and (4) information and data prescribed by the **[**Office of Health Strategy**]** Department of Public Health concerning charges for trauma activation fees. For purposes of this subsection, "health system" has the same meaning as provided in section 33-182aa.

(b) The **[**Office of Health Strategy**]** Commissioner of Public Health shall adopt regulations in accordance with chapter 54 to provide for the collection of data and information in addition to the annual report required in subsection (a) of this section. Such regulations shall provide for the submission of information about the operations of the following entities: Persons or parent corporations that own or control the health care facility, institution or provider; corporations, including limited liability corporations, in which the health care facility, institution, provider, its parent, any type of affiliate or any combination thereof, owns more than an aggregate of fifty per cent of the stock or, in the case of nonstock corporations, is the sole member; and any partnerships in which the person, health care facility, institution, provider, its parent or an affiliate or any combination thereof, or any combination of health care providers or related persons, owns a greater than fifty per cent interest. For purposes of this subsection, "affiliate" means any person that directly or indirectly through one or more intermediaries, controls

or is controlled by or is under common control with any health care facility, institution, provider or person that is regulated in any way under this chapter. A person is deemed controlled by another person if the other person, or one of that other person's affiliates, officers, agents or management employees, acts as a general partner or manager of the person in question.

Sec. 63. Section 19a-645 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

A nonprofit hospital, licensed by the Department of Public Health, **[**which**]** that provides lodging, care and treatment to members of the public, and **[**which**]** that wishes to enlarge its public facilities by adding contiguous land and buildings thereon, if any, the title to which it cannot otherwise acquire, may prefer a complaint for the right to take such land to the superior court for the judicial district in which such land is located, provided such hospital shall have received the approval of the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health in accordance with the provisions of this chapter. Said court shall appoint a committee of three disinterested persons, who, after examining the premises and hearing the parties, shall report to the court as to the necessity and propriety of such enlargement and as to the quantity, boundaries and value of the land and buildings thereon, if any, **[**which**]** that they deem proper to be taken for such purpose and the damages resulting from such taking. If such committee reports that such enlargement is necessary and proper and the court accepts such report, the decision of said court thereon shall have the effect of a judgment and execution may be issued thereon accordingly, in favor of the person to whom damages may be assessed, for the amount thereof; and, on payment thereof, the title to the land and buildings thereon, if any, for such purpose shall be vested in the complainant, but such land and buildings thereon, if any, shall not be taken until such damages are paid to such owner or deposited with said court, for such owner's use, **[**within**]** not later than thirty days after such report is accepted. If such application is denied, the owner of the land

shall recover costs of the applicant, to be taxed by said court, which may issue execution therefor. Land so taken shall be held by such hospital and used only for the public purpose stated in its complaint to the superior court. No land dedicated or otherwise reserved as open space or park land or for other recreational purposes and no land belonging to any town, city or borough shall be taken under the provisions of this section.

Sec. 64. Subdivision (1) of subsection (a) of section 19a-646 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(1) "Unit" means the Health Systems Planning Unit within the **[**Office of Health Strategy**]** Department of Public Health, established under section 19a-612, as amended by this act;

Sec. 65. Subsections (a) to (d), inclusive, of section 19a-653 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) Any person or health care facility or institution that is required to file a certificate of need for any of the activities described in section 19a-638, and any person or health care facility or institution that is required to file data or information under any public or special act or under this chapter or sections 19a-486 to 19a-486h, inclusive, as amended by this act, or any regulation adopted or order issued under this chapter or said sections, and negligently fails to seek certificate of need approval for any of the activities described in section 19a-638, or to so file within prescribed time periods, and any person or health care facility or institution that has agreed to fully resolve a certificate of need application through settlement and negligently fails to comply with any term or condition enumerated in the settlement agreement, shall be subject to a civil penalty of up to one thousand dollars a day for each day such person or health care facility or institution conducts any of the described activities without certificate of need approval as required by

section 19a-638, for each day such information is missing, incomplete or inaccurate or for each day any condition of a settlement agreement is not met. Any civil penalty authorized by this section shall be imposed by the **[**Office of Health Strategy**]** Department of Public Health in accordance with subsections (b) to (e), inclusive, of this section.

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

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days **[**from**]** after the date of mailing of the notice to make written application to the unit to (1) request a hearing to contest the imposition of the penalty, (2) request an extension of time to file the required data, or (3) comply with enumerated conditions of an agreed settlement. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The **[**Office of Health Strategy**]** Department of Public Health may grant an extension of time for filing the required data or mitigate or waive the penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

(d) A final order of the **[**Office of Health Strategy**]** Department of Public Health assessing a civil penalty shall be subject to appeal as set

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

Sec. 66. Subsections (b) to (g), inclusive, of section 19a-654 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Each short-term acute care general or children's hospital shall submit patient-identifiable inpatient discharge data and emergency department data to the **[**Health Systems Planning Unit of the Office of Health Strategy**]** Department of Public Health to **[**fulfill the**]** (i) assist the department in fulfilling its responsibilities **[**of the unit**]** under chapter 368z, and (ii) for the purposes set forth in section 19a-25 and the regulations promulgated thereunder. Such data shall include data taken from patient medical record abstracts and bills. The **[**unit**]** department shall specify the timing and format of such submissions. Data submitted pursuant to this section may be submitted through a contractual arrangement with an intermediary and such contractual arrangement shall (1) comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191 (HIPAA), and (2) ensure that such submission of data is timely and accurate. The **[**unit**]** department may conduct an audit of the data submitted through such intermediary in order to verify its accuracy.

(c) An outpatient surgical facility, as defined in section 19a-493b, as amended by this act, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the unit the data identified in subsection (c) of section 19a-634. The unit shall convene a working group consisting of

representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. **[**On or before February 1, 2012, the**]** The working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance and real estate **[**. Additional reporting of**]** such outpatient data as the unit deems necessary. **[**shall begin not later than July 1, 2015. On or before July 1, 2018, and annually thereafter,**]** Not later than July first annually, the Connecticut Association of Ambulatory Surgery Centers shall provide a progress report to the **[**Office of Health Strategy**]** Department of Public Health, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that allow for the reporting of outpatient data as required by the **[**commissioner**]** Commissioner of Public Health. Until such additional reporting requirements take effect on July 1, 2015, the department may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

(d) Except as provided in this subsection and section 19a-25, and the regulations promulgated thereunder, patient-identifiable data received by the unit shall be kept confidential by the department and shall not be considered public records or files subject to disclosure under the Freedom of Information Act, as defined in section 1-200. The **[**unit**]** department may release de-identified patient data or aggregate patient data to the public in a manner consistent with the provisions of 45 CFR 164.514. **[**Any de-identified patient data released by the unit shall exclude provider, physician and payer organization names or codes and shall be kept confidential by the recipient. The unit**]** The department may release patient-identifiable data (1) for **[**medical and scientific

research as provided for in section 19a-25-3 of the regulations of Connecticut state agencies, and (2) to (A) a state agency for the purpose of improving health care service delivery, (B)**]** the purposes set forth in and pursuant to section 19a-25 and the regulations promulgated thereunder, and (2) to (A) a federal agency or the office of the Attorney General for the purpose of investigating hospital mergers and acquisitions, **[**(C)**]** (B) another state's health data collection agency with which the unit has entered into a reciprocal data-sharing agreement for the purpose of certificate of need review or evaluation of health care services, upon receipt of a request from such agency, provided, prior to the release of such patient-identifiable data, such agency enters into a written agreement with the unit pursuant to which such agency agrees to protect the confidentiality of such patient-identifiable data and not to use such patient-identifiable data as a basis for any decision concerning a patient, or **[**(D)**]** (C) a consultant or independent professional contracted by the **[**Office of Health Strategy**]** Department of Public Health pursuant to section 19a-614, as amended by this act, to carry out the functions of the **[**unit**]** department, including collecting, managing or organizing such patient-identifiable data. **[**No**]** Except as provided under section 19a-25 and the regulations promulgated thereunder, no individual or entity receiving patient-identifiable data may release such data in any manner that may result in an individual patient, physician, provider or payer being identified. The unit shall impose a reasonable, cost-based fee for any patient data provided to a nongovernmental entity.

(e) Not later than October 1, 2018, the **[**Health Systems Planning Unit**]** department shall enter into a memorandum of understanding with the Comptroller that shall permit the Comptroller to access the data set forth in subsections (b) and (c) of this section, provided the Comptroller agrees, in writing, to keep individual patient and provider data identified by proper name or personal identification code and submitted pursuant to this section confidential.

(f) The Commissioner of **[**Health Strategy**]** Public Health shall adopt

regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

(g) The duties assigned to the **[**Office of Health Strategy**]** Department of Public Health under the provisions of this section shall be implemented within available appropriations.

Sec. 67. Subdivision (1) of section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(1) "Unit" means the Health Systems Planning Unit within the **[**Office of Health Strategy**]** Department of Public Health, established under section 19a-612, as amended by this act;

Sec. 68. Section 19a-673a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of **[**Health Strategy**]** Public Health shall adopt regulations, in accordance with chapter 54, to establish uniform debt collection standards for hospitals.

Sec. 69. Subsection (c) of section 19a-681 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(c) Upon the request of the **[**Office of Health Strategy, established under section 19a-754a**]** Department of Public Health, or a patient, a hospital shall provide to the **[**office**]** department or the patient a detailed patient bill. If the billing detail by line item on a detailed patient bill does not agree with the detailed schedule of charges on file with the unit for the date of service specified on the bill, the hospital shall be subject to a civil penalty of five hundred dollars per occurrence payable to the state not later than fourteen days after the date of notification. The penalty shall be imposed in accordance with section 19a-653, as amended by this act. The unit may issue an order requiring such hospital, not later than

fourteen days after the date of notification of an overcharge to a patient, to adjust the bill to be consistent with the detailed schedule of charges on file with the unit for the date of service specified on the detailed patient bill.

Sec. 70. Subsections (b) to (f), inclusive, of section 19a-754b of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Beginning on January 1, 2020, each sponsor shall submit to the **[**Office of Health Strategy, established in section 19a-754a**]** Department of Public Health, in a form and manner specified by the **[**office**]** department, written notice informing the **[**office**]** department that such sponsor has filed with the federal Food and Drug Administration:

(1) A new drug application or biologics license application for a pipeline drug, not later than sixty days after such sponsor receives an action date from the federal Food and Drug Administration regarding such application; or

(2) A biologics license application for a biosimilar drug, not later than sixty days after such sponsor's receipt of an action date from the federal Food and Drug Administration regarding such application.

