



General Assembly

February Session, 2026

Governor's Bill No. 5030

LCO No. 498



* 0 0 4 9 8 *

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:

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

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

15 account established under subsection (d) of this section. Except as
16 provided in subsection (f) of this section, no additional fee shall be
17 charged in connection with the renewal of such number plates. No
18 transfer fee shall be charged for transfer of an existing registration to or
19 from a registration with Pizza State commemorative number plates.
20 Such number plates shall have letters and numbers selected by the
21 Commissioner of Motor Vehicles. The commissioner may establish a
22 higher fee for number plates: (1) That contain the numbers and letters
23 from a previously issued number plate; (2) that contain letters in place
24 of numbers, as authorized by section 14-49 of the general statutes, in
25 addition to the fee or fees prescribed for registration under said section;
26 and (3) that are low number plates issued in accordance with section 14-
27 160 of the general statutes, in addition to the fee or fees prescribed for
28 registration under said section. All fees established and collected
29 pursuant to this section, except moneys designated for administrative
30 costs of the Department of Motor Vehicles, shall be deposited in the
31 Pizza State commemorative account.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

121 (a) The commission shall consist of nine persons. On and after
122 October 1, 2000, such persons shall be appointed with the advice and
123 consent of both houses of the General Assembly. (1) On or before July
124 15, 1990, the Governor shall appoint five members of the commission,
125 three of whom shall serve for terms of five years and two of whom shall
126 serve for terms of three years. Upon the expiration of such terms, and
127 thereafter, the Governor shall appoint either two or three members, as
128 appropriate, to serve for terms of five years. On or before July 14, 1990,
129 the president pro tempore of the Senate, the minority leader of the
130 Senate, the speaker of the House of Representatives and the minority
131 leader of the House of Representatives shall each appoint one member
132 to serve for a term of three years. Upon the expiration of such terms, and
133 thereafter, members so appointed shall serve for terms of three years.
134 (2) If any vacancy occurs, the appointing authority making the initial
135 appointment shall appoint a person to serve for the remainder of the
136 unexpired term. The Governor shall select one of the members of the
137 commission to serve as chairperson for a term of one year. The
138 commission shall meet at least once during each two-month period and
139 at such other times as the chairperson deems necessary. Special
140 meetings shall be held on the request of a majority of the members of

141 the commission after notice in accordance with the provisions of section
142 1-225.

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

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

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

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

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

195 Sec. 7. Section 10-76000 of the 2026 supplement to the general statutes
196 is repealed and the following is substituted in lieu thereof (*Effective from*
197 *passage*):

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

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

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

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

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

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

261 Sec. 10. Subsection (c) of section 1-84b of the general statutes is
262 repealed and the following is substituted in lieu thereof (*Effective July 1,*
263 *2026*):

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

270 members or former members of the boards or commissions who serve
271 ex officio, who are required by statute to represent the regulated
272 industry or who are permitted by statute to have a past or present
273 affiliation with the regulated industry. On or before November [1, 2021,
274 and not less than] first annually, [thereafter,] the head of each agency
275 concerned, or his or her designee, shall submit the designation of all
276 positions in existence on such date that are subject to the provisions of
277 this subsection to the office electronically, in a manner prescribed by the
278 Citizen's Ethics Advisory Board. If an agency creates such a position
279 after its annual submission under this subsection, the head of such
280 agency, or his or her designee, shall submit the designation of the newly
281 created position not later than thirty days after the creation of such
282 position. As used in this subsection, "agency" means the Health Systems
283 Planning Unit of the [Office of Health Strategy] Department of Public
284 Health, the Connecticut Siting Council, the Department of Banking, the
285 Insurance Department, the Department of Emergency Services and
286 Public Protection, the office within the Department of Consumer
287 Protection that carries out the duties and responsibilities of sections 30-
288 2 to 30-68m, inclusive, the Public Utilities Regulatory Authority,
289 including the Office of Consumer Counsel, and the Department of
290 Consumer Protection and the term "employment" means professional
291 services or other services rendered as an employee or as an independent
292 contractor.

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

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

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

302 state employee in violation of this subsection.

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

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

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

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

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

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

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

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

331 a representative of public school superintendents in the state;

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

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

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

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

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

348 [(12)] (11) The Child Advocate, or the Child Advocate's designee;

349 [(13)] (12) The Healthcare Advocate and the Behavioral Health
350 Advocate, or their designees;

351 [(14)] (13) The executive director of the Court Support Services
352 Division of the Judicial Branch, or the executive director's designee;

353 [(15)] (14) The executive director of the Commission on Women,
354 Children, Seniors, Equity and Opportunity, or the executive director's
355 designee;

356 [(16)] (15) The Secretary of the Office of Policy and Management, or
357 the secretary's designee; and

358 [(17)] (16) One representative from each administrative services
359 organization under contract with the Department of Social Services to
360 provide such services for recipients of assistance under the HUSKY
361 Health program, who shall be ex-officio, nonvoting members.

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

364 As used in sections 4-6, 4-7 and 4-8, the term "department head"
365 means the Secretary of the Office of Policy and Management,
366 Commissioner of Administrative Services, Commissioner of Revenue
367 Services, Banking Commissioner, Commissioner of Children and
368 Families, Commissioner of Consumer Protection, Commissioner of
369 Correction, Commissioner of Economic and Community Development,
370 State Board of Education, Commissioner of Emergency Services and
371 Public Protection, Commissioner of Energy and Environmental
372 Protection, Commissioner of Agriculture, Commissioner of Public
373 Health, Insurance Commissioner, Labor Commissioner, Commissioner
374 of Mental Health and Addiction Services, Commissioner of Social
375 Services, Commissioner of Developmental Services, Commissioner of
376 Motor Vehicles, Commissioner of Transportation, Commissioner of
377 Veterans Affairs, Commissioner of Housing, Commissioner of Aging
378 and Disability Services, Commissioner of Early Childhood,
379 [Commissioner of Health Strategy] executive director of the Office of
380 Military Affairs, executive director of the Technical Education and
381 Career System, Chief Workforce Officer and Commissioner of Higher
382 Education. As used in sections 4-6 and 4-7, "department head" also
383 means the Commissioner of Education.

384 Sec. 13. Subsection (b) of section 4-101a of the general statutes is
385 repealed and the following is substituted in lieu thereof (*Effective July 1,
386 2026*):

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

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

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

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

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

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

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

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

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

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

442 (7) Two appointed by the Commissioner of Housing;

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

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

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

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

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

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

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

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

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

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

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

463 [(19)] (18) The chief executive officer of the Connecticut Housing
464 Finance Authority, or the chief executive officer's designee; and

465 [(20)] (19) The Long-Term Care Ombudsman.

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

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

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

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

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

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

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

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

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

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

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

528 Sec. 19. Section 17b-59a of the 2026 supplement to the general statutes
529 is repealed and the following is substituted in lieu thereof (*Effective July
530 1, 2026*):

531 (a) As used in this section:

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

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

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

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

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

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

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

601 (d) The [Commissioner of Health Strategy] Secretary of the Office of
602 Policy and Management shall, within existing resources and in
603 consultation with the State Health Information Technology Advisory
604 Council: (1) Oversee the development and implementation of the State-
605 wide Health Information Exchange in conformance with section 17b-
606 59d, as amended by this act; (2) coordinate the state's health information
607 technology and health information exchange efforts to ensure consistent
608 and collaborative cross-agency planning and implementation; and (3)
609 serve as the state liaison to, and work collaboratively with, the State-
610 wide Health Information Exchange established pursuant to section 17b-
611 59d, as amended by this act, to ensure consistency between the state-
612 wide health information technology plan and the State-wide Health
613 Information Exchange and to support the state's health information
614 technology and exchange goals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

738 (a) There shall be a State Health Information Technology Advisory
739 Council to advise the [Commissioner of Health Strategy] Secretary of
740 the Office of Policy and Management and the health information
741 technology officer, designated in accordance with section [19a-754a] 4-
742 66, as amended by this act in developing priorities and policy
743 recommendations for advancing the state's health information
744 technology and health information exchange efforts and goals and to
745 advise the [commissioner] secretary and officer in the development and
746 implementation of the state-wide health information technology plan
747 and standards and the State-wide Health Information Exchange,
748 established pursuant to section 17b-59d, as amended by this act. The
749 advisory council shall also advise the [commissioner] secretary and
750 officer regarding the development of appropriate governance, oversight
751 and accountability measures to ensure success in achieving the state's
752 health information technology and exchange goals.

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

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

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

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

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

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

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

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

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

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

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

772 (10) Five members appointed by the Governor, one each who shall be
773 (A) a representative of a health system that includes more than one
774 hospital, (B) a representative of the health insurance industry, (C) an
775 expert in health information technology, (D) a health care consumer or
776 consumer advocate, and (E) a current or former employee or trustee of
777 a plan established pursuant to subdivision (5) of subsection (c) of 29 USC
778 186;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

896 Sec. 25. Subsection (c) of section 17b-337 of the general statutes is
897 repealed and the following is substituted in lieu thereof (*Effective July 1,*
898 *2026*):

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

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

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

929 (3) For the fiscal year ending June 30, 1992, per diem maximum
930 allowable costs for each cost component shall be as follows: For direct
931 costs, the maximum shall be equal to one hundred forty per cent of the
932 median allowable cost of that peer grouping; for indirect costs, the
933 maximum shall be equal to one hundred thirty per cent of the state-wide
934 median allowable cost; for fair rent, the amount shall be calculated
935 utilizing the amount approved by the [Office of Health Care Access]
936 Health Systems Planning Unit of the Department of Public Health
937 pursuant to section 19a-638, as amended by this act; for capital-related
938 costs, there shall be no maximum; and for administrative and general
939 costs, the maximum shall be equal to one hundred twenty-five per cent
940 of the state-wide median allowable cost. For the fiscal year ending June
941 30, 1993, per diem maximum allowable costs for each cost component
942 shall be as follows: For direct costs, the maximum shall be equal to one

943 hundred forty per cent of the median allowable cost of that peer
944 grouping; for indirect costs, the maximum shall be equal to one hundred
945 twenty-five per cent of the state-wide median allowable cost; for fair
946 rent, the amount shall be calculated utilizing the amount approved by
947 the [Office of Health Care Access] Health Systems Planning Unit
948 pursuant to section 19a-638, as amended by this act; for capital-related
949 costs, there shall be no maximum; and for administrative and general
950 costs the maximum shall be equal to one hundred fifteen per cent of the
951 state-wide median allowable cost. For the fiscal year ending June 30,
952 1994, per diem maximum allowable costs for each cost component shall
953 be as follows: For direct costs, the maximum shall be equal to one
954 hundred thirty-five per cent of the median allowable cost of that peer
955 grouping; for indirect costs, the maximum shall be equal to one hundred
956 twenty per cent of the state-wide median allowable cost; for fair rent,
957 the amount shall be calculated utilizing the amount approved by the
958 [Office of Health Care Access] Health Systems Planning Unit pursuant
959 to section 19a-638, as amended by this act; for capital-related costs, there
960 shall be no maximum; and for administrative and general costs the
961 maximum shall be equal to one hundred ten per cent of the state-wide
962 median allowable cost. For the fiscal year ending June 30, 1995, per diem
963 maximum allowable costs for each cost component shall be as follows:
964 For direct costs, the maximum shall be equal to one hundred thirty-five
965 per cent of the median allowable cost of that peer grouping; for indirect
966 costs, the maximum shall be equal to one hundred twenty per cent of
967 the state-wide median allowable cost; for fair rent, the amount shall be
968 calculated utilizing the amount approved by the [Office of Health Care
969 Access] Health Systems Planning Unit pursuant to section 19a-638, as
970 amended by this act; for capital-related costs, there shall be no
971 maximum; and for administrative and general costs the maximum shall
972 be equal to one hundred five per cent of the state-wide median
973 allowable cost. For the fiscal year ending June 30, 1996, and any
974 succeeding fiscal year, except for the fiscal years ending June 30, 2000,
975 and June 30, 2001, for facilities with an interim rate in one or both
976 periods, per diem maximum allowable costs for each cost component

977 shall be as follows: For direct costs, the maximum shall be equal to one
978 hundred thirty-five per cent of the median allowable cost of that peer
979 grouping; for indirect costs, the maximum shall be equal to one hundred
980 fifteen per cent of the state-wide median allowable cost; for fair rent, the
981 amount shall be calculated utilizing the amount approved pursuant to
982 section 19a-638, as amended by this act; for capital-related costs, there
983 shall be no maximum; and for administrative and general costs the
984 maximum shall be equal to the state-wide median allowable cost. For
985 the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with
986 an interim rate in one or both periods, per diem maximum allowable
987 costs for each cost component shall be as follows: For direct costs, the
988 maximum shall be equal to one hundred forty-five per cent of the
989 median allowable cost of that peer grouping; for indirect costs, the
990 maximum shall be equal to one hundred twenty-five per cent of the
991 state-wide median allowable cost; for fair rent, the amount shall be
992 calculated utilizing the amount approved pursuant to section 19a-638,
993 as amended by this act; for capital-related costs, there shall be no
994 maximum; and for administrative and general costs, the maximum shall
995 be equal to the state-wide median allowable cost and such medians shall
996 be based upon the same cost year used to set rates for facilities with
997 prospective rates. Costs in excess of the maximum amounts established
998 under this subsection shall not be recognized as allowable costs, except
999 that the Commissioner of Social Services (A) may allow costs in excess
1000 of maximum amounts for any facility with patient days covered by
1001 Medicare, including days requiring coinsurance, in excess of twelve per
1002 cent of annual patient days which also has patient days covered by
1003 Medicaid in excess of fifty per cent of annual patient days; (B) may
1004 establish a pilot program whereby costs in excess of maximum amounts
1005 shall be allowed for beds in a nursing home which has a managed care
1006 program and is affiliated with a hospital licensed under chapter 368v;
1007 and (C) may establish rates whereby allowable costs may exceed such
1008 maximum amounts for beds approved on or after July 1, 1991, which are
1009 restricted to use by patients with acquired immune deficiency syndrome
1010 or traumatic brain injury.

1011 Sec. 27. Section 17b-356 of the general statutes is repealed and the
1012 following is substituted in lieu thereof (*Effective July 1, 2026*):

1013 Any health care facility or institution, as defined in subsection (a) of
1014 section 19a-490, except a nursing home, rest home, residential care home
1015 or residential facility for persons with intellectual disability licensed
1016 pursuant to section 17a-227 and certified to participate in the Title XIX
1017 Medicaid program as an intermediate care facility for individuals with
1018 intellectual disabilities, proposing to expand its services by adding
1019 nursing home beds shall obtain the approval of the Commissioner of
1020 Social Services in accordance with the procedures established pursuant
1021 to sections 17b-352, 17b-353 and 17b-354 for a facility, as defined in
1022 section 17b-352, prior to obtaining the approval of the Health Systems
1023 Planning Unit of the [Office of Health Strategy] Department of Public
1024 Health pursuant to section 19a-639, as amended by this act.

1025 Sec. 28. Section 19a-6q of the general statutes is repealed and the
1026 following is substituted in lieu thereof (*Effective July 1, 2026*):

1027 The Commissioner of Public Health, in consultation with the
1028 [Commissioner of Health Strategy and] local and regional health
1029 departments, shall, within available resources, develop a plan that is
1030 consistent with the Department of Public Health's Healthy Connecticut
1031 2020 health improvement plan and the state healthcare innovation plan
1032 developed pursuant to the State Innovation Model Initiative by the
1033 Centers for Medicare and Medicaid Services Innovation Center. The
1034 Commissioner of Public Health shall develop and implement such plan
1035 to: (1) Reduce the incidence of tobacco use, high blood pressure, health
1036 care associated infections, asthma, unintended pregnancy and diabetes;
1037 (2) improve chronic disease care coordination in the state; and (3) reduce
1038 the incidence and effects of chronic disease and improve outcomes for
1039 conditions associated with chronic disease in the state. The
1040 Commissioner of Public Health shall post such plan on the Department
1041 of Public Health's Internet web site.

1042 Sec. 29. Subsection (b) of section 19a-7 of the general statutes is
1043 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1044 2026>):

1045 (b) For the purposes of establishing a state health plan as required by
1046 subsection (a) of this section and consistent with state and federal law
1047 on patient records, the department is entitled to access hospital
1048 discharge data, emergency room and ambulatory surgery encounter
1049 data, data on home health care agency client encounters and services,
1050 data from community health centers on client encounters and services
1051 and all data collected or compiled by the Health Systems Planning Unit
1052 of the [Office of Health Strategy] Department of Public Health pursuant
1053 to section 19a-613, as amended by this act.

1054 Sec. 30. Subsection (l) of section 19a-7h of the general statutes is
1055 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1056 2026>):

1057 (l) The commissioner shall, in consultation with the [Office of Health
1058 Strategy] Secretary of the Office of Policy and Management, adopt
1059 regulations, in accordance with the provisions of chapter 54, to facilitate
1060 interoperability between the immunization information system and the
1061 State-wide Health Information Exchange established pursuant to
1062 section 17b-59d, as amended by this act. The commissioner may
1063 implement policies and procedures necessary to administer the
1064 provisions of this section while in the process of adopting such policies
1065 and procedures as regulations, provided the department posts such
1066 policies and procedures on the eRegulations System prior to adopting
1067 them. Policies and procedures implemented pursuant to this section
1068 shall be valid until regulations are adopted in accordance with the
1069 provisions of chapter 54.

1070 Sec. 31. Subsection (a) of section 19a-75a of the general statutes is
1071 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1072 2026>):

1073 (a) On or before January 1, 2023, the Department of Public Health
1074 shall establish and administer a child and adolescent psychiatrist grant
1075 program. The program shall provide incentive grants to employers of
1076 child and adolescent psychiatrists for recruiting and hiring new child
1077 and adolescent psychiatrists and retaining child and adolescent
1078 psychiatrists who are in their employ. The Commissioner of Public
1079 Health shall establish eligibility requirements, priority categories,
1080 funding limitations and the application process for the grant program.
1081 Such priority categories shall include, but need not be limited to,
1082 nonhospital employers. The commissioner [, in consultation with the
1083 Office of Health Strategy,] shall distribute incentive grant funds
1084 equitably with regard to the type of employer and location of such
1085 employer.

1086 Sec. 32. Section 19a-127k of the general statutes is repealed and the
1087 following is substituted in lieu thereof (*Effective July 1, 2026*):

1088 (a) As used in this section:

1089 (1) "Community benefit partners" means federal, state and municipal
1090 government entities and private sector entities, including, but not
1091 limited to, faith-based organizations, businesses, educational and
1092 academic organizations, health care organizations, health departments,
1093 philanthropic organizations, organizations specializing in housing
1094 justice, planning and land use organizations, public safety
1095 organizations, transportation organizations and tribal organizations,
1096 that, in partnership with hospitals, play an essential role with respect to
1097 the policy, system, program and financing solutions necessary to
1098 achieve community benefit program goals;

1099 (2) "Community benefit program" means any voluntary program or
1100 activity to promote preventive health care, protect health and safety,
1101 improve health equity and reduce health disparities, reduce the cost and
1102 economic burden of poor health and improve the health status for all
1103 populations within the geographic service areas of a hospital, regardless

1104 of whether a member of any such population is a patient of such
1105 hospital;

1106 (3) "Community benefit program reporting" means the community
1107 health needs assessment, implementation strategy and annual report
1108 submitted by a hospital to the [Office of Health Strategy] Department of
1109 Social Services pursuant to the provisions of this section;

1110 (4) "Community health needs assessment" means a written
1111 assessment, as described in 26 CFR 1.501(r)-(3);

1112 (5) "Health disparities" means health differences that are closely
1113 linked with social or economic disadvantages that adversely affect one
1114 or more groups of people who have experienced greater systemic social
1115 or economic obstacles to health or a safe environment based on race or
1116 ethnicity, religion, socioeconomic status, gender, age, mental health,
1117 cognitive, sensory or physical disability, sexual orientation, gender
1118 identity, geographic location or other characteristics historically linked
1119 to discrimination or exclusion;

1120 (6) "Health equity" means that every person has a fair and just
1121 opportunity to be as healthy as possible, which encompasses removing
1122 obstacles to health, such as poverty, racism and the adverse
1123 consequences of poverty and racism, including, but not limited to, a lack
1124 of equitable opportunities, access to good jobs with fair pay, quality
1125 education and housing, safe environments and health care;

1126 (7) "Hospital" means a nonprofit entity licensed as a hospital
1127 pursuant to chapter 368v that is required to annually file Internal
1128 Revenue Service form 990. "Hospital" includes a for-profit entity
1129 licensed as an acute care general hospital;

1130 (8) "Implementation strategy" means a written plan, as described in
1131 26 CFR 1.501(r)-(3), that is adopted by an authorized body of a hospital
1132 and documents how such hospital intends to address the needs
1133 identified in the community health needs assessment; and

1134 (9) "Meaningful participation" means that (A) residents of a hospital's
1135 community, including, but not limited to, residents of such community
1136 that experience the greatest health disparities, have an appropriate
1137 opportunity to participate in such hospital's planning and decisions, (B)
1138 community participation influences a hospital's planning, and (C)
1139 participants receive information from a hospital summarizing how their
1140 input was or was not used by such hospital.

1141 (b) On and after January 1, 2023, each hospital shall submit
1142 community benefit program reporting to the [Office of Health Strategy]
1143 Department of Social Services, or to a designee selected by the
1144 Commissioner of [Health Strategy] Social Services, in the form and
1145 manner described in subsections (c) to (e), inclusive, of this section.

1146 (c) Each hospital shall submit its community health needs assessment
1147 to the [Office of Health Strategy] Department of Social Services not later
1148 than thirty days after the date on which such assessment is made
1149 available to the public pursuant to 26 CFR 1.501(r)-(3)(b), provided the
1150 Commissioner of [Health Strategy] Social Services, or the
1151 commissioner's designee, may grant an extension of time to a hospital
1152 for the filing of such assessment. Such submission shall contain the
1153 following:

1154 (1) Consistent with the requirements set forth in 26 CFR 1.501(r)-
1155 (3)(b)(6)(i), and as included in a hospital's federal filing submitted to the
1156 Internal Revenue Service:

1157 (A) A definition of the community served by the hospital and a
1158 description of how the community was determined;

1159 (B) A description of the process and methods used to conduct the
1160 community health needs assessment;

1161 (C) A description of how the hospital solicited and took into account
1162 input received from persons who represent the broad interests of the
1163 community it serves;

1164 (D) A prioritized description of the significant health needs of the
1165 community identified through the community health needs assessment,
1166 and a description of the process and criteria used in identifying certain
1167 health needs as significant and prioritizing those significant health
1168 needs;

1169 (E) A description of the resources potentially available to address the
1170 significant health needs identified through the community health needs
1171 assessment;

1172 (F) An evaluation of the impact of any actions that were taken, since
1173 the hospital finished conducting its immediately preceding community
1174 health needs assessment, to address the significant health needs
1175 identified in the hospital's prior community health needs assessment;
1176 and

1177 (2) Additional documentation of the following:

1178 (A) The names of the individuals responsible for developing the
1179 community health needs assessment;

1180 (B) The demographics of the population within the geographic
1181 service area of the hospital and, to the extent feasible, a detailed
1182 description of the health disparities, health risks, insurance status,
1183 service utilization patterns and health care costs within such geographic
1184 service area;

1185 (C) A description of the health status and health disparities affecting
1186 the population within the geographic service area of the hospital,
1187 including, but not limited to, the health status and health disparities
1188 affecting a representative spectrum of age, racial and ethnic groups,
1189 incomes and medically underserved populations;

1190 (D) A description of the meaningful participation afforded to
1191 community benefit partners and diverse community members in
1192 assessing community health needs, priorities and target populations;

1193 (E) A description of the barriers to achieving or maintaining health
1194 and to accessing health care, including, but not limited to, social,
1195 economic and environmental barriers, lack of access to or availability of
1196 sources of health care coverage and services and a lack of access to and
1197 availability of prevention and health promotion services and support;

1198 (F) Recommendations regarding the role that the state and other
1199 community benefit partners could play in removing the barriers
1200 described in subparagraph (E) of this subdivision and enabling effective
1201 solutions; and

1202 (G) Any additional information, data or disclosures that the hospital
1203 voluntarily chooses to include as may be relevant to its community
1204 benefit program.

1205 (d) Each hospital shall submit its implementation strategy to the
1206 [Office of Health Strategy] Department of Social Services not later than
1207 thirty days after the date on which such implementation strategy is
1208 adopted pursuant to 26 CFR 1.501(r)-(3)(c), provided the Commissioner
1209 of [Health Strategy] Social Services, or the commissioner's designee,
1210 may grant an extension to a hospital for the filing of such
1211 implementation strategy. Such submission shall contain the following:

1212 (1) Consistent with the requirements set forth in 26 CFR 1.501(r)-
1213 (3)(b)(6)(i), and as included in a hospital's federal filing submitted to the
1214 Internal Revenue Service:

1215 (A) With respect to each significant health need identified through
1216 the community health needs assessment, either (i) a description of how
1217 the hospital plans to address the health need, or (ii) identification of the
1218 health need as one which the hospital does not intend to address;

1219 (B) For significant health needs described in subparagraph (A)(i) of
1220 this subdivision, (i) a description of the actions that the hospital intends
1221 to take to address the health need and the anticipated impact of such
1222 actions, (ii) identification of the resources that the hospital plans to

1223 commit to address the health need, and (iii) a description of any planned
1224 collaboration between the hospital and other facilities or organizations
1225 to address the health need;

1226 (C) For significant health needs identified in subparagraph (A)(ii) of
1227 this subdivision, an explanation of why the hospital does not intend to
1228 address such health need; and

1229 (2) Additional documentation of the following:

1230 (A) The names of the individuals responsible for developing the
1231 implementation strategy;

1232 (B) A description of the meaningful participation afforded to
1233 community benefit partners and diverse community members;

1234 (C) A description of the community health needs and health
1235 disparities that were prioritized in developing the implementation
1236 strategy with consideration given to the most recent version of the state
1237 health plan prepared by the Department of Public Health pursuant to
1238 section 19a-7, as amended by this act;

1239 (D) Reference-citing evidence, if available, that shows how the
1240 implementation strategy is intended to address the corresponding
1241 health need or reduction in health disparity;

1242 (E) A description of the planned methods for the ongoing evaluation
1243 of proposed actions and corresponding process or outcome measures
1244 intended for use in assessing progress or impact;

1245 (F) A description of how the hospital solicited commentary on the
1246 implementation strategy from the communities within such hospital's
1247 geographic service area and revisions to such strategy based on such
1248 commentary; and

1249 (G) Any other information that the hospital voluntarily chooses to
1250 include as may be relevant to its implementation strategy, including, but

1251 not limited to, data, disclosures, expected or planned resource outlay,
1252 investments or commitments, including, but not limited to, staff,
1253 financial or in-kind commitments.