(c) (1) Beginning on January 1, 2020, the Commissioner of **[**Health Strategy**]** Public Health may conduct a study, with the assistance of the Comptroller and not more frequently than once annually, of each pharmaceutical manufacturer of a pipeline drug that, in the opinion of the commissioner in consultation with the Comptroller and the Commissioner of Social Services, may have a significant impact on state expenditures for outpatient prescription drugs. The **[**office**]** Department of Public Health may work with the Comptroller to utilize existing state resources and contracts, or contract with a third party, including, but not limited to, an accounting firm, to conduct such study.

(2) Each pharmaceutical manufacturer that is the subject of a study

conducted pursuant to subdivision (1) of this subsection shall submit to the **[**office**]** Department of Public Health, or any contractor engaged by the **[**office**]** department or the Comptroller to perform such study, the following information for the pipeline drug that is the subject of such study:

(A) The primary disease, condition or therapeutic area studied in connection with such drug, and whether such drug is therapeutically indicated for such disease, condition or therapeutic area;

(B) Each route of administration studied for such drug;

(C) Clinical trial comparators, if applicable, for such drug;

(D) The estimated year of market entry for such drug;

(E) Whether the federal Food and Drug Administration has designated such drug as an orphan drug, a fast track product or a breakthrough therapy; and

(F) Whether the federal Food and Drug Administration has designated such drug for accelerated approval and, if such drug contains a new molecular entity, for priority review.

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

(2) Prior to publishing the annual list pursuant to subdivision (1) of

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

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

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

development costs and such other capital expenditures that the commissioner, in the commissioner's discretion, deems relevant for the most recent year for which final audited data are available.

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

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

(e) The **[**office**]** Department of Public Health may impose a penalty of not more than seven thousand five hundred dollars on a pharmaceutical manufacturer or sponsor for each violation of this section by the pharmaceutical manufacturer or sponsor.

(f) The **[**office**]** Department of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of this section.

Sec. 71. Subsections (a) to (c), inclusive, of section 19a-754c of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) For the purposes of this section:

(1) "Affordable Care Act" has the same meaning as provided in section 38a-1080;

(2) "Covered Connecticut program" means the program established under subsection (b) of this section;

(3) "Exchange" has the same meaning as provided in section 38a-1080;

(4) "Health carrier" has the same meaning as provided in section 38a-1080;

(5) "Individual market" has the same meaning as provided in 42 USC 18024(a), as amended from time to time; and

[(6) "Office of Health Strategy" means the Office of Health Strategy established under section 19a-754a; and**]**

[(7)**]** (6) "Silver level" has the same meaning as provided in 42 USC 18022(d), as amended from time to time.

(b) There is established within the Department of Social Services the Covered Connecticut program for the purpose of reducing the state's uninsured rate. The Commissioner of Social Services shall administer said program in consultation with the **[**Office of Health Strategy,**]** Insurance Commissioner and exchange, and, as part of said program, the Department of Social Services shall:

(1) Provide premium and cost-sharing subsidies that are sufficient to ensure fully subsidized coverage:

(A) On and after July 1, 2021, for parents and needy caretaker relatives, and their tax dependents not older than twenty-six years of age, who (i) are eligible for premium and cost-sharing subsidies for a qualified health plan, (ii) are ineligible for Medicaid because their income exceeds the Medicaid income limits under chapter 319v, (iii) have household income up to one hundred seventy-five per cent of the federal poverty level, (iv) are receiving coverage under a qualified health plan offered through the exchange in the individual market at a silver level of coverage, and (v) are utilizing the full amount of applicable premium subsidies for such plan;

(B) On and after July 1, 2021, for the following additional family members of parents and caretaker relatives receiving coverage under such qualified health plan, provided the requirements of subparagraph (A) of subdivision (1) of this subsection are met: (i) A child over twenty-six years of age who is permanently and totally disabled, as defined by the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who is over the age of twenty-six and is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the parent or caretaker relative for support and maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a child or stepchild receiving coverage under such qualified health plan as described in sections 38a-497 and 38a-512b;

(C) On and after July 1, 2022, for all parents, needy caretaker relatives and low-income adults who (i) are at least nineteen but not more than sixty-four years of age, (ii) are eligible for premium and cost-sharing subsidies for a qualified health plan, (iii) are ineligible for Medicaid because their income exceeds the Medicaid income limits under chapter 319v, (iv) have household income up to one hundred seventy-five per cent of the federal poverty level, (v) are receiving coverage under a qualified health plan offered through the exchange in the individual market at a silver level of coverage, and (vi) are utilizing the full amount of applicable premium subsidies for such plan; and

(D) On and after July 1, 2022, for the following additional family members of parents, caretaker relatives, and adults receiving coverage under such qualified health plan, provided the requirements of subparagraph (C) of subdivision (1) of this subsection are met: (i) A child over twenty-six years of age who is permanently and totally disabled, as defined by the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who is over the age of twenty-six and is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the parent or caretaker relative for support and maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a child or stepchild, as described in sections 38a-497 and 38a-512b.

(2) Not earlier than July 1, 2022, provide dental and nonemergency medical transportation services, as provided under chapter 319v, to all eligible individuals described in subdivision (1) of this subsection;

(3) Establish procedures to, on a quarterly basis, pay in reimbursement to each health carrier offering the qualified health plan described in subparagraph (A) or (B) of subdivision (1) of this subsection, as applicable, the premium and cost-sharing subsidies required under subdivision (1) of this subsection to ensure fully subsidized coverage; and

(4) Consult with the **[**Office of Health Strategy and**]** Insurance Commissioner for the purposes set forth in section 17b-312, as amended by this act.

(c) (1) The **[**Office of Health Strategy**]** Department of Social Services may, subject to the approval required under subdivision (3) of this subsection, seek a waiver pursuant to Section 1332 of the Affordable Care Act, as amended from time to time, to advance the purpose of the Covered Connecticut program. The **[**Office of Health Strategy**]** department shall implement such waiver if the federal government issues such waiver.

(2) The **[**Office of Health Strategy**]** Commissioner of Social Services shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance containing any proposed waiver described in subdivision (1) of this subsection before seeking such waiver from the federal government.

(3) Not later than thirty days after the **[**Office of Health Strategy**]** Commissioner of Social Services submits a report under subdivision (2) of this subsection, the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services and insurance shall convene a joint public hearing on the proposed waiver contained in the report submitted pursuant to

subdivision (2) of this subsection, separately vote to approve or reject such proposed waiver and advise the **[**Office of Health Strategy**]** commissioner of their approval or rejection of such proposed waiver. If any committee takes no action on such proposed waiver within the thirty-day period, the proposed waiver shall be deemed rejected.

Sec. 72. Section 19a-754d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) **[**On and after January 1, 2022, any**]** Any state agency, board or commission that directly, or by contract with another entity, collects demographic data concerning the ancestry or ethnic origin, ethnicity, race or primary language of residents of the state in the context of health care or for the provision or receipt of health care services or for any public health purpose shall:

(1) Collect such data in a manner that allows for aggregation and disaggregation of data;

(2) Expand race and ethnicity categories to include subgroup identities as specified by the **[**Community and Clinical Integration Program of the Office of Health Strategy**]** Office of Policy and Management and follow the hierarchical mapping to align with United States Office of Management and Budget standards;

(3) Provide the option to individuals of selecting one or more ethnic or racial designations and include an "other" designation with the ability to write in identities not represented by other codes;

(4) Provide the option to individuals to refuse to identify with any ethnic or racial designations;

(5) Collect primary language data employing language codes set by the International Organization for Standardization; and

(6) Ensure, in cases where data concerning an individual's ethnic origin, ethnicity or race is reported to any other state agency, board or

commission, that such data is neither tabulated nor reported without all of the following information: (A) The number or percentage of individuals who identify with each ethnic or racial designation as their sole ethnic or racial designation and not in combination with any other ethnic or racial designation; (B) the number or percentage of individuals who identify with each ethnic or racial designation, whether as their sole ethnic or racial designation or in combination with other ethnic or racial designations; (C) the number or percentage of individuals who identify with multiple ethnic or racial designations; and (D) the number or percentage of individuals who do not identify or refuse to identify with any ethnic or racial designations.

(b) Each health care provider with an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange as specified in section 17b-59e, as amended by this act, shall, collect and include in its electronic health record system self-reported patient demographic data including, but not limited to, race, ethnicity, primary language, insurance status and disability status based upon the implementation plan developed **[**under subsection (c) of this section**]** in consultation with consumer advocates, health equity experts, state agencies and health care providers for the changes required by this section. Race and ethnicity data shall adhere to standard categories as determined in subsection (a) of this section.

[(c) Not later than August 1, 2021, the Office of Health Strategy shall consult with consumer advocates, health equity experts, state agencies and health care providers, to create an implementation plan for the changes required by this section.**]**

[(d)**]** (c) The Office of **[**Health Strategy**]** Policy and Management shall (1) review (A) demographic changes in race and ethnicity, as determined by the U.S. Census Bureau, and (B) health data collected by the state, and (2) reevaluate the standard race and ethnicity categories from time to time, in consultation with health care providers, consumers and the joint standing committee of the General Assembly having

cognizance of matters relating to public health.