1254 (e) On or before October 1, 2023, and annually thereafter, each
1255 hospital shall submit to the [Office of Health Strategy] Department of
1256 Social Services a status report on such hospital's community benefit
1257 program, provided the Commissioner of [Health Strategy] Social
1258 Services, or the commissioner's designee, may grant an extension to a
1259 hospital for the filing of such report. Such report shall include the
1260 following:

1261 (1) A description of major updates regarding community health
1262 needs, priorities and target populations, if any;

1263 (2) A description of progress made regarding the hospital's actions in
1264 support of its implementation strategy;

1265 (3) A description of any major changes to the proposed
1266 implementation strategy and associated hospital actions; and

1267 (4) A description of financial resources and other resources allocated
1268 or expended that supported the actions taken in support of the hospital's
1269 implementation strategy.

1270 (f) Notwithstanding the provisions of section 19a-755a, as amended
1271 by this act, and to the full extent permitted by 45 CFR 164.514(e), the
1272 [Office of Health Strategy] Department of Social Services shall make
1273 data in the all-payer claims database available to hospitals for use in
1274 their community benefit programs and activities solely for the purposes
1275 of (1) preparing the hospital's community health needs assessment, (2)
1276 preparing and executing the hospital's implementation strategy, and (3)
1277 fulfilling community benefit program reporting, as described in
1278 subsections (c) to (e), inclusive, of this section. Any disclosure made by
1279 said [office] department pursuant to this subsection of information other
1280 than health information shall be made in a manner to protect the

1281 confidentiality of such information as may be required by state or
1282 federal law.

1283 (g) A hospital shall not be responsible for limitations in its ability to
1284 fulfill community benefit program reporting requirements, as described
1285 in subsections (c) to (e), inclusive, of this section, if the all-payer claims
1286 database data is not provided to such hospital, as required by subsection
1287 (f) of this section.

1288 (h) [On or before] Not later than April [1, 2024, and] first, annually,
1289 [thereafter,] the Commissioner of [Health Strategy] Social Services shall
1290 develop a summary and analysis of the community benefit program
1291 reporting submitted by hospitals under this section during the previous
1292 calendar year and post such summary and analysis on its Internet web
1293 site and solicit stakeholder input through a public comment period. The
1294 [Office of Health Strategy] Department of Social Services shall use such
1295 reporting and stakeholder input to:

1296 (1) Identify additional stakeholders that may be engaged to address
1297 identified community health needs, including, but not limited to,
1298 federal, state and municipal entities, nonhospital private sector health
1299 care providers and private sector entities that are not health care
1300 providers, including community-based organizations, insurers and
1301 charitable organizations;

1302 (2) Determine how each identified stakeholder could assist in
1303 addressing identified community health needs or augmenting solutions
1304 or approaches reported in the implementation strategies;

1305 (3) Determine whether to make recommendations to the Department
1306 of Public Health in the development of its state health plan; and

1307 (4) Inform the state-wide health care facilities and services plan
1308 established pursuant to section 19a-634, as amended by this act.

1309 (i) Each for-profit entity licensed as an acute care general hospital

1310 shall submit community benefit program reporting consistent with the
1311 reporting schedules of subsections (c) to (e), inclusive, of this section,
1312 and reasonably similar to what would be included on such hospital's
1313 federal filings to the Internal Revenue Service, where applicable.

1314 Sec. 33. Section 19a-486 of the general statutes is repealed and the
1315 following is substituted in lieu thereof (*Effective July 1, 2026*):

1316 For purposes of sections 19a-486 to 19a-486h, inclusive, as amended
1317 by this act:

1318 (1) "Nonprofit hospital" means a nonprofit entity licensed as a
1319 hospital pursuant to this chapter and any entity affiliated with such a
1320 hospital through governance or membership, including, but not limited
1321 to, a holding company or subsidiary.

1322 (2) "Purchaser" means a person acquiring any assets of a nonprofit
1323 hospital through a transfer.

1324 (3) "Person" means any individual, firm, partnership, corporation,
1325 limited liability company, association or other entity.

1326 (4) "Transfer" means to sell, transfer, lease, exchange, option, convey,
1327 give or otherwise dispose of or transfer control over, including, but not
1328 limited to, transfer by way of merger or joint venture not in the ordinary
1329 course of business.

1330 (5) "Control" has the meaning assigned to it in section 36b-41.

1331 (6) "Commissioner" means the Commissioner of [Health Strategy]
1332 Public Health, or the commissioner's designee.

1333 Sec. 34. Section 19a-486g of the general statutes is repealed and the
1334 following is substituted in lieu thereof (*Effective July 1, 2026*):

1335 The Commissioner of Public Health shall refuse to issue a license to,
1336 or if issued shall suspend or revoke the license of, a hospital if the

1337 commissioner finds, after a hearing and opportunity to be heard, that:

1338 (1) There was a transaction described in section 19a-486a that
1339 occurred without the commissioner's approval, [of the Commissioner of
1340 Health Strategy,] if such approval was required by sections 19a-486 to
1341 19a-486h, inclusive, as amended by this act;

1342 (2) There was a transaction described in section 19a-486a without the
1343 approval of the Attorney General, if such approval was required by
1344 sections 19a-486 to 19a-486h, inclusive, as amended by this act, and the
1345 Attorney General certifies to the [Commissioner of Health Strategy]
1346 commissioner that such transaction involved a material amount of the
1347 nonprofit hospital's assets or operations or a change in control of
1348 operations; or

1349 (3) The hospital is not complying with the terms of an agreement
1350 approved by the Attorney General and [Commissioner of Health
1351 Strategy] commissioner pursuant to sections 19a-486 to 19a-486h,
1352 inclusive, as amended by this act.

1353 Sec. 35. Section 19a-486h of the general statutes is repealed and the
1354 following is substituted in lieu thereof (*Effective July 1, 2026*):

1355 Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by
1356 this act, shall be construed to limit: (1) The common law or statutory
1357 authority of the Attorney General; (2) the statutory authority of the
1358 Commissioner of Public Health including, but not limited to, licensing
1359 [: (3) the statutory authority of the Commissioner of Health Strategy,
1360 including, but not limited to, certificate of need authority; or (4)] and
1361 certificate of need authority; or (3) the application of the doctrine of cy
1362 pres or approximation.

1363 Sec. 36. Subsections (d) to (i), inclusive, of section 19a-486i of the
1364 general statutes are repealed and the following is substituted in lieu
1365 thereof (*Effective July 1, 2026*):

1366 (d) (1) The written notice required under subsection (c) of this section
1367 shall identify each party to the transaction and describe the material
1368 change as of the date of such notice to the business or corporate structure
1369 of the group practice, including: (A) A description of the nature of the
1370 proposed relationship among the parties to the proposed transaction;
1371 (B) the names and specialties of each physician that is a member of the
1372 group practice that is the subject of the proposed transaction and who
1373 will practice medicine with the resulting group practice, hospital,
1374 hospital system, captive professional entity, medical foundation or
1375 other entity organized by, controlled by, or otherwise affiliated with
1376 such hospital or hospital system following the effective date of the
1377 transaction; (C) the names of the business entities that are to provide
1378 services following the effective date of the transaction; (D) the address
1379 for each location where such services are to be provided; (E) a
1380 description of the services to be provided at each such location; and (F)
1381 the primary service area to be served by each such location.

1382 (2) Not later than thirty days after the effective date of any transaction
1383 described in subsection (c) of this section, the parties to the transaction
1384 shall submit written notice to the Commissioner of [Health Strategy]
1385 Public Health. Such written notice shall include, but need not be limited
1386 to, the same information described in subdivision (1) of this subsection.
1387 The commissioner shall post a link to such notice on the [Office of Health
1388 Strategy's] Department of Public Health's Internet web site.

1389 (e) Not less than thirty days prior to the effective date of any
1390 transaction that results in an affiliation between one hospital or hospital
1391 system and another hospital or hospital system, the parties to the
1392 affiliation shall submit written notice to the Attorney General of such
1393 affiliation. Such written notice shall identify each party to the affiliation
1394 and describe the affiliation as of the date of such notice, including: (1) A
1395 description of the nature of the proposed relationship among the parties
1396 to the affiliation; (2) the names of the business entities that are to provide
1397 services following the effective date of the affiliation; (3) the address for
1398 each location where such services are to be provided; (4) a description

1399 of the services to be provided at each such location; and (5) the primary
1400 service area to be served by each such location.

1401 (f) Written information submitted to the Attorney General pursuant
1402 to subsections (b) to (e), inclusive, of this section shall be maintained and
1403 used by the Attorney General in the same manner as provided in section
1404 35-42.

1405 (g) Not later than January [15, 2018, and] fifteenth annually,
1406 [thereafter,] each hospital and hospital system shall file with the
1407 Attorney General and the Commissioner of [Health Strategy] Public
1408 Health a written report describing the activities of the group practices
1409 owned or affiliated with such hospital or hospital system. Such report
1410 shall include, for each such group practice: (1) A description of the
1411 nature of the relationship between the hospital or hospital system and
1412 the group practice; (2) the names and specialties of each physician
1413 practicing medicine with the group practice; (3) the names of the
1414 business entities that provide services as part of the group practice and
1415 the address for each location where such services are provided; (4) a
1416 description of the services provided at each such location; and (5) the
1417 primary service area served by each such location.

1418 (h) Not later than January [15, 2018, and] fifteenth annually,
1419 [thereafter,] each group practice comprised of thirty or more physicians
1420 that is not the subject of a report filed under subsection (g) of this section
1421 shall file with the Attorney General and the Commissioner of [Health
1422 Strategy] Public Health a written report concerning the group practice.
1423 Such report shall include, for each such group practice: (1) The names
1424 and specialties of each physician practicing medicine with the group
1425 practice; (2) the names of the business entities that provide services as
1426 part of the group practice and the address for each location where such
1427 services are provided; (3) a description of the services provided at each
1428 such location; and (4) the primary service area served by each such
1429 location.

1430 (i) Not later than January [15, 2018, and] fifteenth annually,
1431 [thereafter,] each hospital and hospital system shall file with the
1432 Attorney General and the Commissioner of [Health Strategy] Public
1433 Health a written report describing each affiliation with another hospital
1434 or hospital system. Such report shall include: (1) The name and address
1435 of each party to the affiliation; (2) a description of the nature of the
1436 relationship among the parties to the affiliation; (3) the names of the
1437 business entities that provide services as part of the affiliation and the
1438 address for each location where such services are provided; (4) a
1439 description of the services provided at each such location; and (5) the
1440 primary service area served by each such location.

1441 Sec. 37. Section 19a-486j of the general statutes is repealed and the
1442 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

1463 commissioner. The commissioner may grant such request for good
1464 cause, as determined by the commissioner. Such template shall be based
1465 on generally accepted accounting principles as prescribed by the
1466 Financial Accounting Standards Board.

1467 (b) If a hospital submits a report pursuant to the provisions of
1468 subsection (a) of this section reflecting two consecutive quarters of sixty
1469 days or less of days of cash on hand, or days cash and cash equivalents
1470 otherwise available to the hospital, the commissioner may require the
1471 hospital to provide the [Office of Health Strategy] Department of Social
1472 Services with additional information that the commissioner deems
1473 relevant to understanding the financial health of the hospital.

1474 (c) If a hospital submits a report pursuant to the provisions of
1475 subsection (a) of this section reflecting two consecutive quarters of forty-
1476 five days or less of cash on hand, or days cash and cash equivalents
1477 otherwise available to the hospital, the [Office of Health Strategy]
1478 Department of Social Services shall contact the hospital to offer
1479 assistance.

1480 (d) If a hospital has multiple consecutive quarters of one hundred or
1481 more days of cash on hand, or days cash and cash equivalents otherwise
1482 available to the hospital, the commissioner may waive one of the
1483 hospital's two semiannual reports required pursuant to the provisions
1484 of subsection (a) of this section.