Sec. 73. Section 19a-754f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

For the purposes of this section and sections 19a-754g to 19a-754k, inclusive, as amended by this act:

(1) "Drug manufacturer" means the manufacturer of a drug that is: (A) Included in the information and data submitted by a health carrier pursuant to section 38a-479qqq, (B) studied or listed pursuant to subsection (c) or (d) of section 19a-754b, as amended by this act, or (C) in a therapeutic class of drugs that the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management determines, through public or private reports, has had a substantial impact on prescription drug expenditures, net of rebates, as a percentage of total health care expenditures;

[(2) "Commissioner" means the Commissioner of Health Strategy;**]**

[(3)**]** (2) "Health care cost growth benchmark" means the annual benchmark established pursuant to section 19a-754g, as amended by this act;

[(4)**]** (3) "Health care quality benchmark" means an annual benchmark established pursuant to section 19a-754g, as amended by this act;

[(5)**]** (4) "Health care provider" has the same meaning as provided in subdivision (1) of subsection (a) of section 19a-17b;

[(6)**]** (5) "Net cost of private health insurance" means the difference between premiums earned and benefits incurred, and includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, net additions or subtractions from reserves, rate credits and dividends, premium taxes and profits or losses;

[(7)**]** (6) "Office" means the Office of **[**Health Strategy established under section 19a-754a**]** Policy and Management;

[(8)**]** (7) "Other entity" means a drug manufacturer, pharmacy benefits manager or other health care provider that is not considered a provider entity;

[(9)**]** (8) "Payer" means a payer, including Medicaid, Medicare and governmental and nongovernment health plans, and includes any organization acting as payer that is a subsidiary, affiliate or business owned or controlled by a payer that, during a given calendar year, pays health care providers for health care services or pharmacies or provider entities for prescription drugs designated by the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management;

[(10)**]** (9) "Performance year" means the most recent calendar year for which data were submitted for the applicable health care cost growth benchmark, primary care spending target or health care quality benchmark;

[(11)**]** (10) "Pharmacy benefits manager" has the same meaning as provided in subdivision (10) of section 38a-479ooo;

[(12)**]** (11) "Primary care spending target" means the annual target established pursuant to section 19a-754g, as amended by this act;

[(13)**]** (12) "Provider entity" means an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract;

[(14)**]** (13) "Potential gross state product" means a forecasted measure of the economy that equals the sum of the (A) expected growth in national labor force productivity, (B) expected growth in the state's labor

force, and (C) expected national inflation, minus the expected state population growth;

(14) "Secretary" means the Secretary of the Office of Policy and Management;

(15) "Total health care expenditures" means the sum of all health care expenditures in this state from public and private sources for a given calendar year, including: (A) All claims-based spending paid to providers, net of pharmacy rebates, (B) all patient cost-sharing amounts, and (C) the net cost of private health insurance; and

(16) "Total medical expense" means the total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of (A) all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates, (B) all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments, and (C) all patient cost-sharing amounts expressed on a per capita basis for the patient population of a payer or provider entity in this state.

Sec. 74. Section 19a-754g of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

[(a) Not later than July 1, 2022, the commissioner shall publish (1) the health care cost growth benchmarks and annual primary care spending targets as a percentage of total medical expenses for the calendar years 2021 to 2025, inclusive, and (2) the annual health care quality benchmarks for the calendar years 2022 to 2025, inclusive, on the office's Internet web site.**]**

[(b)**]** (a) (1) (A) Not later than July 1, 2025, and every five years thereafter, the **[**commissioner**]** secretary shall develop and adopt annual health care cost growth benchmarks and annual primary care spending

targets for the succeeding five calendar years for provider entities and payers.

(B) In developing the health care cost growth benchmarks and primary care spending targets pursuant to this subdivision, the **[**commissioner**]** secretary shall consider (i) any historical and forecasted changes in median income for individuals in the state and the growth rate of potential gross state product, (ii) the rate of inflation, and (iii) the most recent report prepared by the **[**commissioner**]** secretary pursuant to subsection (b) of section 19a-754h, as amended by this act.

(C) (i) The **[**commissioner**]** secretary shall hold at least one informational public hearing prior to adopting the health care cost growth benchmarks and primary care spending targets for each succeeding five-year period described in this subdivision. The **[**commissioner**]** secretary may hold informational public hearings concerning any annual health care cost growth benchmark and primary care spending target set pursuant to **[**subsection (a) of this section or**]** this subdivision. **[**(1) of subsection (b) of this section.**]** Such informational public hearings shall be held at a time and place designated by the **[**commissioner**]** secretary in a notice prominently posted by the **[**commissioner**]** secretary on the office's Internet web site and in a form and manner prescribed by the **[**commissioner**]** secretary. The **[**commissioner**]** secretary shall make available on the office's Internet web site a summary of any such informational public hearing and include the **[**commissioner's**]** secretary's recommendations, if any, to modify or not to modify any such annual benchmark or target.

(ii) If the **[**commissioner**]** secretary determines, after any informational public hearing held pursuant to this subparagraph, that a modification to any health care cost growth benchmark or annual primary care spending target is, in the **[**commissioner's**]** secretary's discretion, reasonably warranted, the **[**commissioner**]** secretary may modify such benchmark or target.

(iii) The **[**commissioner**]** secretary shall annually (I) review the current and projected rate of inflation, and (II) include on the office's Internet web site the **[**commissioner's**]** secretary's findings of such review, including the reasons for making or not making a modification to any applicable health care cost growth benchmark. If the **[**commissioner**]** secretary determines that the rate of inflation requires modification of any health care cost growth benchmark adopted under this section, the **[**commissioner**]** secretary may modify such benchmark. In such event, the **[**commissioner**]** secretary shall not be required to hold an informational public hearing concerning such modified health care cost growth benchmark.

(D) The **[**commissioner**]** secretary shall post each adopted health care cost growth benchmark and annual primary care spending target on the office's Internet web site.

(E) Notwithstanding the provisions of subparagraphs (A) to (D), inclusive, of this subdivision, if the average annual health care cost growth benchmark for a succeeding five-year period described in this subdivision differs from the average annual health care cost growth benchmark for the five-year period preceding such succeeding five-year period by more than one-half of one per cent, the **[**commissioner**]** secretary shall submit the annual health care cost growth benchmarks developed for such succeeding five-year period to the joint standing committee of the General Assembly having cognizance of matters relating to insurance for the committee's review and approval. The committee shall be deemed to have approved such annual health care cost growth benchmarks for such succeeding five-year period, except upon a vote to reject such benchmarks by the majority of committee members at a meeting of such committee called for the purpose of reviewing such benchmarks and held not later than thirty days after the **[**commissioner**]** secretary submitted such benchmarks to such committee. If the committee votes to reject such benchmarks, the **[**commissioner**]** secretary may submit to the committee modified annual health care cost growth benchmarks for such succeeding five-year

period for the committee's review and approval in accordance with the provisions of this subparagraph. The **[**commissioner**]** secretary shall not be required to hold an informational public hearing concerning such modified benchmarks. Until the joint standing committee of the General Assembly having cognizance of matters relating to insurance approves annual health care cost growth benchmarks for the succeeding five-year period, such benchmarks shall be deemed to be equal to the average annual health care cost growth benchmark for the preceding five-year period.

(2) (A) Not later than July 1, 2025, and every five years thereafter, the **[**commissioner**]** secretary shall develop and adopt annual health care quality benchmarks for the succeeding five calendar years for provider entities and payers.

(B) In developing annual health care quality benchmarks pursuant to this subdivision, the **[**commissioner**]** secretary shall consider (i) quality measures endorsed by nationally recognized organizations, including, but not limited to, the National Quality Forum, the National Committee for Quality Assurance, the Centers for Medicare and Medicaid Services, the National Centers for Disease Control and Prevention, the Joint Commission and expert organizations that develop health equity measures, and (ii) measures that: (I) Concern health outcomes, overutilization, underutilization and patient safety, (II) meet standards of patient-centeredness and ensure consideration of differences in preferences and clinical characteristics within patient subpopulations, and (III) concern community health or population health.

(C) (i) The **[**commissioner**]** secretary shall hold at least one informational public hearing prior to adopting the health care quality benchmarks for each succeeding five-year period described in this subdivision. The **[**commissioner**]** secretary may hold informational public hearings concerning the quality measures the **[**commissioner**]** secretary proposes to adopt as health care quality benchmarks. Such informational public hearings shall be held at a time and place

designated by the **[**commissioner**]** secretary in a notice prominently posted by the **[**commissioner**]** secretary on the office's Internet web site and in a form and manner prescribed by the **[**commissioner**]** secretary. The **[**commissioner**]** secretary shall make available on the office's Internet web site a summary of any such informational public hearing and include the recommendations, if any, to modify or not modify any such health care quality benchmark.

(ii) If the **[**commissioner**]** secretary determines, after any informational public hearing held pursuant to this subparagraph, that modifications to any health care quality benchmarks are, in the **[**commissioner's**]** secretary's discretion, reasonably warranted, the **[**commissioner**]** secretary may modify such quality benchmarks. The **[**commissioner**]** secretary shall not be required to hold an additional informational public hearing concerning such modified quality benchmarks.

(D) The **[**commissioner**]** secretary shall post each adopted health care quality benchmark on the office's Internet web site.

(c) The **[**commissioner**]** secretary may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants.

Sec. 75. Section 19a-754h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) Not later than August **[**15, 2022, and**]** fifteenth annually**,** **[**thereafter,**]** each payer shall report to the **[**commissioner**]** secretary, in a form and manner prescribed by the **[**commissioner**]** secretary, for the preceding or prior years, if the **[**commissioner**]** secretary so requests based on material changes to data previously submitted, aggregated data, including aggregated self-funded data as applicable, necessary for the **[**commissioner**]** secretary to calculate total health care expenditures, primary care spending as a percentage of total medical expenses and net

cost of private health insurance. Each payer shall also disclose, as requested by the **[**commissioner**]** secretary, payer data required for adjusting total medical expense calculations to reflect changes in the patient population.

(b) Not later than March **[**31, 2023, and**]** thirty-first annually, **[**thereafter,**]** the **[**commissioner**]** secretary shall prepare and post on the office's Internet web site, a report concerning the total health care expenditures utilizing the total aggregate medical expenses reported by payers pursuant to subsection (a) of this section, including, but not limited to, a breakdown of such population-adjusted total medical expenses by payer and provider entities. The report may include, but **[**shall**]** need not be limited to, information regarding the following:

(1) Trends in major service category spending;

(2) Primary care spending as a percentage of total medical expenses;

(3) The net cost of private health insurance by payer by market segment, including individual, small group, large group, self-insured, student and Medicare Advantage markets; and

(4) Any other factors the **[**commissioner**]** secretary deems relevant to providing context on such data, which shall include, but not be limited to, the following factors: (A) The impact of the rate of inflation and rate of medical inflation; (B) impacts, if any, on access to care; and (C) responses to public health crises or similar emergencies.

(c) The **[**commissioner**]** secretary shall annually submit a request to the federal Centers for Medicare and Medicaid Services for the unadjusted total medical expenses of Connecticut residents.

(d) Not later than August **[**15, 2023, and**]** fifteenth annually, **[**thereafter,**]** each payer or provider entity shall report to the **[**commissioner**]** secretary, in a form and manner prescribed by the **[**commissioner**]** secretary, for the preceding year, and for prior years if

the **[**commissioner**]** secretary so requests based on material changes to data previously submitted, on the health care quality benchmarks adopted pursuant to section 19a-754g, as amended by this act.

(e) Not later than March **[**31, 2024, and**]** thirty-first annually, **[**thereafter,**]** the **[**commissioner**]** secretary shall prepare and post on the office's Internet web site, a report concerning health care quality benchmarks reported by payers and provider entities pursuant to subsection (d) of this section.

(f) The commissioner may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants.