1485 Sec. 38. Subsection (b) of section 19a-490ii of the 2026 supplement to
1486 the general statutes is repealed and the following is substituted in lieu
1487 thereof (*Effective July 1, 2026*):

1488 (b) Not later than March [1, 2025, and] first annually, [thereafter] until
1489 March 1, 2029, each hospital that conducts an analysis pursuant to
1490 subsection (a) of this section shall submit a report, in accordance with
1491 the provisions of section 11-4a, to the joint standing committee of the
1492 General Assembly having cognizance of matters relating to public
1493 health and, not later than March [1, 2026, and] first annually [thereafter]

1494 until March 1, 2029, shall also submit such report to the
1495 [Commissioners] Commissioner of Public Health [and Health Strategy]
1496 and the Healthcare Advocate, regarding its findings and any
1497 recommendations for achieving the goals described in subparagraphs
1498 (A) to (C), inclusive, of subdivision (4) of subsection (a) of this section.

1499 Sec. 39. Subsections (b) and (c) of section 19a-493b of the general
1500 statutes are repealed and the following is substituted in lieu thereof
1501 (*Effective July 1, 2026*):

1502 (b) No entity, individual, firm, partnership, corporation, limited
1503 liability company or association, other than a hospital, shall individually
1504 or jointly establish or operate an outpatient surgical facility in this state
1505 without complying with chapter 368z, except as otherwise provided by
1506 this section, and obtaining a license within the time specified in this
1507 subsection from the Department of Public Health for such facility
1508 pursuant to the provisions of this chapter, unless such entity, individual,
1509 firm, partnership, corporation, limited liability company or association:
1510 (1) Provides to the Health Systems Planning Unit of the [Office of Health
1511 Strategy] Department of Public Health satisfactory evidence that it was
1512 in operation on or before July 1, 2003, or (2) obtained, on or before July
1513 1, 2003, from the Office of Health Care Access, a determination that a
1514 certificate of need is not required. An entity, individual, firm,
1515 partnership, corporation, limited liability company or association
1516 otherwise in compliance with this section may operate an outpatient
1517 surgical facility without a license through March 30, 2007, and shall have
1518 until March 30, 2007, to obtain a license from the Department of Public
1519 Health.

1520 (c) Notwithstanding the provisions of this section, no outpatient
1521 surgical facility shall be required to comply with section 19a-631, as
1522 amended by this act, 19a-632, 19a-644, as amended by this act, 19a-645,
1523 as amended by this act, 19a-646, as amended by this act, 19a-649, 19a-
1524 664 to 19a-666, inclusive, 19a-673 to 19a-676, inclusive, 19a-678, 19a-681,
1525 as amended by this act, or 19a-683. Each outpatient surgical facility shall

1526 continue to be subject to the obligations and requirements applicable to
1527 such facility, including, but not limited to, any applicable provision of
1528 this chapter and those provisions of chapter 368z not specified in this
1529 subsection, except that a request for permission to undertake a transfer
1530 or change of ownership or control shall not be required pursuant to
1531 subsection (a) of section 19a-638 if the Health Systems Planning Unit of
1532 the [Office of Health Strategy] Department of Public Health determines
1533 that the following conditions are satisfied: (1) Prior to any such transfer
1534 or change of ownership or control, the outpatient surgical facility shall
1535 be owned and controlled exclusively by persons licensed pursuant to
1536 section 20-13 or chapter 375, either directly or through a limited liability
1537 company, formed pursuant to chapter 613, a corporation, formed
1538 pursuant to chapters 601 and 602, or a limited liability partnership,
1539 formed pursuant to chapter 614, that is exclusively owned by persons
1540 licensed pursuant to section 20-13 or chapter 375, or is under the interim
1541 control of an estate executor or conservator pending transfer of an
1542 ownership interest or control to a person licensed under section 20-13 or
1543 chapter 375, and (2) after any such transfer or change of ownership or
1544 control, persons licensed pursuant to section 20-13 or chapter 375, a
1545 limited liability company, formed pursuant to chapter 613, a
1546 corporation, formed pursuant to chapters 601 and 602, or a limited
1547 liability partnership, formed pursuant to chapter 614, that is exclusively
1548 owned by persons licensed pursuant to section 20-13 or chapter 375,
1549 shall own and control no less than a sixty per cent interest in the
1550 outpatient surgical facility.

1551 Sec. 40. Subsection (a) of section 19a-507 of the general statutes is
1552 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1553 *2026*):

1554 (a) Notwithstanding the provisions of chapter 368z, New Horizons,
1555 Inc., a nonprofit, nonsectarian organization, or a subsidiary
1556 organization controlled by New Horizons, Inc., is authorized to
1557 construct and operate an independent living facility for severely
1558 physically disabled adults, in the town of Farmington, provided such

1559 facility shall be constructed in accordance with applicable building
1560 codes. The Farmington Housing Authority, or any issuer acting on
1561 behalf of said authority, subject to the provisions of this section, may
1562 issue tax-exempt revenue bonds on a competitive or negotiated basis for
1563 the purpose of providing construction and permanent mortgage
1564 financing for the facility in accordance with Section 103 of the Internal
1565 Revenue Code. Prior to the issuance of such bonds, plans for the
1566 construction of the facility shall be submitted to and approved by the
1567 Health Systems Planning Unit of the [Office of Health Strategy]
1568 Department of Public Health. The unit shall approve or disapprove such
1569 plans within thirty days of receipt thereof. If the plans are disapproved
1570 they may be resubmitted. Failure of the unit to act on the plans within
1571 such thirty-day period shall be deemed approval thereof. The payments
1572 to residents of the facility who are eligible for assistance under the state
1573 supplement program for room and board and necessary services, shall
1574 be determined annually to be effective July first of each year. Such
1575 payments shall be determined on a basis of a reasonable payment for
1576 necessary services, which basis shall take into account as a factor the
1577 costs of providing those services and such other factors as the
1578 commissioner deems reasonable, including anticipated fluctuations in
1579 the cost of providing services. Such payments shall be calculated in
1580 accordance with the manner in which rates are calculated pursuant to
1581 subsection (i) of section 17b-340 and the cost-related reimbursement
1582 system pursuant to said section except that efficiency incentives shall
1583 not be granted. The commissioner may adjust such rates to account for
1584 the availability of personal care services for residents under the
1585 Medicaid program. The commissioner shall, upon submission of a
1586 request, allow actual debt service, comprised of principal and interest,
1587 in excess of property costs allowed pursuant to section 17-313b-5 of the
1588 regulations of Connecticut state agencies, provided such debt service
1589 terms and amounts are reasonable in relation to the useful life and the
1590 base value of the property. The cost basis for such payment shall be
1591 subject to audit, and a recomputation of the rate shall be made based
1592 upon such audit. The facility shall report on a fiscal year ending on the

1593 thirtieth day of September on forms provided by the commissioner. The
1594 required report shall be received by the commissioner no later than
1595 December thirty-first of each year. The Department of Social Services
1596 may use its existing utilization review procedures to monitor utilization
1597 of the facility. If the facility is aggrieved by any decision of the
1598 commissioner, the facility may, within ten days, after written notice
1599 thereof from the commissioner, obtain by written request to the
1600 commissioner, a hearing on all items of aggrievement. If the facility is
1601 aggrieved by the decision of the commissioner after such hearing, the
1602 facility may appeal to the Superior Court in accordance with the
1603 provisions of section 4-183.

1604 Sec. 41. Subsections (d) to (m), inclusive, of section 19a-508c of the
1605 2026 supplement to the general statutes are repealed and the following
1606 is substituted in lieu thereof (*Effective July 1, 2026*):

1607 (d) Each initial billing statement that includes a facility fee shall: (1)
1608 Clearly identify the fee as a facility fee that is billed in addition to, or
1609 separately from, any professional fee billed by the provider; (2) provide
1610 the corresponding Medicare facility fee reimbursement rate for the same
1611 service as a comparison or, if there is no corresponding Medicare facility
1612 fee for such service, (A) the approximate amount Medicare would have
1613 paid the hospital for the facility fee on the billing statement, or (B) the
1614 percentage of the hospital's charges that Medicare would have paid the
1615 hospital for the facility fee; (3) include a statement that the facility fee is
1616 intended to cover the hospital's or health system's operational expenses;
1617 (4) inform the patient that the patient's financial liability may have been
1618 less if the services had been provided at a facility not owned or operated
1619 by the hospital or health system; and (5) include written notice of the
1620 patient's right to request a reduction in the facility fee or any other
1621 portion of the bill and a telephone number that the patient may use to
1622 request such a reduction without regard to whether such patient
1623 qualifies for, or is likely to be granted, any reduction. Not later than
1624 October 15, 2022, and annually thereafter, each hospital, health system
1625 and hospital-based facility shall submit to the Health Systems Planning

1626 Unit of the [Office of Health Strategy] Department of Public Health,
1627 established pursuant to section 19a-612, as amended by this act, a
1628 sample of a billing statement issued by such hospital, health system or
1629 hospital-based facility that complies with the provisions of this
1630 subsection and [which] represents the format of billing statements
1631 received by patients. Such billing statement shall not contain patient
1632 identifying information.

1633 (e) The written notice described in subsections (b) to (d), inclusive,
1634 and (h) to (j), inclusive, of this section shall be in plain language and in
1635 a form that may be reasonably understood by a patient who does not
1636 possess special knowledge regarding hospital or health system facility
1637 fee charges. On and after October 1, 2022, such notices shall include tag
1638 lines in at least the top fifteen languages spoken in the state indicating
1639 that the notice is available in each of those top fifteen languages. The
1640 fifteen languages shall be either the languages in the list published by
1641 the Department of Health and Human Services in connection with
1642 section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-
1643 148, or, as determined by the hospital or health system, the top fifteen
1644 languages in the geographic area of the hospital-based facility.

1645 (f) (1) For nonemergency care, if a patient's appointment is scheduled
1646 to occur ten or more days after the appointment is made, such written
1647 notice shall be sent to the patient by first class mail, encrypted electronic
1648 mail or a secure patient Internet portal not less than three days after the
1649 appointment is made. If an appointment is scheduled to occur less than
1650 ten days after the appointment is made or if the patient arrives without
1651 an appointment, such notice shall be hand-delivered to the patient when
1652 the patient arrives at the hospital-based facility.

1653 (2) For emergency care, such written notice shall be provided to the
1654 patient as soon as practicable after the patient is stabilized in accordance
1655 with the federal Emergency Medical Treatment and Active Labor Act,
1656 42 USC 1395dd, as amended from time to time, or is determined not to
1657 have an emergency medical condition and before the patient leaves the

1658 hospital-based facility. If the patient is unconscious, under great duress
1659 or for any other reason unable to read the notice and understand and
1660 act on his or her rights, the notice shall be provided to the patient's
1661 representative as soon as practicable.

1662 (g) Subsections (b) to (f), inclusive, and (l) of this section shall not
1663 apply if a patient is insured by Medicare or Medicaid or is receiving
1664 services under a workers' compensation plan established to provide
1665 medical services pursuant to chapter 568.

1666 (h) A hospital-based facility shall prominently display written notice
1667 in locations that are readily accessible to and visible by patients,
1668 including patient waiting or appointment check-in areas, stating: (1)
1669 That the hospital-based facility is part of a hospital or health system, (2)
1670 the name of the hospital or health system, and (3) that if the hospital-
1671 based facility charges a facility fee, the patient may incur a financial
1672 liability greater than the patient would incur if the hospital-based
1673 facility was not hospital-based. On and after October 1, 2022, such
1674 notices shall include tag lines in at least the top fifteen languages spoken
1675 in the state indicating that the notice is available in each of those top
1676 fifteen languages. The fifteen languages shall be either the languages in
1677 the list published by the Department of Health and Human Services in
1678 connection with section 1557 of the Patient Protection and Affordable
1679 Care Act, P.L. 111-148, or, as determined by the hospital or health
1680 system, the top fifteen languages in the geographic area of the hospital-
1681 based facility. Not later than October 1, 2022, and annually thereafter,
1682 each hospital-based facility shall submit a copy of the written notice
1683 required by this subsection to the Health Systems Planning Unit of the
1684 [Office of Health Strategy] Department of Public Health.

1685 (i) A hospital-based facility shall clearly hold itself out to the public
1686 and payers as being hospital-based, including, at a minimum, by stating
1687 the name of the hospital or health system in its signage, marketing
1688 materials, Internet web sites and stationery.

1689 (j) A hospital-based facility shall, when scheduling services for which
1690 a facility fee may be charged, inform the patient (1) that the hospital-
1691 based facility is part of a hospital or health system, (2) of the name of the
1692 hospital or health system, (3) that the hospital or health system may
1693 charge a facility fee in addition to and separate from the professional fee
1694 charged by the provider, and (4) of the telephone number the patient
1695 may call for additional information regarding such patient's potential
1696 financial liability.

1697 (k) (1) If any transaction described in subsection (c) of section 19a-
1698 486i results in the establishment of a hospital-based facility at which
1699 facility fees may be billed, the hospital or health system, that is the
1700 purchaser in such transaction shall, not later than thirty days after such
1701 transaction, provide written notice, by first class mail, of the transaction
1702 to each patient served within the three years preceding the date of the
1703 transaction by the health care facility that has been purchased as part of
1704 such transaction.

1705 (2) Such notice shall include the following information:

1706 (A) A statement that the health care facility is now a hospital-based
1707 facility and is part of a hospital or health system, the health care facility's
1708 full legal and business name and the date of such facility's acquisition
1709 by a hospital or health system;

1710 (B) The name, business address and phone number of the hospital or
1711 health system that is the purchaser of the health care facility;

1712 (C) A statement that the hospital-based facility bills, or is likely to bill,
1713 patients a facility fee that may be in addition to, and separate from, any
1714 professional fee billed by a health care provider at the hospital-based
1715 facility;

1716 (D) (i) A statement that the patient's actual financial liability will
1717 depend on the professional medical services actually provided to the
1718 patient, and (ii) an explanation that the patient may incur financial

1719 liability that is greater than the patient would incur if the hospital-based
1720 facility were not a hospital-based facility;

1721 (E) The estimated amount or range of amounts the hospital-based
1722 facility may bill for a facility fee or an example of the average facility fee
1723 billed at such hospital-based facility for the most common services
1724 provided at such hospital-based facility; and

1725 (F) A statement that, prior to seeking services at such hospital-based
1726 facility, a patient covered by a health insurance policy should contact
1727 the patient's health insurer for additional information regarding the
1728 hospital-based facility fees, including the patient's potential financial
1729 liability, if any, for such fees.

1730 (3) A copy of the written notice provided to patients in accordance
1731 with this subsection shall be filed with the Health Systems Planning
1732 Unit of the [Office of Health Strategy] Department of Public Health,
1733 established under section 19a-612, as amended by this act. Said unit
1734 shall post a link to such notice on its Internet web site.

1735 (4) A hospital, health system or hospital-based facility shall not collect
1736 a facility fee for services provided at a hospital-based facility that is
1737 subject to the provisions of this subsection from the date of the
1738 transaction until at least thirty days after the written notice required
1739 pursuant to this subsection is mailed to the patient or a copy of such
1740 notice is filed with the Health Systems Planning Unit of the [Office of
1741 Health Strategy] Department of Public Health, whichever is later. A
1742 violation of this subsection shall be considered an unfair trade practice
1743 pursuant to section 42-110b.

1744 (5) Not later than July [1, 2023, and] first annually, [thereafter,] each
1745 hospital-based facility that was the subject of a transaction, as described
1746 in subsection (c) of section 19a-486i, during the preceding calendar year
1747 shall report to the Health Systems Planning Unit of the [Office of Health
1748 Strategy] Department of Public Health the number of patients served by
1749 such hospital-based facility in the preceding three years.

1750 (l) (1) Notwithstanding the provisions of this section, no hospital,
1751 health system or hospital-based facility shall collect a facility fee for (A)
1752 outpatient health care services that use a current procedural
1753 terminology evaluation and management (CPT E/M) code or
1754 assessment and management (CPT A/M) code and are provided at a
1755 hospital-based facility located off-site from a hospital campus, or (B)
1756 outpatient health care services provided at a hospital-based facility
1757 located off-site from a hospital campus received by a patient who is
1758 uninsured of more than the Medicare rate.

1759 (2) Notwithstanding the provisions of this section, on and after July
1760 1, 2024, no hospital or health system shall collect a facility fee for
1761 outpatient health care services that use a current procedural
1762 terminology evaluation and management (CPT E/M) code or
1763 assessment and management (CPT A/M) code and are provided on the
1764 hospital campus. The provisions of this subdivision shall not apply to
1765 (A) an emergency department located on a hospital campus, or (B)
1766 observation stays on a hospital campus and (CPT E/M) and (CPT A/M)
1767 codes when billed for the following services: (i) Wound care, (ii)
1768 orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi)
1769 solid organ transplant.

1770 (3) Notwithstanding the provisions of subdivisions (1) and (2) of this
1771 subsection, in circumstances when an insurance contract that is in effect
1772 on July 1, 2016, provides reimbursement for facility fees prohibited
1773 under the provisions of subdivision (1) of this subsection, and in
1774 circumstances when an insurance contract that is in effect on July 1,
1775 2024, provides reimbursement for facility fees prohibited under the
1776 provisions of subdivision (2) of this subsection, a hospital or health
1777 system may continue to collect reimbursement from the health insurer
1778 for such facility fees until the applicable date of expiration, renewal or
1779 amendment of such contract, whichever such date is the earliest.

1780 (4) The provisions of this subsection shall not apply to a freestanding
1781 emergency department. As used in this subdivision, "freestanding

1782 "emergency department" means a freestanding facility that (A) is
1783 structurally separate and distinct from a hospital, (B) provides
1784 emergency care, (C) is a department of a hospital licensed under chapter
1785 368v, and (D) has been issued a certificate of need to operate as a
1786 freestanding emergency department pursuant to chapter 368z.

1787 (5) (A) On and after July 1, 2024, if the Commissioner of [Health
1788 Strategy] Public Health receives information and has a reasonable belief,
1789 after evaluating such information, that any hospital, health system or
1790 hospital-based facility charged facility fees, other than through isolated
1791 clerical or electronic billing errors, in violation of any provision of this
1792 section, or rule or regulation adopted thereunder, such hospital, health
1793 system or hospital-based facility shall be subject to a civil penalty of up
1794 to one thousand dollars. The commissioner may issue a notice of
1795 violation and civil penalty by first class mail or personal service. Such
1796 notice shall include: (i) A reference to the section of the general statutes,
1797 rule or section of the regulations of Connecticut state agencies believed
1798 or alleged to have been violated; (ii) a short and plain language
1799 statement of the matters asserted or charged; (iii) a description of the
1800 activity to cease; (iv) a statement of the amount of the civil penalty or
1801 penalties that may be imposed; (v) a statement concerning the right to a
1802 hearing; and (vi) a statement that such hospital, health system or
1803 hospital-based facility may, not later than ten business days after receipt
1804 of such notice, make a request for a hearing on the matters asserted.

1805 (B) The hospital, health system or hospital-based facility to whom
1806 such notice is provided pursuant to subparagraph (A) of this
1807 subdivision may, not later than ten business days after receipt of such
1808 notice, make written application to the [Office of Health Strategy]
1809 Department of Public Health to request a hearing to demonstrate that
1810 such violation did not occur. The failure to make a timely request for a
1811 hearing shall result in the issuance of a cease and desist order or civil
1812 penalty. All hearings held under this subsection shall be conducted in
1813 accordance with the provisions of chapter 54.

1814 (C) Following any hearing before the [Office of Health Strategy]
1815 Department of Public Health pursuant to this subdivision, if said [office]
1816 department finds, by a preponderance of the evidence, that such
1817 hospital, health system or hospital-based facility violated or is violating
1818 any provision of this subsection, any rule or regulation adopted
1819 thereunder or any order issued by said [office] department, said [office]
1820 department shall issue a final cease and desist order in addition to any
1821 civil penalty said [office] department imposes.

1822 (6) A violation of this subsection shall be considered an unfair trade
1823 practice pursuant to section 42-110b.

1824 (m) (1) Each hospital and health system shall report not later than
1825 October 1, 2023, and thereafter not later than July 1, 2024, and annually
1826 thereafter, to the Commissioner of [Health Strategy] Public Health, on a
1827 form prescribed by the commissioner, concerning facility fees charged
1828 or billed during the preceding calendar year. Such report shall include,
1829 but need not be limited to, (A) the name and address of each facility
1830 owned or operated by the hospital or health system that provides
1831 services for which a facility fee is charged or billed, and an indication as
1832 to whether each facility is located on or outside of the hospital or health
1833 system campus, (B) the number of patient visits at each such facility for
1834 which a facility fee was charged or billed, (C) the number, total amount
1835 and range of allowable facility fees paid at each such facility
1836 disaggregated by payer mix, (D) for each facility, the total amount of
1837 facility fees charged and the total amount of revenue received by the
1838 hospital or health system derived from facility fees, (E) the total amount
1839 of facility fees charged and the total amount of revenue received by the
1840 hospital or health system from all facilities derived from facility fees, (F)
1841 a description of the ten procedures or services that generated the
1842 greatest amount of facility fee gross revenue, disaggregated by current
1843 procedural terminology (CPT) category code for each such procedure or
1844 service and, for each such procedure or service, patient volume and the
1845 total amount of gross and net revenue received by the hospital or health
1846 system derived from facility fees, disaggregated by on-campus and off-

1847 campus, and (G) the top ten procedures or services for which facility
1848 fees are charged based on patient volume and the gross and net revenue
1849 received by the hospital or health system for each such procedure or
1850 service, disaggregated by on-campus and off-campus. For purposes of
1851 this subsection, "facility" means a hospital-based facility that is located
1852 on a hospital campus or outside a hospital campus.

1853 (2) The commissioner shall publish the information reported
1854 pursuant to subdivision (1) of this subsection, or post a link to such
1855 information, on the Internet web site of the [Office of Health Strategy]
1856 Department of Public Health.

1857 Sec. 42. Subsection (c) of section 19a-509b of the general statutes is
1858 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1859 *2026):*

1860 (c) Each hospital that holds or administers one or more hospital bed
1861 funds shall make available in a place and manner allowing individual
1862 members of the public to easily obtain it, a one-page summary in
1863 English and Spanish describing hospital bed funds and how to apply for
1864 them. The summary shall also describe any other policies regarding the
1865 provision of charity care and reduced cost services for the indigent as
1866 reported by the hospital to the Health Systems Planning Unit of the
1867 [Office of Health Strategy] Department of Public Health pursuant to
1868 section 19a-649 and shall clearly distinguish hospital bed funds from
1869 other sources of financial assistance. The summary shall include
1870 notification that the patient is entitled to reapply upon rejection, and
1871 that additional funds may become available on an annual basis. The
1872 summary shall be available in the patient admissions office, emergency
1873 room, social services department and patient accounts or billing office,
1874 and from any collection agent. If during the admission process or during
1875 its review of the financial resources of the patient, the hospital
1876 reasonably believes the patient will have limited funds to pay for any
1877 portion of the patient's hospitalization not covered by insurance, the
1878 hospital shall provide the summary to each such patient.

1879 Sec. 43. Section 19a-612 of the general statutes is repealed and the
1880 following is substituted in lieu thereof (*Effective July 1, 2026*):

1881 [(a)] There is established, within the [Office of Health Strategy,
1882 established under section 19a-754a] Department of Public Health, a unit
1883 to be known as the Health Systems Planning Unit [. The unit, under]
1884 that shall be under the direction of the Commissioner of [Health
1885 Strategy] Public Health, [, shall constitute a successor to the former
1886 Office of Health Care Access, in accordance with the provisions of
1887 sections 4-38d and 4-39.]

1888 [(b)] Any order, decision, agreed settlement or regulation of the
1889 former Office of Health Care Access which is in force on July 1, 2018,
1890 shall continue in force and effect as an order or regulation of the Office
1891 of Health Strategy until amended, repealed or superseded pursuant to
1892 law.

1893 (c) If the words "Office of Health Care Access" are used or referred to
1894 in any public or special act of 2009 or in any section of the general
1895 statutes which is amended in 2009, such words shall be deemed to mean
1896 or refer to the Office of Health Care Access division within the
1897 Department of Public Health. If the words "Office of Health Care
1898 Access" are used or referred to in any public or special act of 2018 or in
1899 any section of the general statutes which is amended in 2018, such
1900 words shall be deemed to mean or refer to the Health Systems Planning
1901 Unit within the Office of Health Strategy.]

1902 Sec. 44. Section 19a-612d of the general statutes is repealed and the
1903 following is substituted in lieu thereof (*Effective July 1, 2026*):

1904 [(a)] The Commissioner of [Health Strategy] Public Health shall
1905 oversee the Health Systems Planning Unit and shall exercise
1906 independent decision-making authority over all certificate of need
1907 decisions.

1908 [(b)] Notwithstanding the provisions of subsection (a) of this section,

1909 the Deputy Commissioner of Public Health shall retain independent
1910 decision-making authority over only the certificate of need applications
1911 that are pending before the Office of Health Care Access and have been
1912 deemed completed by said office on or before May 14, 2018. Following
1913 the issuance by the Deputy Commissioner of Public Health of a final
1914 decision on any such certificate of need application, the Commissioner
1915 of Health Strategy shall exercise independent authority on any further
1916 action required on such certificate of need application or the certificate
1917 of need issued pursuant to such application.]

1918 Sec. 45. Subsection (c) of section 19a-613 of the general statutes is
1919 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1920 *2026*):

1921 (c) The Commissioner of [Health Strategy] Public Health or any
1922 person the commissioner designates, may conduct a hearing and render
1923 a final decision in any case when a hearing is required or authorized
1924 under the provisions of any statute dealing with the Health Systems
1925 Planning Unit.