Sec. 76. Section 19a-754i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) (1) For each calendar year, beginning on January 1, 2023, the **[**commissioner**]** secretary shall, if the payer or provider entity subject to the cost growth benchmark or primary care spending target **[**so**]** requests **[**,**]** a meeting, the secretary shall meet with such payer or provider entity to review and validate the total medical expenses data collected pursuant to section 19a-754h, as amended by this act, for such payer or provider entity. The **[**commissioner**]** secretary shall review information provided by the payer or provider entity and, if deemed necessary, amend findings for such payer or provider prior to the identification of payer or provider entities that exceeded the health care cost growth benchmark or failed to meet the primary care spending target for the performance year as set forth in section 19a-754h, as amended by this act. The **[**commissioner**]** secretary shall identify, not later than May first of such calendar year, each payer or provider entity that exceeded the health care cost growth benchmark or failed to meet the primary care spending target for the performance year.

(2) For each calendar year beginning on or after January 1, 2024, the

[commissioner**]** secretary shall, if the payer or provider entity subject to the health care quality benchmarks for the performance year **[**so**]** requests **[**,**]** a meeting, the secretary shall meet with such payer or provider entity to review and validate the quality data collected pursuant to section 19a-754h, as amended by this act, for such payer or provider entity. The **[**commissioner**]** secretary shall review information provided by the payer or provider entity and, if deemed necessary, amend findings for such payer or provider prior to the identification of payer or provider entities that exceeded the health care quality benchmark as set forth in section 19a-754h, as amended by this act. The **[**commissioner**]** secretary shall identify, not later than May first of such calendar year, each payer or provider entity that exceeded the health care quality benchmark for the performance year.

(3) Not later than thirty days after the **[**commissioner**]** secretary identifies each payer or provider entity pursuant to subdivisions (1) and (2) of this subsection, the **[**commissioner**]** secretary shall send a notice to each such payer or provider entity. Such notice shall be in a form and manner prescribed by the **[**commissioner**]** secretary, and shall disclose to each such payer or provider entity:

(A) That the **[**commissioner**]** secretary has identified such payer or provider entity pursuant to subdivision (1) or (2) of this subsection; and

(B) The factual basis for the **[**commissioner's**]** secretary's identification of such payer or provider entity pursuant to subdivision (1) or (2) of this subsection.

(b) (1) For each calendar year beginning on and after January 1, 2023, if the **[**commissioner**]** secretary determines that the annual percentage change in total health care expenditures for the performance year exceeded the health care cost growth benchmark for such year, the **[**commissioner**]** secretary shall identify, not later than May first of such calendar year, any other entity that significantly contributed to exceeding such benchmark. Each identification shall be based on:

(A) The report prepared by the **[**commissioner**]** secretary pursuant to subsection (b) of section 19a-754h, as amended by this act, for such calendar year;

(B) The report filed pursuant to section 38a-479ppp for such calendar year;

(C) The information and data reported to the office pursuant to subsection (d) of section 19a-754b, as amended by this act, for such calendar year;

(D) Information obtained from the all-payer claims database established under section 19a-755a, as amended by this act; and

(E) Any other information that the **[**commissioner**]** secretary, in the **[**commissioner's**]** secretary's discretion, deems relevant for the purposes of this section.

(2) The **[**commissioner**]** secretary shall account for costs, net of rebates and discounts, when identifying other entities pursuant to this section.

Sec. 77. Section 19a-754j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) (1) Not later than June **[**30, 2023, and**]** thirtieth annually, **[**thereafter,**]** the **[**commissioner**]** secretary shall hold an informational public hearing to compare the growth in total health care expenditures in the performance year to the health care cost growth benchmark established pursuant to section 19a-754g, as amended by this act, for such year. Such hearing shall involve an examination of:

(A) The report most recently prepared by the **[**commissioner**]** secretary pursuant to subsection (b) of section 19a-754h, as amended by this act;

(B) The expenditures of provider entities and payers, including, but not limited to, health care cost trends, primary care spending as a

percentage of total medical expenses and the factors contributing to such costs and expenditures; and

(C) Any other matters that the **[**commissioner**]** secretary, in the **[**commissioner's**]** secretary's discretion, deems relevant for the purposes of this section.

(2) The **[**commissioner**]** secretary may require any payer or provider entity that, for the performance year, is found to be a significant contributor to health care cost growth in the state or has failed to meet the primary care spending target, to participate in such hearing. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the **[**commissioner**]** secretary and provide additional information on actions taken to reduce such payer's or entity's contribution to future state-wide health care costs and expenditures or to increase such payer's or provider entity's primary care spending as a percentage of total medical expenses.

(3) The **[**commissioner**]** secretary may require that any other entity that is found to be a significant contributor to health care cost growth in this state during the performance year participate in such hearing. Any other entity that is required to participate in such hearing shall provide testimony on issues identified by the **[**commissioner**]** secretary and provide additional information on actions taken to reduce such other entity's contribution to future state-wide health care costs. If such other entity is a drug manufacturer, and the **[**commissioner**]** secretary requires that such drug manufacturer participate in such hearing with respect to a specific drug or class of drugs, such hearing may, to the extent possible, include representatives from at least one brand-name manufacturer, one generic manufacturer and one innovator company that is less than ten years old.

(4) Not later than October **[**15, 2023, and**]** fifteenth annually, **[**thereafter,**]** the **[**commissioner**]** secretary shall prepare and submit a

report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the **[**commissioner's**]** secretary's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the **[**commissioner**]** secretary, in the **[**commissioner's**]** secretary's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care spending trends in this state, including, but not limited to, trends in primary care spending as a percentage of total medical expense, and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (b) of section 19a-754h, as amended by this act;

(C) Describe a plan for monitoring any unintended adverse consequences resulting from the adoption of cost growth benchmarks and primary care spending targets and the results of any findings from the implementation of such plan; and

(D) Disclose the **[**commissioner's**]** secretary's recommendations, if any, concerning strategies to increase the efficiency of the state's health care system, including, but not limited to, any recommended legislation concerning the state's health care system.

(b) (1) Not later than June **[**30, 2024, and**]** thirtieth annually, **[**thereafter,**]** the **[**commissioner**]** secretary shall hold an informational public hearing to compare the performance of payers and provider entities in the performance year to the quality benchmarks established for such year pursuant to section 19a-754g, as amended by this act. Such hearing shall include an examination of:

(A) The report most recently prepared by the **[**commissioner**]** secretary pursuant to subsection (e) of section 19a-754h, as amended by this act; and

(B) Any other matters that the **[**commissioner**]** secretary, in the **[**commissioner's**]** secretary's discretion, deems relevant for the purposes of this section.

(2) The **[**commissioner**]** secretary may require any payer or provider entity that failed to meet any health care quality benchmarks in this state during the performance year to participate in such hearing. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the **[**commissioner**]** secretary and provide additional information on actions taken to improve such payer's or provider entity's quality benchmark performance.

(3) Not later than October **[**15, 2024, and**]** fifteenth annually, **[**thereafter,**]** the **[**commissioner**]** secretary shall prepare and submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the **[**commissioner's**]** secretary's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the **[**commissioner**]** secretary, in the **[**commissioner's**]** secretary's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care quality trends in this state and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (e) of section 19a-754h, as amended by this act; and

(C) Disclose the **[**commissioner's**]** secretary's recommendations, if any, concerning strategies to improve the quality of the state's health care system, including, but not limited to, any recommended legislation concerning the state's health care system.

Sec. 78. Section 19a-754k of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2026*):

The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management may adopt regulations, in accordance with chapter 54, to implement the provisions of **[**section 19a-754a and**]** sections 19a-754f to 19a-754j, inclusive, as amended by this act.

Sec. 79. Section 19a-755a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) As used in this section:

(1) "All-payer claims database" means a database that receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.

(2) (A) "Reporting entity" means:

(i) An insurer, as described in section 38a-1, licensed to do health insurance business in this state;

(ii) A health care center, as defined in section 38a-175;

(iii) An insurer or health care center that provides coverage under Part C or Part D of Title XVIII of the Social Security Act, as amended from time to time, to residents of this state;

(iv) A third-party administrator, as defined in section 38a-720;

(v) A pharmacy benefits manager, as defined in section 38a-479aaa;

(vi) A hospital service corporation, as defined in section 38a-199;

(vii) A nonprofit medical service corporation, as defined in section 38a-214;

(viii) A fraternal benefit society, as described in section 38a-595, that

transacts health insurance business in this state;

(ix) A dental plan organization, as defined in section 38a-577;

(x) A preferred provider network, as defined in section 38a-479aa; and

(xi) Any other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments.

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

(3) "Medicaid data" means the Medicaid provider registry, health claims data and Medicaid recipient data maintained by the Department of Social Services.

(4) "CHIP data" means the provider registry, health claims data and recipient data maintained by the Department of Social Services to administer the Children's Health Insurance Program.

(b) (1) There is established an all-payer claims database program. The Office of **[**Health Strategy**]** Policy and Management shall: (A) Oversee the planning, implementation and administration of the all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care; (B) ensure that data received is securely collected, compiled and stored in accordance with state and federal law; (C) conduct audits of data submitted by reporting entities in order to verify its accuracy; and (D) in consultation with the Health Information Technology Advisory Council established under section 17b-59f, as amended by this act, maintain written procedures for

the administration of such all-payer claims database. Any such written procedures shall include (i) reporting requirements for reporting entities, and (ii) requirements for providing notice to a reporting entity regarding any alleged failure on the part of such reporting entity to comply with such reporting requirements.

(2) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall seek funding from the federal government, other public sources and other private sources to cover costs associated with the planning, implementation and administration of the all-payer claims database program.

(3) (A) Upon the adoption of reporting requirements as set forth in subdivision (1) of this subsection, a reporting entity shall report health care information for inclusion in the all-payer claims database in a form and manner prescribed by the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management. The **[**commissioner**]** secretary may, after notice and hearing, impose a civil penalty on any reporting entity that fails to report health care information as prescribed. Such civil penalty shall not exceed one thousand dollars per day for each day of violation and shall not be imposed as a cost for the purpose of rate determination or reimbursement by a third-party payer.

(B) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management may provide the name of any reporting entity on which such penalty has been imposed to the Insurance Commissioner. After consultation with the **[**Commissioner of Health Strategy**]** secretary, the Insurance Commissioner may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any penalty imposed pursuant to subparagraph (A) of this subdivision.

(4) The Commissioner of Social Services shall submit Medicaid and CHIP data to the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management for inclusion in the all-payer claims

database only for purposes related to administration of the State Medicaid and CHIP Plans, in accordance with 42 CFR 431.301 to 42 CFR 431.306, inclusive.

(5) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management shall: (A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services for the purpose of allowing such consumers to make economically sound and medically appropriate health care decisions; and (B) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. If health information, as defined in 45 CFR 160.103, as amended from time to time, is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder, any disclosure thereof made pursuant to this subdivision shall have identifiers removed, as set forth in 45 CFR 164.514, as amended from time to time. Any disclosure made pursuant to this subdivision of information other than health information shall be made in a manner to protect the confidentiality of such other information as required by state and federal law. The **[**Commissioner of Health Strategy**]** secretary may set a fee to be charged to each person or entity requesting access to data stored in the all-payer claims database.

(6) The **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management may (A) in consultation with the All-Payer Claims Database Advisory Group set forth in section 17b-59f, as amended by this act, enter into a contract with a person or entity to plan, implement or administer the all-payer claims database program, (B) enter into a contract or take any action that is necessary to obtain data that is the same data required to be submitted by reporting entities under Medicare Part A or Part B, (C) enter into a contract for the

collection, management or analysis of data received from reporting entities, and (D) in accordance with subdivision (4) of this subsection, enter into a contract or take any action that is necessary to obtain Medicaid and CHIP data. Any such contract for the collection, management or analysis of such data shall expressly prohibit the disclosure of such data for purposes other than the purposes described in this subsection.

(c) Unless otherwise specified, nothing in this section and no action taken by the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management pursuant to this section or section 19a-755b, as amended by this act, shall be construed to preempt, supersede or affect the authority of the Insurance Commissioner to regulate the business of insurance in the state.

Sec. 80. Section 19a-755b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) For purposes of this section and sections 19a-904a, 19a-904b and 38a-477d to 38a-477f, inclusive:

(1) "Allowed amount" means the maximum reimbursement dollar amount that an insured's health insurance policy allows for a specific procedure or service;

(2) "Consumer health information Internet web site" means an Internet web site developed and operated by the Office of **[**Health Strategy**]** Policy and Management to assist consumers in making informed decisions concerning their health care and informed choices among health care providers;

(3) "Episode of care" means all health care services related to the treatment of a condition or a service category for such treatment and, for acute conditions, includes health care services and treatment provided from the onset of the condition to its resolution or a service category for such treatment and, for chronic conditions, includes health

care services and treatment provided over a given period of time or a service category for such treatment;

[(4) "Commissioner" means the Commissioner of Health Strategy;**]**

[(5)**]** (4) "Health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services;

[(6)**]** (5) "Health carrier" means any insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity delivering, issuing for delivery, renewing, amending or continuing any individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

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

[(8)**]** (7) "Out-of-pocket costs" means costs that are not reimbursed by a health insurance policy and includes deductibles, coinsurance and copayments for covered services and other costs to the consumer associated with a procedure or service;

[(9)**]** (8) "Outpatient surgical facility" has the same meaning as provided in section 19a-493b, as amended by this act; **[**and**]**

[(10)**]** (9) "Public or private third party" means the state, the federal government, employers, a health carrier, third-party administrator, as defined in section 38a-720, or managed care organization; and

(10) "Secretary" means the Secretary of the Office of Policy and Management.

(b) (1) Within available resources, the consumer health information Internet web site shall: (A) Contain information comparing the quality, price and cost of health care services, including, to the extent practicable,

(i) comparative price and cost information for the health care services and procedures reported pursuant to subsection (c) of this section categorized by payer or listed by health care provider, (ii) links to Internet web sites and consumer tools where consumers may obtain comparative cost and quality information, including The Joint Commission and Medicare hospital compare tool, (iii) definitions of common health insurance and medical terms so consumers may compare health coverage and understand the terms of their coverage, and (iv) factors consumers should consider when choosing an insurance product or provider group, including provider network, premium, cost sharing, covered services and tier information; (B) be designed to assist consumers and institutional purchasers in making informed decisions regarding their health care and informed choices among health care providers and, to the extent practicable, provide reference pricing for services paid by various health carriers to health care providers; (C) present information in language and a format that is understandable to the average consumer; and (D) be publicized to the general public. All information outlined in this section shall be posted on an Internet web site established, or to be established, by the **[**Commissioner of Health Strategy**]** secretary in a manner and time frame as may be organizationally and financially reasonable in **[**his or her**]** the secretary's sole discretion.

(2) Information collected, stored and published by the Office of **[**Health Strategy**]** Policy and Management pursuant to this section is subject to the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time.

(3) The **[**Commissioner of Health Strategy**]** secretary may consider adding quality measures to the consumer health information Internet web site.

(c) Not later than January **[**1, 2018, and**]** first annually, **[**thereafter,**]** the **[**Commissioner of Health Strategy**]** secretary shall, to the extent the information is available, make available to the public on the consumer

health information Internet web site a list of: (1) The fifty most frequently occurring inpatient services or procedures in the state; (2) the fifty most frequently provided outpatient services or procedures in the state; (3) the twenty-five most frequent surgical services or procedures in the state; (4) the twenty-five most frequent imaging services or procedures in the state; and (5) the twenty-five most frequently used pharmaceutical products and medical devices in the state. Such lists may (A) be expanded to include additional admissions and procedures, (B) be based upon those services and procedures that are most commonly performed by volume or that represent the greatest percentage of related health care expenditures, or (C) be designed to include those services and procedures most likely to result in out-of-pocket costs to consumers or include bundled episodes of care.

(d) Not later than January **[**1, 2018, and**]** first annually, **[**thereafter,**]** to the extent practicable, the **[**Commissioner of Health Strategy**]** secretary shall issue a report, in a form and manner prescribed by the **[**commissioner**]** secretary, that includes the (1) billed and allowed amounts paid to health care providers in each health carrier's network for each service and procedure included pursuant to subsection (c) of this section, and (2) out-of-pocket costs for each such service and procedure.

(e) (1) **[**On and after January 1, 2018, each**]** Each hospital shall, at the time of scheduling a service or procedure for nonemergency care that is included in the report prepared by the **[**Commissioner of Health Strategy**]** secretary pursuant to subsection (d) of this section, regardless of the location or setting where such services are delivered, notify the patient of the patient's right to make a request for cost and quality information. Upon the request of a patient for a diagnosis or procedure included in such report, the hospital shall, not later than three business days after scheduling such service or procedure, provide written notice, electronically or by mail, to the patient who is the subject of the service or procedure concerning: (A) If the patient is uninsured, the amount to be charged for the service or procedure if all charges are paid in full

without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the service or procedure, including the amount of any facility fee; (B) the corresponding Medicare reimbursement amount or, if there is no corresponding Medicare reimbursement amount for such diagnosis or procedure, (i) the approximate amount Medicare would have paid the hospital for the services on the billing statement, or (ii) the percentage of the hospital's charges that Medicare would have paid the hospital for the services; (C) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs; (D) The Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

(2) If the patient is insured and the hospital is out-of-network under the patient's health insurance policy, such written notice shall include a statement that the service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply.

Sec. 81. Subsection (b) of section 19a-911 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) The Council on Protecting Women's Health shall be comprised of (1) the following ex-officio voting members: (A) The Commissioner of Public Health, or the commissioner's designee; (B) the Commissioner of Mental Health and Addiction Services, or the commissioner's designee; (C) the Insurance Commissioner, or the commissioner's designee; (D)

[the Commissioner of Health Strategy, or the commissioner's designee; (E)**]** the Healthcare Advocate, or the Healthcare Advocate's designee; and **[**(F)**]** (E) the Secretary of the Office of Policy and Management, or the secretary's designee; and (2) fourteen public members, three of whom shall be appointed by the president pro tempore of the Senate, three of whom shall be appointed by the speaker of the House of Representatives, two of whom shall be appointed by the majority leader of the Senate, two of whom shall be appointed by the majority leader of the House of Representatives, two of whom shall be appointed by the minority leader of the Senate and two of whom shall be appointed by the minority leader of the House of Representatives, and all of whom shall be knowledgeable on issues relative to women's health care in the state. The membership of the council shall fairly and adequately represent women who have had issues accessing quality health care in the state.

Sec. 82. Subsections (b) and (c) of section 20-195ttt of the 2026 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) There is established within the **[**Office of Health Strategy**]** Department of Social Services a Community Health Worker Advisory Body. Said body shall (1) advise **[**said office and the Department of Public Health**]** the department on matters relating to the educational and certification requirements for training programs for community health workers, including the minimum number of hours and internship requirements for certification of community health workers, (2) conduct a continuous review of such educational and certification programs, and (3) provide the department with a list of approved educational and certification programs for community health workers.

(c) The Commissioner **[**of Health Strategy**]** Social Services, or the commissioner's designee, shall act as the chair of the Community Health Worker Advisory Body and shall appoint the following members to said body:

(1) Six members who are actively practicing as community health workers in the state;

(2) A member of the Community Health Workers Association of Connecticut;

(3) A representative of a community-based community health worker training organization;

(4) A representative of the Connecticut State Community College;

(5) An employer of community health workers;

(6) A representative of a health care organization that employs community health workers;

(7) A health care provider who works directly with community health workers; and

(8) The Commissioner of Public Health, or the commissioner's designee.

Sec. 83. Subsection (b) of section 28-33 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom has expertise in prescription drug supply chains and one of whom has expertise in federal law concerning prescription drug shortages;

(2) Two appointed by the president pro tempore of the Senate, one of whom represents hospitals and one of whom represents health care providers who treat patients with rare diseases;

(3) One appointed by the majority leader of the House of

Representatives, who represents one of the two federally recognized Indian tribes in the state;

(4) One appointed by the majority leader of the Senate, who represents one of the two federally recognized Indian tribes in the state;

(5) One appointed by the minority leader of the House of Representatives, who represents health insurance companies;

(6) One appointed by the minority leader of the Senate, who is a representative of the Connecticut Health Insurance Exchange;

[(7) The Commissioner of Health Strategy, or the commissioner's designee;**]**

[(8)**]** (7) The Commissioner of Consumer Protection, or the commissioner's designee;

[(9)**]** (8) The Commissioner of Social Services, or the commissioner's designee;

[(10)**]** (9) The Commissioner of Public Health, or the commissioner's designee;

[(11)**]** (10) The chief executive officer of The University of Connecticut Health Center, or the chief executive officer's designee;

[(12)**]** (11) The Insurance Commissioner, or the commissioner's designee;

[(13)**]** (12) The Commissioner of Economic and Community Development, or the commissioner's designee; and

[(14)**]** (13) Any other members as deemed necessary by the chairpersons of the task force.