1926 Sec. 46. Section 19a-614 of the general statutes is repealed and the
1927 following is substituted in lieu thereof (*Effective July 1, 2026*):

1928 The Commissioner of [Health Strategy] Public Health may employ
1929 and pay professional and support staff subject to the provisions of
1930 chapter 67 and contract with and engage consultants and other
1931 independent professionals as may be necessary or desirable to carry out
1932 the functions of the Health Systems Planning Unit.

1933 Sec. 47. Section 19a-630 of the 2026 supplement to the general statutes
1934 is repealed and the following is substituted in lieu thereof (*Effective July
1, 2026*):

1936 As used in this chapter, unless the context otherwise requires:

1937 (1) "Affiliate" means a person, entity or organization controlling,

1938 controlled by or under common control with another person, entity or
1939 organization. Affiliate does not include a medical foundation organized
1940 under chapter 594b.

1941 (2) "Applicant" means any person or health care facility that applies
1942 for a certificate of need pursuant to section 19a-639a, as amended by this
1943 act.

1944 (3) "Bed capacity" means the total number of inpatient beds in a
1945 facility licensed by the Department of Public Health under sections 19a-
1946 490 to 19a-503, inclusive.

1947 (4) "Capital expenditure" means an expenditure that under generally
1948 accepted accounting principles consistently applied is not properly
1949 chargeable as an expense of operation or maintenance and includes
1950 acquisition by purchase, transfer, lease or comparable arrangement, or
1951 through donation, if the expenditure would have been considered a
1952 capital expenditure had the acquisition been by purchase.

1953 (5) "Certificate of need" means a certificate issued by the unit.

1954 (6) "Days" means calendar days.

1955 (7) "Commissioner" means the Commissioner of [Health Strategy]
1956 Public Health.

1957 (8) "Free clinic" means a private, nonprofit community-based
1958 organization that provides medical, dental, pharmaceutical or mental
1959 health services at reduced cost or no cost to low-income, uninsured and
1960 underinsured individuals.

1961 (9) "Large group practice" means eight or more full-time equivalent
1962 physicians, legally organized in a partnership, professional corporation,
1963 limited liability company formed to render professional services,
1964 medical foundation, not-for-profit corporation, faculty practice plan or
1965 other similar entity (A) in which each physician who is a member of the
1966 group provides substantially the full range of services that the physician

1967 routinely provides, including, but not limited to, medical care,
1968 consultation, diagnosis or treatment, through the joint use of shared
1969 office space, facilities, equipment or personnel; (B) for which
1970 substantially all of the services of the physicians who are members of
1971 the group are provided through the group and are billed in the name of
1972 the group practice and amounts so received are treated as receipts of the
1973 group; or (C) in which the overhead expenses of, and the income from,
1974 the group are distributed in accordance with methods previously
1975 determined by members of the group. An entity that otherwise meets
1976 the definition of group practice under this section shall be considered a
1977 group practice although its shareholders, partners or owners of the
1978 group practice include single-physician professional corporations,
1979 limited liability companies formed to render professional services or
1980 other entities in which beneficial owners are individual physicians.

1981 (10) "Health care facility" means (A) hospitals licensed by the
1982 Department of Public Health under chapter 368v; (B) specialty hospitals;
1983 (C) freestanding emergency departments; (D) outpatient surgical
1984 facilities, as defined in section 19a-493b, as amended by this act, and
1985 licensed under chapter 368v; (E) a hospital or other facility or institution
1986 operated by the state that provides services that are eligible for
1987 reimbursement under Title XVIII or XIX of the federal Social Security
1988 Act, 42 USC 301, as amended; (F) a central service facility; (G) mental
1989 health facilities; (H) substance abuse treatment facilities; and (I) any
1990 other facility requiring certificate of need review pursuant to subsection
1991 (a) of section 19a-638. "Health care facility" includes any parent
1992 company, subsidiary, affiliate or joint venture, or any combination
1993 thereof, of any such facility.

1994 (11) "Nonhospital based" means located at a site other than the main
1995 campus of the hospital.

1996 (12) ["Office" means the Office of Health Strategy] "Department"
1997 means the Department of Public Health.

1998 (13) "Person" means any individual, partnership, corporation, limited
1999 liability company, association, governmental subdivision, agency or
2000 public or private organization of any character, but does not include the
2001 agency conducting the proceeding.

2002 (14) "Physician" has the same meaning as provided in section 20-13a.

2003 (15) "Termination of services" means the cessation of any services for
2004 a combined total of greater than one hundred eighty days within any
2005 consecutive two-year period.

2006 (16) "Transfer of ownership" means a transfer that impacts or changes
2007 the governance or controlling body of a health care facility, institution
2008 or large group practice, including, but not limited to, all affiliations,
2009 mergers or any sale or transfer of net assets of a health care facility.

2010 (17) "Unit" means the Health Systems Planning Unit.

2011 Sec. 48. Subsection (b) of section 19a-631 of the general statutes is
2012 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2013 *2026*):

2014 (b) Each hospital shall annually pay to the Commissioner of [Health
2015 Strategy] Public Health, for deposit in the General Fund, an amount
2016 equal to its share of the actual expenditures made by the unit during
2017 each fiscal year including the cost of fringe benefits for unit personnel
2018 as estimated by the Comptroller, the amount of expenses for central
2019 state services attributable to the unit for the fiscal year as estimated by
2020 the Comptroller, plus the expenditures made on behalf of the unit from
2021 the Capital Equipment Purchase Fund pursuant to section 4a-9 for such
2022 year. Payments shall be made by assessment of all hospitals of the costs
2023 calculated and collected in accordance with the provisions of this section
2024 and section 19a-632. If for any reason a hospital ceases operation, any
2025 unpaid assessment for the operations of the unit shall be reapportioned
2026 among the remaining hospitals to be paid in addition to any other
2027 assessment.

2028 Sec. 49. Section 19a-632a of the general statutes is repealed and the
2029 following is substituted in lieu thereof (*Effective July 1, 2026*):

2030 (a) For purposes of this section, "electronic funds transfer" has the
2031 same meaning as provided in section 12-685.

2032 (b) The [Office of Health Strategy] Department of Public Health may
2033 require a hospital to pay an assessment levied pursuant to section 19a-
2034 632 by way of an approved method of electronic funds transfer.

2035 (c) A hospital making an electronic funds transfer pursuant to this
2036 section shall initiate such transfer in a timely fashion to ensure that a
2037 bank account designated by the department is credited by electronic
2038 funds transfer for the amount of the assessment required to be made by
2039 such method on or before the date such assessment is due.

2040 (d) Where an assessment is required to be made by electronic funds
2041 transfer, any payment made by a method other than electronic funds
2042 transfer shall be treated as an assessment not made in a timely manner,
2043 and any payment made by electronic funds transfer, where the bank
2044 account designated by the department is not credited for the amount of
2045 the assessment on or before the date such assessment is due, shall be
2046 treated as an assessment not made in a timely manner. Any assessment
2047 treated under this subsection as an assessment not made in a timely
2048 manner shall be subject to a penalty in accordance with subsection (e) of
2049 this section.

2050 (e) Where any assessment is treated under subsection (d) of this
2051 section as an assessment not made in a timely manner because it is made
2052 by means other than electronic funds transfer, [there shall be imposed]
2053 the department shall impose a penalty equal to ten per cent of the
2054 assessment required to be made by electronic funds transfer. Where any
2055 assessment made by electronic funds transfer is treated under
2056 subsection (d) of this section as an assessment not made in a timely
2057 manner because the bank account designated by the department is not
2058 credited by electronic funds transfer for the amount of the assessment

2059 on or before the date such assessment is due, [there shall be imposed]
2060 the department shall impose a penalty equal to (1) two per cent of the
2061 assessment required to be made by electronic funds transfer, if such
2062 failure to pay by electronic funds transfer is for not more than five days;
2063 (2) five per cent of the assessment required to be made by electronic
2064 funds transfer, if such failure to pay by electronic funds transfer is for
2065 more than five days but not more than fifteen days; or (3) ten per cent of
2066 the assessment required to be made by electronic funds transfer, if such
2067 failure to pay by electronic funds transfer is for more than fifteen days.

2068 (f) The [office] department shall deposit all payments received
2069 pursuant to this section with the State Treasurer. The moneys so
2070 deposited shall be credited to the General Fund and shall be accounted
2071 for as expenses recovered from hospitals.

2072 Sec. 50. Subsection (a) of section 19a-634 of the 2026 supplement to
2073 the general statutes is repealed and the following is substituted in lieu
2074 thereof (*Effective July 1, 2026*):

2075 (a) The Health Systems Planning Unit shall conduct, on a biennial
2076 basis, within available appropriations, a state-wide health care facility
2077 utilization study. Such study may include an assessment of: (1) Current
2078 availability and utilization of acute hospital care, hospital emergency
2079 care, specialty hospital care, outpatient surgical care, primary care and
2080 clinic care; (2) geographic areas and subpopulations that may be
2081 underserved or have reduced access to specific types of health care
2082 services; and (3) other factors that the unit deems pertinent to health care
2083 facility utilization. Not later than June thirtieth of the year in which the
2084 biennial study is conducted, the Commissioner of [Health Strategy]
2085 Public Health shall report, in accordance with section 11-4a, to the
2086 Governor and the joint standing committees of the General Assembly
2087 having cognizance of matters relating to public health and human
2088 services on the findings of the study. Such report may also include the
2089 unit's recommendations for addressing identified gaps in the provision
2090 of health care services and recommendations concerning a lack of access

2091 to health care services.

2092 Sec. 51. Subsections (d) and (e) of section 19a-638 of the general
2093 statutes are repealed and the following is substituted in lieu thereof
2094 (*Effective July 1, 2026*):

2095 (d) The Commissioner of [Health Strategy] Public Health may
2096 implement policies and procedures necessary to administer the
2097 provisions of this section while in the process of adopting such policies
2098 and procedures as regulation, provided the commissioner holds a
2099 public hearing prior to implementing the policies and procedures and
2100 posts notice of intent to adopt regulations on the [office's] department's
2101 Internet web site and the eRegulations System not later than twenty
2102 days after the date of implementation. Policies and procedures
2103 implemented pursuant to this section shall be valid until the time final
2104 regulations are adopted.

2105 (e) On or before June 30, 2026, a mental health facility seeking to
2106 increase licensed bed capacity without applying for a certificate of need,
2107 as permitted pursuant to subdivision (23) of subsection (b) of this
2108 section, shall notify the [Office of Health Strategy] Department of Public
2109 Health in a form and manner prescribed by the commissioner,
2110 regarding (1) such facility's intent to increase licensed bed capacity, (2)
2111 the address of such facility, and (3) a description of all services that are
2112 being or will be provided at such facility.

2113 Sec. 52. Subdivision (1) of subsection (a) of section 19a-639 of the 2026
2114 supplement to the general statutes is repealed and the following is
2115 substituted in lieu thereof (*Effective July 1, 2026*):

2116 (1) Whether the proposed project is consistent with any applicable
2117 policies and standards adopted in regulations by the [Office of Health
2118 Strategy] Department of Public Health;

2119 Sec. 53. Subsection (a) of section 19a-639a of the general statutes is
2120 repealed and the following is substituted in lieu thereof (*Effective July 1,*

2121 2026):

2122 (a) An application for a certificate of need shall be filed with the unit
2123 in accordance with the provisions of this section and any regulations
2124 adopted by the [Office of Health Strategy] Department of Public Health.
2125 The application shall address the guidelines and principles set forth in
2126 (1) subsection (a) of section 19a-639, as amended by this act, and (2)
2127 regulations adopted by the department. The applicant shall include
2128 with the application a nonrefundable application fee based on the cost
2129 of the project. The amount of the fee shall be as follows: (A) One
2130 thousand dollars for a project that will cost not greater than fifty
2131 thousand dollars; (B) two thousand dollars for a project that will cost
2132 greater than fifty thousand dollars but not greater than one hundred
2133 thousand dollars; (C) three thousand dollars for a project that will cost
2134 greater than one hundred thousand dollars but not greater than five
2135 hundred thousand dollars; (D) four thousand dollars for a project that
2136 will cost greater than five hundred thousand dollars but not greater than
2137 one million dollars; (E) five thousand dollars for a project that will cost
2138 greater than one million dollars but not greater than five million dollars;
2139 (F) eight thousand dollars for a project that will cost greater than five
2140 million dollars but not greater than ten million dollars; and (G) ten
2141 thousand dollars for a project that will cost greater than ten million
2142 dollars.

2143 Sec. 54. Subsection (h) of section 19a-639a of the general statutes is
2144 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2145 2026):

2146 (h) The Commissioner of [Health Strategy] Public Health may
2147 implement policies and procedures necessary to administer the
2148 provisions of this section while in the process of adopting such policies
2149 and procedures as regulation, provided the commissioner holds a
2150 public hearing prior to implementing the policies and procedures and
2151 posts notice of intent to adopt regulations on the [office's] department's
2152 Internet web site and the eRegulations System not later than twenty

2153 days after the date of implementation. Policies and procedures
2154 implemented pursuant to this section shall be valid until the time final
2155 regulations are adopted.