Sec. 84. Subsections (e) to (g), inclusive, of section 33-182bb of the general statutes are repealed and the following is substituted in lieu

thereof (*Effective July 1, 2026*):

(e) Any medical foundation organized on or after July 1, 2009, shall file a copy of its certificate of incorporation and any amendments to its certificate of incorporation with the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health not later than ten business days after the medical foundation files such certificate of incorporation or amendment with the Secretary of the State pursuant to chapter 602.

(f) Any medical group clinic corporation formed under chapter 594 of the general statutes, revision of 1958, revised to 1995, which amends its certificate of incorporation pursuant to subsection (a) of section 33-182cc, shall file with the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health a copy of its certificate of incorporation and any amendments to its certificate of incorporation, including any amendment to its certificate of incorporation that complies with the requirements of subsection (a) of section 33-182cc, not later than ten business days after the medical foundation files its certificate of incorporation or any amendments to its certificate of incorporation with the Secretary of the State.

(g) Any medical foundation, regardless of when organized, shall file notice with the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health and the Secretary of the State of its liquidation, termination, dissolution or cessation of operations not later than ten business days after a vote by its board of directors or members to take such action. A medical foundation shall, annually, provide the office with (1) a statement of its mission, (2) the name and address of the organizing members, (3) the name and specialty of each physician employed by or acting as an agent of the medical foundation, (4) the location or locations where each such physician practices, (5) a description of the services provided at each such location, (6) a description of any significant change in its services during the preceding year, (7) a copy of the medical foundation's governing documents and

bylaws, (8) the name and employer of each member of the board of directors, and (9) other financial information as reported on the medical foundation's most recently filed Internal Revenue Service return of organization exempt from income tax form, or any replacement form adopted by the Internal Revenue Service, or, if such medical foundation is not required to file such form, information substantially similar to that required by such form. The Health Systems Planning Unit shall make such forms and information available to members of the public and accessible on said unit's Internet web site.

Sec. 85. Subdivisions (2) and (3) of subsection (a) of section 38a-47 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(2) The amount appropriated to the Office of **[**Health Strategy**]** Policy and Management from the Insurance Fund for the fiscal year, including the cost of fringe benefits for office personnel as estimated by the Comptroller, which shall be reduced by the amount of federal reimbursement received for allowable Medicaid administrative expenses;

(3) The expenditures made on behalf of the department and said offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, but excluding such estimated expenditures made on behalf of the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health; and

Sec. 86. Subsections (b) to (f), inclusive, of section 38a-48 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) On or before July thirty-first, annually, the Insurance Commissioner shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47, as amended by this act:

(1) A statement that includes (A) the amount appropriated to the Insurance Department **[**,**]** and the Office of the Healthcare Advocate **[**and the Office of Health Strategy**]** from the Insurance Fund established under section 38a-52a for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, not including such estimated expenditures made on behalf of the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health, and (D) the amount appropriated to the Department of Aging and Disability Services for the fall prevention program established in section 17a-859 from the Insurance Fund for the fiscal year;

(2) A statement of the total amount of taxes reported in the annual statement rendered to the Insurance Commissioner pursuant to subsection (a) of this section; and

(3) The proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided for the purposes of this calculation the amount appropriated to the Insurance Department **[**,**]** and the Office of the Healthcare Advocate **[**and the Office of Health Strategy**]** from the Insurance Fund plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and said offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health shall be deemed to be the actual expenditures of the department and said offices, and the amount appropriated to the Department of Aging and Disability Services from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-859 shall be deemed to be the actual expenditures for the program.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47, as amended by this act, among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total amount of taxes reported in the annual statement rendered to the Insurance Commissioner pursuant to subsection (a) of this section, and (B) allocating eighty per cent of the amount to be paid under section 38a-47, as amended by this act, among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total amount of taxes reported in the annual statement rendered to the Insurance Commissioner pursuant to subsection (a) of this section, provided if there are no domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47, as amended by this act, shall be allocated among such domestic insurance companies and domestic entities.

(2) When the amount any such company or entity is assessed pursuant to this section exceeds twenty-five per cent of the actual expenditures of the Insurance Department **[**,**]** and the Office of the Healthcare Advocate **[**and the Office of Health Strategy**]** from the Insurance Fund, such excess amount shall not be paid by such company or entity but rather shall be assessed against and paid by all other such companies and entities in proportion to their respective shares of the total amount of taxes reported in the annual statement rendered to the Insurance Commissioner pursuant to subsection (a) of this section, except that for purposes of any assessment made to fund payments to the Department of Public Health to purchase vaccines, such company or entity shall be responsible for its share of the costs, notwithstanding whether its assessment exceeds twenty-five per cent of the actual

expenditures of the Insurance Department **[**,**]** and the Office of the Healthcare Advocate **[**and the Office of Health Strategy**]** from the Insurance Fund. The provisions of this subdivision shall not be applicable to any corporation that has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the effective date of any public act that amends said section to modify or remove any restriction on the business such a company may engage in, for purposes of any assessment due from such company on and after such effective date.

(d) Each annual payment determined under section 38a-47, as amended by this act, and each annual assessment determined under this section shall be calculated based on the total amount of taxes reported in the annual statement rendered to the Insurance Commissioner pursuant to subsection (a) of this section.

(e) On or before September first, annually, for each fiscal year, the Insurance Commissioner, after receiving any objections to the proposed assessments and making such adjustments as in the commissioner's opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner (1) on or before June thirtieth, annually, an estimated payment against its assessment for the following year equal to twenty-five per cent of its assessment for the fiscal year ending such June thirtieth, (2) on or before September thirtieth, annually, twenty-five per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (f) of this section, and (3) on or before the following December thirty-first and March thirty-first, annually, each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner the remaining fifty per cent of its proposed assessment to the department in two equal installments.

(f) If the actual expenditures for the fall prevention program established in section 17a-859 are less than the amount allocated, the Commissioner of Aging and Disability Services shall notify the Insurance Commissioner. Immediately following the close of the fiscal year, the Insurance Commissioner shall recalculate the proposed assessment for each domestic insurance company or other domestic entity in accordance with subsection (c) of this section using the actual expenditures made during the fiscal year by the Insurance Department **[**,**]** and the Office of the Healthcare Advocate **[**and the Office of Health Strategy**]** from the Insurance Fund, the actual expenditures made on behalf of the department and said offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the **[**Office of Health Strategy**]** Department of Public Health, and the actual expenditures for the fall prevention program. On or before July thirty-first, annually, the Insurance Commissioner shall render to each such domestic insurance company and other domestic entity a statement showing the difference between their respective recalculated assessments and the amount they have previously paid. On or before August thirty-first, the Insurance Commissioner, after receiving any objections to such statements, shall make such adjustments that in the commissioner's opinion may be indicated, and shall render an adjusted assessment, if any, to the affected companies. Any such domestic insurance company or other domestic entity may pay to the Insurance Commissioner the entire assessment required under this subsection in one payment when the first installment of such assessment is due.

Sec. 87. Subsection (a) of section 38a-477e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) **[**On and after January 1, 2017, each**]** Each health carrier, as defined in section 19a-755b, as amended by this act, shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient

admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the **[**Commissioner of Health Strategy**]** Secretary of the Office of Policy and Management pursuant to section 19a-755b, as amended by this act, for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) a directory of participating providers, as defined in section 38a-472f, in accordance with the provisions of section 38a-477h; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

Sec. 88. Subdivision (2) of subsection (c) of section 38a-477ee of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

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

Sec. 89. Subdivisions (13) to (17), inclusive, of subsection (c) of section 38a-1083 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(13) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers, including, but not limited to, an agreement with the Office of **[**Health Strategy**]** Policy and Management to use funds collected under this section for the operation of the all-payer claims database established under section 19a-755a, as amended by this act, and to receive data from such database. The contracts entered into by the exchange shall not be subject to the approval of any other state department, office or agency, provided copies of all contracts of the exchange shall be maintained by

the exchange as public records, subject to the proprietary rights of any party to the contract, except any agreement with the Office of **[**Health Strategy**]** Policy and Management shall be subject to approval by said office **[**and the Office of Policy and Management**]** and no portion of such agreement shall be considered proprietary;

(14) To the extent permitted under its contract with other persons, consent to any termination, modification, forgiveness or other change of any term of any contractual right, payment, royalty, contract or agreement of any kind to which the exchange is a party;

(15) Award grants to trained and certified individuals and institutions that will assist individuals, families and small employers and their employees in enrolling in appropriate coverage through the exchange. Applications for grants from the exchange shall be made on a form prescribed by the board;

(16) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices;

(17) Evaluate **[**jointly with the Health Care Cabinet established pursuant to section 19a-725**]** the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;

Sec. 90. Subdivision (26) of section 38a-1084 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(26) Consult with the Commissioner of Social Services, Insurance Commissioner and Office of **[**Health Strategy, established under section 19a-754a**]** Policy and Management for the purposes set forth in section 19a-754c, as amended by this act;

Sec. 91. Subsection (d) of section 3-123ddd of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(d) Nothing in sections 3-123aaa to 3-123hhh, inclusive, 19a-654, as amended by this act, **[**19a-725,**]** 19a-755a, as amended by this act, 38a-513f or 38a-513g shall diminish any right to retiree health insurance pursuant to a collective bargaining agreement or any other provision of the general statutes.

Sec. 92. Subsection (b) of section 3-123hhh of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) Nothing in this section or sections 3-123aaa to 3-123ggg, inclusive, 19a-654, as amended by this act, **[**19a-725,**]** 19a-755a, as amended by this act, 38a-513f or 38a-513g shall modify the state employee plan in any way without the written consent of the State Employees Bargaining Agent Coalition and the Secretary of the Office of Policy and Management.

Sec. 93. (NEW) (*Effective July 1, 2026*) (a) The Department of Public Health shall constitute a successor agency, in accordance with the provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the Office of Health Strategy with respect to all functions, powers and duties of the Office of Health Strategy concerning (1) the Health Systems Planning Unit established pursuant to section 19a-612 of the general statutes, as amended by this act, and (2) the certificate of need process set forth in sections 19a-638 to 19a-641, inclusive, of the general statutes, as amended by this act. Any order, decision, agreed settlement or regulation of the former Office of Health Strategy concerning any of the functions described in subdivisions (1) and (2) of this subsection that is in force on July 1, 2026, shall continue in force and effect as an order, decision, agreed settlement or regulation of the Department of Public Health until amended, repealed or superseded pursuant to law. Where

any order, decision, agreed settlement or regulation of said department and said former office conflict, the Commissioner of Public Health may implement policies and procedures consistent with the provisions of chapters 368v and 368z of the general statutes while in the process of adopting the policies or procedures in regulation form, provided the commissioner shall publish notice of intention to adopt regulations on the Department of Public Health's Internet web site and the eRegulations System not later than twenty days after implementation of such policies and procedures. Any such policies or procedures shall be valid until such regulations are adopted.

(b) If the words "Office of Health Strategy" or "Commissioner of Health Strategy" are used or referred to in any public or special act of 2026, or in any section of the general statutes that is amended in 2026 that concerns said office's or commissioner's functions with regard to (1) the Health Systems Planning Unit established pursuant to section 19a-612 of the general statutes, as amended by this act, or (2) the certificate of need process set forth in sections 19a-638 to 19a-641, inclusive, of the general statutes, as amended by this act, such words shall be deemed to mean or refer to the Department of Public Health or the Commissioner of Public Health, respectively.

Sec. 94. (NEW) (*Effective July 1, 2026*) (a) The Office of Policy and Management shall constitute a successor agency, in accordance with the provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the Office of Health Strategy with respect to all functions, powers and duties of the Office of Health Strategy concerning (1) the State-wide Health Information Exchange, established pursuant to section 17b-59d of the general statutes, as amended by this act, (2) the all-payer claims database program, established pursuant to section 19a-755a of the general statutes, as amended by this act, and (3) the development, publication and modification of health care cost growth benchmarks and health care quality benchmarks required pursuant to sections 19a-754f to 19a-754k, inclusive, of the general statutes, as amended by this act. Any order, decision, agreed settlement or regulation of the former

Office of Health Strategy concerning any of the functions described in subdivisions (1) to (3), inclusive, of this subsection that is in force on July 1, 2026, shall continue in force and effect as an order, decision, agreed settlement or regulation of the Office of Policy and Management until amended, repealed or superseded pursuant to law. Where any order, decision, agreed settlement or regulation of said offices conflict, the Secretary of the Office of Policy and Management may implement policies and procedures consistent with the provisions of part III of chapter 319o and chapter 368ee of the general statutes while in the process of adopting the policies or procedures in regulation form, provided the secretary shall publish notice of intention to adopt regulations on the Office of Policy and Management's Internet web site and the eRegulations System not later than twenty days after implementation of such policies and procedures. Any such policy or procedure shall be valid until such regulations are adopted.

(b) If the words "Office of Health Strategy" or "Commissioner of Health Strategy" are used or referred to in any public or special act of 2026, or in any section of the general statutes that is amended in 2026 that concerns said office's or commissioner's functions with regard to (1) the State-wide Health Information Exchange, established pursuant to section 17b-59d of the general statutes, as amended by this act, (2) the all-payer claims database program, established pursuant to section 19a-755a of the general statutes, as amended by this act, or (3) the development, publication and modification of health care cost growth benchmarks and health care quality benchmarks required pursuant to sections 19a-754f to 19a-754k, inclusive, of the general statutes, as amended by this act, such words shall be deemed to mean or refer to the Office of Policy and Management or the Secretary of the Office of Policy and Management, respectively.

Sec. 95. (NEW) (*Effective July 1, 2026*) (a) The Department of Social Services shall constitute a successor agency, in accordance with the provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the Office of Health Strategy with respect to all functions, powers and

duties of the Office of Health Strategy concerning (1) community benefit program reporting by hospitals pursuant to section 19a-127k of the general statutes, as amended by this act, and (2) hospital financial health reporting by hospitals pursuant to section 19a-486j, as amended by this act. Any order, decision, agreed settlement or regulation of the former Office of Health Strategy concerning any of the functions described in subdivisions (1) and (2) of this subsection that is in force on July 1, 2026, shall continue in force and effect as an order, decision, agreed settlement or regulation of the Department of Social Services until amended, repealed or superseded pursuant to law. Where any order, decision, agreed settlement or regulation of said offices conflict, the Commissioner of Social Services may implement policies and procedures consistent with the provisions of part III of chapter 319o and chapter 368ee of the general statutes while in the process of adopting the policies or procedures in regulation form, provided the secretary shall publish notice of intention to adopt regulations on the Department of Social Services' Internet web site and the eRegulations System not later than twenty days after implementation of such policies and procedures. Any such policy or procedure shall be valid until such regulations are adopted.

(b) If the words "Office of Health Strategy" or "Commissioner of Health Strategy" are used or referred to in any public or special act of 2026, or in any section of the general statutes that is amended in 2026 that concerns said office's or commissioner's functions with regard to (1) community benefit program reporting by hospitals pursuant to section 19a-127k of the general statutes, as amended by this act, and (2) hospital financial health reporting by hospitals pursuant to section 19a-486j, as amended by this act, such terms shall be deemed to mean or refer to the Department of Social Services or the Commissioner of Social Services, respectively.

Sec. 96. Section 19a-2a of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the Department of Public Health and the Public Health Code. The commissioner shall have responsibility for the overall operation and administration of the Department of Public Health. The commissioner shall have the power and duty to: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as are necessary to carry out the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; (5) enter into a contract, including, but not limited to, a contract with another state, for facilities, services and programs to implement the purposes of the department as established by statute; (6) designate a deputy commissioner or other employee of the department to sign any license, certificate or permit issued by said department; (7) conduct a hearing, issue subpoenas, administer oaths, compel testimony and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Department of Public Health; (8) with the health authorities of this and other states, secure information and data concerning the prevention and control of epidemics and conditions affecting or endangering the public health, and compile such information and statistics and shall disseminate among health authorities and the people of the state such information as may be of value to them; (9) annually issue a list of reportable diseases, emergency illnesses and health conditions and a list of reportable laboratory findings and amend such lists as the commissioner deems necessary and distribute such lists as well as any necessary forms to each licensed physician, licensed physician assistant, licensed advanced practice registered nurse and clinical laboratory in this state. The commissioner shall prepare printed forms for reports and returns, with such instructions as may be necessary, for the use of directors of health,

boards of health and registrars of vital statistics; **[**and**]** (10) specify uniform methods of keeping statistical information by public and private agencies, organizations and individuals, including a client identifier system, and collect and make available relevant statistical information, including the number of persons treated, frequency of admission and readmission, and frequency and duration of treatment. The client identifier system shall be subject to the confidentiality requirements set forth in section 17a-688 and regulations adopted thereunder; and (11) direct and oversee the Health Systems Planning Unit, established under section 19a-612, as amended by this act, and all of its duties and responsibilities concerning the certificate of need process as set forth in chapter 368z. The commissioner may designate any person to perform any of the duties listed in subdivision (7) of this section. The commissioner shall have authority over directors of health and may, for cause, remove any such director; but any person claiming to be aggrieved by such removal may appeal to the Superior Court which may affirm or reverse the action of the commissioner as the public interest requires. The commissioner shall assist and advise local directors of health and district directors of health in the performance of their duties, and may require the enforcement of any law, regulation or ordinance relating to public health. In the event the commissioner reasonably suspects impropriety on the part of a local director of health or district director of health, or employee of such director, in the performance of his or her duties, the commissioner shall provide notification and any evidence of such impropriety to the appropriate governing authority of the municipal health authority, established pursuant to section 19a-200, or the district department of health, established pursuant to section 19a-244, for purposes of reviewing and assessing a director's or an employee's compliance with such duties. Such governing authority shall provide a written report of its findings from the review and assessment to the commissioner not later than ninety days after such review and assessment. When requested by local directors of health or district directors of health, the commissioner shall consult with them and investigate and advise concerning any condition

affecting public health within their jurisdiction. The commissioner shall investigate nuisances and conditions affecting, or that he or she has reason to suspect may affect, the security of life and health in any locality and, for that purpose, the commissioner, or any person authorized by the commissioner, may enter and examine any ground, vehicle, apartment, building or place, and any person designated by the commissioner shall have the authority conferred by law upon constables. Whenever the commissioner determines that any provision of the general statutes or regulation of the Public Health Code is not being enforced effectively by a local health department or health district, he or she shall forthwith take such measures, including the performance of any act required of the local health department or health district, to ensure enforcement of such statute or regulation and shall inform the local health department or health district of such measures. In September of each year the commissioner shall certify to the Secretary of the Office of Policy and Management the population of each municipality. The commissioner may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of or contract for money, services or property from the federal government, the state, any political subdivision thereof, any other state or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant or contract. The commissioner may enter into any contracts or agreements, in accordance with any established procedures, as may be necessary for the distribution or use of such money, services or property in accordance with any requirements to fulfill any conditions of a gift, grant or contract. The commissioner may establish state-wide and regional advisory councils. For purposes of this section, "employee of such director" means an employee of, a consultant employed or retained by or an independent contractor retained by a local director of health, a district director of health, a local health department or a health district.

Sec. 97. Section 4-66 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

The Secretary of the Office of Policy and Management shall have the following functions and powers:

(1) To keep on file information concerning the state's general accounts;

(2) To furnish all accounting statements relating to the financial condition of the state as a whole, to the condition and operation of state funds, to appropriations, to reserves and to costs of operations;

(3) To furnish such statements as and when they are required for administrative purposes and, at the end of each fiscal period, to prepare and publish such financial statements and data as will convey to the General Assembly the essential facts as to the financial condition, the revenues and expenditures and the costs of operations of the state government;

(4) To furnish to the State Comptroller on or before the twentieth day of each month cumulative monthly statements of revenues and expenditures to the end of the last-completed month together with (A) a statement of estimated revenue by source to the end of the fiscal year, at least in the same detail as appears in the budget act, and (B) a statement of appropriation requirements of the state's General Fund to the end of the fiscal year itemized as far as practicable for each budgeted agency, including estimates of lapsing appropriations, unallocated lapsing balances and unallocated appropriation requirements;

(5) To transmit to the Office of Fiscal Analysis a copy of monthly position data and monthly bond project run;

(6) To inquire into the operation of, and make or recommend improvement in, the methods employed in the preparation of the budget and the procedure followed in determining whether the funds expended by the departments, boards, commissions and institutions supported in whole or in part by the state are wisely, judiciously and economically expended and to submit such findings and

recommendations to the General Assembly at each regular session, together with drafts of proposed legislation, if any;

(7) To examine each department, state college, state hospital, state-aided hospital, reformatory and prison and each other institution or other agency supported in whole or in part by the state, except public schools, for the purpose of determining the effectiveness of its policies, management, internal organization and operating procedures and the character, amount, quality and cost of the service rendered by each such department, institution or agency;

(8) To recommend, and to assist any such department, institution or agency to effect, improvements in organization, management methods and procedures and to report its findings and recommendations and submit drafts of proposed legislation, if any, to the General Assembly at each regular session;

(9) To consider and devise ways and means whereby comprehensive plans and designs to meet the needs of the several departments and institutions with respect to physical plant and equipment and whereby financial plans and programs for the capital expenditures involved may be made in advance and to make or assist in making such plans;

(10) To devise and prescribe the form of operating reports that shall be periodically required from the several departments, boards, commissions, institutions and agencies supported in whole or in part by the state;

(11) To require the several departments, boards, commissions, institutions and agencies to make such reports for such periods as said secretary may determine; **[**and**]**

(12) To verify the correctness of, and to analyze, all such reports and to take such action as may be deemed necessary to remedy unsatisfactory conditions disclosed by such reports;

(13) To (A) coordinate the state's health information technology initiatives, (B) seek funding for and oversee the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establish and maintain a consumer health information Internet web site under section 19a-755b, as amended by this act, and (D) designate an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g, as amended by this act; and

(14) To (A) set an annual health care cost growth benchmark and primary care spending target pursuant to section 19a-754g, as amended by this act, (B) develop and adopt health care quality benchmarks pursuant to section 19a-754g, as amended by this act, (C) develop strategies, in consultation with stakeholders, to meet such benchmarks and targets developed pursuant to section 19a-754g, as amended by this act, (D) enhance the transparency of provider entities, as defined in subdivision (13) of section 19a-754f, as amended by this act, (E) monitor the development of accountable care organizations and patient-centered medical homes in the state, and (F) monitor the adoption of alternative payment methodologies in the state.