2156 Sec. 55. Subsection (e) of section 19a-639b of the general statutes is
2157 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2158 2026):

2159 (e) The Commissioner of [Health Strategy] Public Health may
2160 implement policies and procedures necessary to administer the
2161 provisions of this section while in the process of adopting such policies
2162 and procedures as regulation, provided the commissioner holds a
2163 public hearing prior to implementing the policies and procedures and
2164 posts notice of intent to adopt regulations on the [office's] department's
2165 Internet web site and the eRegulations System not later than twenty
2166 days after the date of implementation. Policies and procedures
2167 implemented pursuant to this section shall be valid until the time final
2168 regulations are adopted.

2169 Sec. 56. Subsection (b) of section 19a-639c of the general statutes is
2170 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2171 2026):

2172 (b) The Commissioner of [Health Strategy] Public Health may
2173 implement policies and procedures necessary to administer the
2174 provisions of this section while in the process of adopting such policies
2175 and procedures as regulation, provided the commissioner holds a
2176 public hearing prior to implementing the policies and procedures and
2177 posts notice of intent to adopt regulations on the [office's] department's
2178 Internet web site and the eRegulations System not later than twenty
2179 days after the date of implementation. Policies and procedures
2180 implemented pursuant to this section shall be valid until the time final
2181 regulations are adopted.

2182 Sec. 57. Subsection (d) of section 19a-639e of the general statutes is
2183 repealed and the following is substituted in lieu thereof (*Effective July 1,*

2184 2026):

2185 (d) The Commissioner of [Health Strategy] Public Health may
2186 implement policies and procedures necessary to administer the
2187 provisions of this section while in the process of adopting such policies
2188 and procedures as regulation, provided the commissioner holds a
2189 public hearing prior to implementing the policies and procedures and
2190 posts notice of intent to adopt regulations on the [office's] department's
2191 Internet web site and the eRegulations System not later than twenty
2192 days after the date of implementation. Policies and procedures
2193 implemented pursuant to this section shall be valid until the time final
2194 regulations are adopted.

2195 Sec. 58. Subsection (a) of section 19a-639f of the general statutes is
2196 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2197 2026):

2198 (a) The Health Systems Planning Unit of the [Office of Health
2199 Strategy] Department of Public Health shall conduct a cost and market
2200 impact review in each case where (1) an application for a certificate of
2201 need filed pursuant to section 19a-638, as amended by this act, involves
2202 the transfer of ownership of a hospital, as defined in section 19a-639, as
2203 amended by this act, and (2) the purchaser is a hospital, as defined in
2204 section 19a-490, whether located within or outside the state, that had net
2205 patient revenue for fiscal year 2013 in an amount greater than one billion
2206 five hundred million dollars, or a hospital system, as defined in section
2207 19a-486i, as amended by this act, whether located within or outside the
2208 state, that had net patient revenue for fiscal year 2013 in an amount
2209 greater than one billion five hundred million dollars or any person that
2210 is organized or operated for profit.

2211 Sec. 59. Subsection (l) of section 19a-639f of the general statutes is
2212 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2213 2026):

2214 (l) The Commissioner of [Health Strategy] Public Health shall adopt

2215 regulations, in accordance with the provisions of chapter 54, concerning
2216 cost and market impact reviews and to administer the provisions of this
2217 section. Such regulations shall include definitions of the following
2218 terms: "Dispersed service area", "health status adjusted total medical
2219 expense", "major service category", "relative prices", "total health care
2220 spending" and "health care services". The commissioner may implement
2221 policies and procedures necessary to administer the provisions of this
2222 section while in the process of adopting such policies and procedures in
2223 regulation form, provided the commissioner publishes notice of
2224 intention to adopt the regulations on the [office's] department's Internet
2225 web site and the eRegulations System not later than twenty days after
2226 implementing such policies and procedures. Policies and procedures
2227 implemented pursuant to this subsection shall be valid until the time
2228 such regulations are effective.

2229 Sec. 60. Subsections (a) and (b) of section 19a-639g of the 2026
2230 supplement to the general statutes are repealed and the following is
2231 substituted in lieu thereof (*Effective July 1, 2026*):

2232 (a) Notwithstanding any provision of sections 19a-630 to 19a-639f,
2233 inclusive, as amended by this act, any transacting parties involved in
2234 any transfer of ownership, as defined in section 19a-630, as amended by
2235 this act, of a hospital requiring a certificate of need pursuant to section
2236 19a-638, as amended by this act, in which (1) the hospital subject to the
2237 transfer of ownership has filed for bankruptcy protection in any court
2238 of competent jurisdiction, and (2) a potential purchaser for such hospital
2239 has been or is required to be approved by a bankruptcy court, may, at
2240 the discretion of the Commissioner of [Health Strategy] Public Health,
2241 apply for an emergency certificate of need through the emergency
2242 certificate of need application process described in this section. An
2243 emergency certificate of need issued by the Health Systems Planning
2244 Unit of the [Office of Health Strategy] Department of Public Health
2245 pursuant to the provisions of this section and any conditions imposed
2246 on such issuance shall apply to the applicant applying for the
2247 emergency certificate of need, the hospital subject to the transfer of

2248 ownership and any subsidiary or group practice that would otherwise
2249 require a certificate of need pursuant to the provisions of section 19a-
2250 638, as amended by this act, and that is also subject to the transfer of
2251 ownership as part of the bankruptcy proceeding. The availability of the
2252 emergency certificate of need application process described in this
2253 section shall not affect any existing certificate of need issued pursuant
2254 to the provisions of sections 19a-630 to 19a-639f, inclusive, as amended
2255 by this act.

2256 (b) (1) The unit shall develop an emergency certificate of need
2257 application, which shall identify any data required to be submitted with
2258 such application that the unit deems necessary to analyze the effects of
2259 a hospital's transfer of ownership on health care costs, quality and access
2260 in the affected market. If a potential purchaser of a hospital, described
2261 in subsection (a) of this section, is a for-profit entity, the unit's
2262 emergency certificate of need application may require additional
2263 information or data intended to ensure that the ongoing operation of the
2264 hospital after the transfer of ownership will be maintained in the public
2265 interest. The commissioner shall post any emergency certificate of need
2266 application developed pursuant to the provisions of this subdivision on
2267 the [Office of Health Strategy's] Department of Public Health's Internet
2268 web site and may modify any data required to be submitted with an
2269 emergency certificate of need application, provided the commissioner
2270 posts any such modification to the [office's] department's Internet web
2271 site not later than fifteen days before such a modification becomes
2272 effective.

2273 (2) An applicant seeking an emergency certificate of need shall
2274 submit an emergency certificate of need application to the unit in a form
2275 and manner prescribed by the commissioner.

2276 (3) An emergency certificate of need application shall be deemed
2277 complete on the date the unit determines that an applicant has
2278 submitted a complete application, including data required by the unit
2279 pursuant to subdivision (1) of this subsection. The unit shall determine

2280 whether an application is complete not later than three business days
2281 after an applicant submits an application. If, after making such a
2282 determination, the unit deems an application incomplete, the unit shall,
2283 not more than three business days after deeming such application
2284 incomplete, notify the applicant that such application is incomplete and
2285 identify any application or data elements that were not adequately
2286 addressed by the applicant. The unit shall not review such an
2287 application until the applicant submits any such application or data
2288 elements to the unit.

2289 (4) The unit may hold a public hearing on an emergency certificate of
2290 need application, provided (A) the unit holds such public hearing not
2291 later than thirty days after such application is deemed complete, and (B)
2292 the unit notifies the applicant of such public hearing not less than five
2293 days before the date of the public hearing. Any such public hearing or
2294 any other proceeding related to the emergency certificate of need
2295 application process described in this section shall not be considered a
2296 contested case pursuant to the provisions of chapter 54. Members of the
2297 public may submit public comments at any time during the emergency
2298 certificate of need application process and may request the unit to
2299 exercise its discretion to hold a public hearing pursuant to the
2300 provisions of this subdivision.

2301 (5) When evaluating an emergency certificate of need application, the
2302 unit may consult any person and consider any relevant information,
2303 provided, unless prohibited by federal or state law, the unit includes
2304 any opinion or information gathered from consulting any such person
2305 and any such relevant information considered in the record relating to
2306 the emergency certificate of need application and cites any such opinion
2307 or information and any such relevant information considered in its final
2308 decision on the emergency certificate of need application. The unit may
2309 contract with one or more third-party consultants, at the expense of the
2310 applicant, to analyze (A) the anticipated effect of the hospital's transfer
2311 of ownership on access, cost and quality of health care in the affected
2312 community, and (B) any other issue arising from the application review

2313 process. The aggregate cost of any such third-party consultations shall
2314 not exceed two hundred thousand dollars. Any reports or analyses
2315 generated by any such third-party consultant that the unit considers in
2316 issuing its final decision on an emergency certificate of need application
2317 shall, unless otherwise prohibited by federal or state law, be included in
2318 the record relating to the emergency certificate of need application. The
2319 provisions of chapter 57 and sections 4-212 to 4-219, inclusive, and 4-
2320 19 shall not apply to any retainer agreement executed pursuant to this
2321 subsection.

2322 Sec. 61. Section 19a-643 of the general statutes is repealed and the
2323 following is substituted in lieu thereof (*Effective July 1, 2026*):

2324 (a) The [Office of Health Strategy] Department of Public Health shall
2325 adopt regulations, in accordance with the provisions of chapter 54, to
2326 carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as
2327 amended by this act, and sections 19a-644, as amended by this act, and
2328 19a-645, as amended by this act, concerning the submission of data by
2329 health care facilities and institutions, including data on dealings
2330 between health care facilities and institutions and their affiliates, and,
2331 with regard to requests or proposals pursuant to sections 19a-638 to 19a-
2332 639e, inclusive, as amended by this act, by state health care facilities and
2333 institutions, the ongoing inspections by the unit of operating budgets
2334 that have been approved by the health care facilities and institutions,
2335 standard reporting forms and standard accounting procedures to be
2336 utilized by health care facilities and institutions and the transferability
2337 of line items in the approved operating budgets of the health care
2338 facilities and institutions, except that any health care facility or
2339 institution may transfer any amounts among items in its operating
2340 budget. All such transfers shall be reported to the unit not later than
2341 thirty days after the transfer or transfers.

2342 (b) The [Office of Health Strategy] Department of Public Health may
2343 adopt such regulations, in accordance with the provisions of chapter 54,
2344 as are necessary to implement this chapter.

2345 Sec. 62. Subsections (a) and (b) of section 19a-644 of the general
2346 statutes are repealed and the following is substituted in lieu thereof
2347 (*Effective July 1, 2026*):

2348 (a) On or before February twenty-eighth annually, for the fiscal year
2349 ending on September thirtieth of the immediately preceding year, each
2350 short-term acute care general or children's hospital shall report to the
2351 unit with respect to its operations in such fiscal year, in such form as the
2352 unit may by regulation require. Such report shall include: (1) Salaries
2353 and fringe benefits for the ten highest paid hospital and health system
2354 employees; (2) the name of each joint venture, partnership, subsidiary
2355 and corporation related to the hospital; (3) the salaries paid to hospital
2356 and health system employees by each such joint venture, partnership,
2357 subsidiary and related corporation and by the hospital to the employees
2358 of related corporations; and (4) information and data prescribed by the
2359 [Office of Health Strategy] Department of Public Health concerning
2360 charges for trauma activation fees. For purposes of this subsection,
2361 "health system" has the same meaning as provided in section 33-182aa.

2362 (b) The [Office of Health Strategy] Commissioner of Public Health
2363 shall adopt regulations in accordance with chapter 54 to provide for the
2364 collection of data and information in addition to the annual report
2365 required in subsection (a) of this section. Such regulations shall provide
2366 for the submission of information about the operations of the following
2367 entities: Persons or parent corporations that own or control the health
2368 care facility, institution or provider; corporations, including limited
2369 liability corporations, in which the health care facility, institution,
2370 provider, its parent, any type of affiliate or any combination thereof,
2371 owns more than an aggregate of fifty per cent of the stock or, in the case
2372 of nonstock corporations, is the sole member; and any partnerships in
2373 which the person, health care facility, institution, provider, its parent or
2374 an affiliate or any combination thereof, or any combination of health
2375 care providers or related persons, owns a greater than fifty per cent
2376 interest. For purposes of this subsection, "affiliate" means any person
2377 that directly or indirectly through one or more intermediaries, controls

2378 or is controlled by or is under common control with any health care
2379 facility, institution, provider or person that is regulated in any way
2380 under this chapter. A person is deemed controlled by another person if
2381 the other person, or one of that other person's affiliates, officers, agents
2382 or management employees, acts as a general partner or manager of the
2383 person in question.