Sec. 98. Subsection (a) of section 17b-3 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) The Commissioner of Social Services shall administer all law under the jurisdiction of the Department of Social Services. The commissioner shall have the power and duty to do the following: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce such regulations, in accordance with chapter 54, as are necessary to implement the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as

established by statute; (5) enter into a contract, including, but not limited to, up to five contracts with other states, for facilities, services and programs to implement the purposes of the department as established by statute; (6) process applications and requests for services promptly; (7) with the approval of the Comptroller and in accordance with such procedures as may be specified by the Comptroller, make payments to providers of services for individuals who are eligible for benefits from the department as appropriate; (8) make no duplicate awards for items of assistance once granted, except for replacement of lost or stolen checks on which payment has been stopped; (9) promote economic self-sufficiency where appropriate in the department's programs, policies, practices and staff interactions with recipients; (10) act as advocate for the need of more comprehensive and coordinated programs for persons served by the department; (11) plan services and programs for persons served by the department; (12) coordinate outreach activities by public and private agencies assisting persons served by the department; (13) consult and cooperate with area and private planning agencies; (14) advise and inform municipal officials and officials of social service agencies about social service programs and collect and disseminate information pertaining thereto, including information about federal, state, municipal and private assistance programs and services; (15) encourage and facilitate effective communication and coordination among federal, state, municipal and private agencies; (16) inquire into the utilization of state and federal government resources which offer solutions to problems of the delivery of social services; (17) conduct, encourage and maintain research and studies relating to social services development; (18) prepare, review and encourage model comprehensive social service programs; (19) maintain an inventory of data and information and act as a clearing house and referral agency for information on state and federal programs and services; **[**and**]** (20) conduct, encourage and maintain research and studies and advise municipal officials and officials of social service agencies about forms of intergovernmental cooperation and coordination between public and private agencies designed to advance social service programs; (21)

develop an annual summary and analysis of community benefit reporting by hospitals pursuant to section 19a-127k, as amended by this act, and (22) receive reports from each hospital regarding its financial health pursuant to section 19a-486j, as amended by this act. The commissioner may require notice of the submission of all applications by municipalities, any agency thereof, and social service agencies, for federal and state financial assistance to carry out social services. The commissioner shall establish state-wide and regional advisory councils.

Sec. 99. Subsection (a) of section 19a-7p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(a) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amounts appropriated from the Insurance Fund for the Health Systems Planning Unit, established pursuant to section 19a-612, as amended by this act, syringe services program, AIDS services, breast and cervical cancer detection and treatment, x-ray screening and tuberculosis care, sexually transmitted disease control and children's health initiatives; and (2) inform the Insurance Commissioner of such amounts.

Sec. 100. Sections 19a-754a and 19a-754e of the 2026 supplement to the general statutes are repealed. (*Effective July 1, 2026*)

Sec. 101. Sections 19a-725, 20-195sss and 38a-477jj of the general statutes are repealed. (*Effective July 1, 2026*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2026*	New section
Sec. 2	*from passage*	29-1r(a)
Sec. 3	*July 1, 2026*	14-21cc(d)
Sec. 4	*from passage*	4-65a(a)
Sec. 5	*July 1, 2026*	7-74(b)

Sec. 6	*July 1, 2026*	46a-52
Sec. 7	*from passage*	10-76ooo
Sec. 8	*from passage*	Repealer section
Sec. 9	*July 1, 2026*	1-84(d)
Sec. 10	*July 1, 2026*	1-84b(c)
Sec. 11	*July 1, 2026*	2-137(b)
Sec. 12	*July 1, 2026*	4-5
Sec. 13	*July 1, 2026*	4-101a(b)
Sec. 14	*July 1, 2026*	8-37vvv(b)
Sec. 15	*July 1, 2026*	10-222tt(c)(8)
Sec. 16	*July 1, 2026*	10-532(b) to (d)
Sec. 17	*July 1, 2026*	12-34h(b)
Sec. 18	*July 1, 2026*	12-263q(c)(1)(B)
Sec. 19	*July 1, 2026*	17b-59a
Sec. 20	*July 1, 2026*	17b-59d(d) to (g)
Sec. 21	*July 1, 2026*	17b-59e(f)
Sec. 22	*July 1, 2026*	17b-59f
Sec. 23	*July 1, 2026*	17b-59g(a) and (b)
Sec. 24	*July 1, 2026*	17b-312
Sec. 25	*July 1, 2026*	17b-337(c)
Sec. 26	*July 1, 2026*	17b-340(f)(3)
Sec. 27	*July 1, 2026*	17b-356
Sec. 28	*July 1, 2026*	19a-6q
Sec. 29	*July 1, 2026*	19a-7(b)
Sec. 30	*July 1, 2026*	19a-7h(l)
Sec. 31	*July 1, 2026*	19a-75a(a)
Sec. 32	*July 1, 2026*	19a-127k
Sec. 33	*July 1, 2026*	19a-486
Sec. 34	*July 1, 2026*	19a-486g
Sec. 35	*July 1, 2026*	19a-486h
Sec. 36	*July 1, 2026*	19a-486i(d) to (i)
Sec. 37	*July 1, 2026*	19a-486j
Sec. 38	*July 1, 2026*	19a-490ii(b)
Sec. 39	*July 1, 2026*	19a-493b(b) and (c)
Sec. 40	*July 1, 2026*	19a-507(a)
Sec. 41	*July 1, 2026*	19a-508c(d) to (m)
Sec. 42	*July 1, 2026*	19a-509b(c)
Sec. 43	*July 1, 2026*	19a-612
Sec. 44	*July 1, 2026*	19a-612d

Sec. 45	*July 1, 2026*	19a-613(c)
Sec. 46	*July 1, 2026*	19a-614
Sec. 47	*July 1, 2026*	19a-630
Sec. 48	*July 1, 2026*	19a-631(b)
Sec. 49	*July 1, 2026*	19a-632a
Sec. 50	*July 1, 2026*	19a-634(a)
Sec. 51	*July 1, 2026*	19a-638(d) and (e)
Sec. 52	*July 1, 2026*	19a-639(a)(1)
Sec. 53	*July 1, 2026*	19a-639a(a)
Sec. 54	*July 1, 2026*	19a-639a(h)
Sec. 55	*July 1, 2026*	19a-639b(e)
Sec. 56	*July 1, 2026*	19a-639c(b)
Sec. 57	*July 1, 2026*	19a-639e(d)
Sec. 58	*July 1, 2026*	19a-639f(a)
Sec. 59	*July 1, 2026*	19a-639f(l)
Sec. 60	*July 1, 2026*	19a-639g(a) and (b)
Sec. 61	*July 1, 2026*	19a-643
Sec. 62	*July 1, 2026*	19a-644(a) and (b)
Sec. 63	*July 1, 2026*	19a-645
Sec. 64	*July 1, 2026*	19a-646(a)(1)
Sec. 65	*July 1, 2026*	19a-653(a) to (d)
Sec. 66	*July 1, 2026*	19a-654(b) to (g)
Sec. 67	*July 1, 2026*	19a-659(1)
Sec. 68	*July 1, 2026*	19a-673a
Sec. 69	*July 1, 2026*	19a-681(c)
Sec. 70	*July 1, 2026*	19a-754b(b) to (f)
Sec. 71	*July 1, 2026*	19a-754c(a) to (c)
Sec. 72	*July 1, 2026*	19a-754d
Sec. 73	*July 1, 2026*	19a-754f
Sec. 74	*July 1, 2026*	19a-754g
Sec. 75	*July 1, 2026*	19a-754h
Sec. 76	*July 1, 2026*	19a-754i
Sec. 77	*July 1, 2026*	19a-754j
Sec. 78	*July 1, 2026*	19a-754k
Sec. 79	*July 1, 2026*	19a-755a
Sec. 80	*July 1, 2026*	19a-755b
Sec. 81	*July 1, 2026*	19a-911(b)
Sec. 82	*July 1, 2026*	20-195ttt(b) and (c)
Sec. 83	*July 1, 2026*	28-33(b)

Sec. 84	*July 1, 2026*	33-182bb(e) to (g)
Sec. 85	*July 1, 2026*	38a-47(a)(2) and (3)
Sec. 86	*July 1, 2026*	38a-48(b) to (f)
Sec. 87	*July 1, 2026*	38a-477e(a)
Sec. 88	*July 1, 2026*	38a-477ee(c)(2)
Sec. 89	*July 1, 2026*	38a-1083(c)(13) to (17)
Sec. 90	*July 1, 2026*	38a-1084(26)
Sec. 91	*July 1, 2026*	3-123ddd(d)
Sec. 92	*July 1, 2026*	3-123hhh(b)
Sec. 93	*July 1, 2026*	New section
Sec. 94	*July 1, 2026*	New section
Sec. 95	*July 1, 2026*	New section
Sec. 96	*July 1, 2026*	19a-2a
Sec. 97	*July 1, 2026*	4-66
Sec. 98	*July 1, 2026*	17b-3(a)
Sec. 99	*July 1, 2026*	19a-7p(a)
Sec. 100	*July 1, 2026*	Repealer section
Sec. 101	*July 1, 2026*	Repealer section

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]