2384 Sec. 63. Section 19a-645 of the general statutes is repealed and the
2385 following is substituted in lieu thereof (*Effective July 1, 2026*):

2386 A nonprofit hospital, licensed by the Department of Public Health,
2387 [which] that provides lodging, care and treatment to members of the
2388 public, and [which] that wishes to enlarge its public facilities by adding
2389 contiguous land and buildings thereon, if any, the title to which it
2390 cannot otherwise acquire, may prefer a complaint for the right to take
2391 such land to the superior court for the judicial district in which such land
2392 is located, provided such hospital shall have received the approval of
2393 the Health Systems Planning Unit of the [Office of Health Strategy]
2394 Department of Public Health in accordance with the provisions of this
2395 chapter. Said court shall appoint a committee of three disinterested
2396 persons, who, after examining the premises and hearing the parties,
2397 shall report to the court as to the necessity and propriety of such
2398 enlargement and as to the quantity, boundaries and value of the land
2399 and buildings thereon, if any, [which] that they deem proper to be taken
2400 for such purpose and the damages resulting from such taking. If such
2401 committee reports that such enlargement is necessary and proper and
2402 the court accepts such report, the decision of said court thereon shall
2403 have the effect of a judgment and execution may be issued thereon
2404 accordingly, in favor of the person to whom damages may be assessed,
2405 for the amount thereof; and, on payment thereof, the title to the land and
2406 buildings thereon, if any, for such purpose shall be vested in the
2407 complainant, but such land and buildings thereon, if any, shall not be
2408 taken until such damages are paid to such owner or deposited with said
2409 court, for such owner's use, [within] not later than thirty days after such
2410 report is accepted. If such application is denied, the owner of the land

2411 shall recover costs of the applicant, to be taxed by said court, which may
2412 issue execution therefor. Land so taken shall be held by such hospital
2413 and used only for the public purpose stated in its complaint to the
2414 superior court. No land dedicated or otherwise reserved as open space
2415 or park land or for other recreational purposes and no land belonging
2416 to any town, city or borough shall be taken under the provisions of this
2417 section.

2418 Sec. 64. Subdivision (1) of subsection (a) of section 19a-646 of the
2419 general statutes is repealed and the following is substituted in lieu
2420 thereof (*Effective July 1, 2026*):

2421 (1) "Unit" means the Health Systems Planning Unit within the [Office
2422 of Health Strategy] Department of Public Health, established under
2423 section 19a-612, as amended by this act;

2424 Sec. 65. Subsections (a) to (d), inclusive, of section 19a-653 of the
2425 general statutes are repealed and the following is substituted in lieu
2426 thereof (*Effective July 1, 2026*):

2427 (a) Any person or health care facility or institution that is required to
2428 file a certificate of need for any of the activities described in section 19a-
2429 638, and any person or health care facility or institution that is required
2430 to file data or information under any public or special act or under this
2431 chapter or sections 19a-486 to 19a-486h, inclusive, as amended by this
2432 act, or any regulation adopted or order issued under this chapter or said
2433 sections, and negligently fails to seek certificate of need approval for any
2434 of the activities described in section 19a-638, or to so file within
2435 prescribed time periods, and any person or health care facility or
2436 institution that has agreed to fully resolve a certificate of need
2437 application through settlement and negligently fails to comply with any
2438 term or condition enumerated in the settlement agreement, shall be
2439 subject to a civil penalty of up to one thousand dollars a day for each
2440 day such person or health care facility or institution conducts any of the
2441 described activities without certificate of need approval as required by

2442 section 19a-638, for each day such information is missing, incomplete or
2443 inaccurate or for each day any condition of a settlement agreement is
2444 not met. Any civil penalty authorized by this section shall be imposed
2445 by the [Office of Health Strategy] Department of Public Health in
2446 accordance with subsections (b) to (e), inclusive, of this section.

2447 (b) If the [Office of Health Strategy] Department of Public Health has
2448 reason to believe that a violation has occurred for which a civil penalty
2449 is authorized by subsection (a) of this section or subsection (e) of section
2450 19a-632, [it] the department shall notify the person or health care facility
2451 or institution by first-class mail or personal service. The notice shall
2452 include: (1) A reference to the sections of the statute, regulation or
2453 settlement agreement involved; (2) a short and plain statement of the
2454 matters asserted or charged; (3) a statement of the amount of the civil
2455 penalty or penalties to be imposed; (4) the initial date of the imposition
2456 of the penalty; and (5) a statement of the party's right to a hearing.

2457 (c) The person or health care facility or institution to whom the notice
2458 is addressed shall have fifteen business days [from] after the date of
2459 mailing of the notice to make written application to the unit to (1)
2460 request a hearing to contest the imposition of the penalty, (2) request an
2461 extension of time to file the required data, or (3) comply with
2462 enumerated conditions of an agreed settlement. A failure to make a
2463 timely request for a hearing or an extension of time to file the required
2464 data or a denial of a request for an extension of time shall result in a final
2465 order for the imposition of the penalty. All hearings under this section
2466 shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The
2467 [Office of Health Strategy] Department of Public Health may grant an
2468 extension of time for filing the required data or mitigate or waive the
2469 penalty upon such terms and conditions as, in its discretion, it deems
2470 proper or necessary upon consideration of any extenuating factors or
2471 circumstances.

2472 (d) A final order of the [Office of Health Strategy] Department of
2473 Public Health assessing a civil penalty shall be subject to appeal as set

2474 forth in section 4-183 after a hearing before the unit pursuant to
2475 subsection (c) of this section, except that any such appeal shall be taken
2476 to the superior court for the judicial district of New Britain. Such final
2477 order shall not be subject to appeal under any other provision of the
2478 general statutes. No challenge to any such final order shall be allowed
2479 as to any issue [which] that could have been raised by an appeal of an
2480 earlier order, denial or other final decision by the [office] department.

2481 Sec. 66. Subsections (b) to (g), inclusive, of section 19a-654 of the
2482 general statutes are repealed and the following is substituted in lieu
2483 thereof (*Effective July 1, 2026*):

2484 (b) Each short-term acute care general or children's hospital shall
2485 submit patient-identifiable inpatient discharge data and emergency
2486 department data to the [Health Systems Planning Unit of the Office of
2487 Health Strategy] Department of Public Health to [fulfill the] (i) assist the
2488 department in fulfilling its responsibilities [of the unit] under chapter
2489 368z, and (ii) for the purposes set forth in section 19a-25 and the
2490 regulations promulgated thereunder. Such data shall include data taken
2491 from patient medical record abstracts and bills. The [unit] department
2492 shall specify the timing and format of such submissions. Data submitted
2493 pursuant to this section may be submitted through a contractual
2494 arrangement with an intermediary and such contractual arrangement
2495 shall (1) comply with the provisions of the Health Insurance Portability
2496 and Accountability Act of 1996 P.L. 104-191 (HIPAA), and (2) ensure
2497 that such submission of data is timely and accurate. The [unit] department
2498 may conduct an audit of the data submitted through such
2499 intermediary in order to verify its accuracy.

2500 (c) An outpatient surgical facility, as defined in section 19a-493b, as
2501 amended by this act, a short-term acute care general or children's
2502 hospital, or a facility that provides outpatient surgical services as part of
2503 the outpatient surgery department of a short-term acute care hospital
2504 shall submit to the unit the data identified in subsection (c) of section
2505 19a-634. The unit shall convene a working group consisting of

2506 representatives of outpatient surgical facilities, hospitals and other
2507 individuals necessary to develop recommendations that address current
2508 obstacles to, and proposed requirements for, patient-identifiable data
2509 reporting in the outpatient setting. [On or before February 1, 2012, the]
2510 The working group shall report, in accordance with the provisions of
2511 section 11-4a, on its findings and recommendations to the joint standing
2512 committees of the General Assembly having cognizance of matters
2513 relating to public health and insurance and real estate []. Additional
2514 reporting of] such outpatient data as the unit deems necessary. [shall
2515 begin not later than July 1, 2015. On or before July 1, 2018, and annually
2516 thereafter,] Not later than July first annually, the Connecticut
2517 Association of Ambulatory Surgery Centers shall provide a progress
2518 report to the [Office of Health Strategy] Department of Public Health,
2519 until such time as all ambulatory surgery centers are in full compliance
2520 with the implementation of systems that allow for the reporting of
2521 outpatient data as required by the [commissioner] Commissioner of
2522 Public Health. Until such additional reporting requirements take effect
2523 on July 1, 2015, the department may work with the Connecticut
2524 Association of Ambulatory Surgery Centers and the Connecticut
2525 Hospital Association on specific data reporting initiatives provided that
2526 no penalties shall be assessed under this chapter or any other provision
2527 of law with respect to the failure to submit such data.

2528 (d) Except as provided in this subsection and section 19a-25, and the
2529 regulations promulgated thereunder, patient-identifiable data received
2530 by the unit shall be kept confidential by the department and shall not be
2531 considered public records or files subject to disclosure under the
2532 Freedom of Information Act, as defined in section 1-200. The [unit]
2533 department may release de-identified patient data or aggregate patient
2534 data to the public in a manner consistent with the provisions of 45 CFR
2535 164.514. [Any de-identified patient data released by the unit shall
2536 exclude provider, physician and payer organization names or codes and
2537 shall be kept confidential by the recipient. The unit] The department
2538 may release patient-identifiable data (1) for [medical and scientific

2539 research as provided for in section 19a-25-3 of the regulations of
2540 Connecticut state agencies, and (2) to (A) a state agency for the purpose
2541 of improving health care service delivery, (B)] the purposes set forth in
2542 and pursuant to section 19a-25 and the regulations promulgated
2543 thereunder, and (2) to (A) a federal agency or the office of the Attorney
2544 General for the purpose of investigating hospital mergers and
2545 acquisitions, [(C)] (B) another state's health data collection agency with
2546 which the unit has entered into a reciprocal data-sharing agreement for
2547 the purpose of certificate of need review or evaluation of health care
2548 services, upon receipt of a request from such agency, provided, prior to
2549 the release of such patient-identifiable data, such agency enters into a
2550 written agreement with the unit pursuant to which such agency agrees
2551 to protect the confidentiality of such patient-identifiable data and not to
2552 use such patient-identifiable data as a basis for any decision concerning
2553 a patient, or [(D)] (C) a consultant or independent professional
2554 contracted by the [Office of Health Strategy] Department of Public
2555 Health pursuant to section 19a-614, as amended by this act, to carry out
2556 the functions of the [unit] department, including collecting, managing
2557 or organizing such patient-identifiable data. [No] Except as provided
2558 under section 19a-25 and the regulations promulgated thereunder, no
2559 individual or entity receiving patient-identifiable data may release such
2560 data in any manner that may result in an individual patient, physician,
2561 provider or payer being identified. The unit shall impose a reasonable,
2562 cost-based fee for any patient data provided to a nongovernmental
2563 entity.

2564 (e) Not later than October 1, 2018, the [Health Systems Planning Unit]
2565 department shall enter into a memorandum of understanding with the
2566 Comptroller that shall permit the Comptroller to access the data set forth
2567 in subsections (b) and (c) of this section, provided the Comptroller
2568 agrees, in writing, to keep individual patient and provider data
2569 identified by proper name or personal identification code and submitted
2570 pursuant to this section confidential.

2571 (f) The Commissioner of [Health Strategy] Public Health shall adopt

2572 regulations, in accordance with the provisions of chapter 54, to carry out
2573 the provisions of this section.

2574 (g) The duties assigned to the [Office of Health Strategy] Department
2575 of Public Health under the provisions of this section shall be
2576 implemented within available appropriations.

2577 Sec. 67. Subdivision (1) of section 19a-659 of the general statutes is
2578 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2579 2026):

2580 (1) "Unit" means the Health Systems Planning Unit within the [Office
2581 of Health Strategy] Department of Public Health, established under
2582 section 19a-612, as amended by this act;

2583 Sec. 68. Section 19a-673a of the general statutes is repealed and the
2584 following is substituted in lieu thereof (*Effective July 1, 2026*):

2585 The Commissioner of [Health Strategy] Public Health shall adopt
2586 regulations, in accordance with chapter 54, to establish uniform debt
2587 collection standards for hospitals.

2588 Sec. 69. Subsection (c) of section 19a-681 of the general statutes is
2589 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2590 2026):

2591 (c) Upon the request of the [Office of Health Strategy, established
2592 under section 19a-754a] Department of Public Health, or a patient, a
2593 hospital shall provide to the [office] department or the patient a detailed
2594 patient bill. If the billing detail by line item on a detailed patient bill does
2595 not agree with the detailed schedule of charges on file with the unit for
2596 the date of service specified on the bill, the hospital shall be subject to a
2597 civil penalty of five hundred dollars per occurrence payable to the state
2598 not later than fourteen days after the date of notification. The penalty
2599 shall be imposed in accordance with section 19a-653, as amended by this
2600 act. The unit may issue an order requiring such hospital, not later than

2601 fourteen days after the date of notification of an overcharge to a patient,
2602 to adjust the bill to be consistent with the detailed schedule of charges
2603 on file with the unit for the date of service specified on the detailed
2604 patient bill.

2605 Sec. 70. Subsections (b) to (f), inclusive, of section 19a-754b of the
2606 general statutes are repealed and the following is substituted in lieu
2607 thereof (*Effective July 1, 2026*):

2608 (b) Beginning on January 1, 2020, each sponsor shall submit to the
2609 [Office of Health Strategy, established in section 19a-754a] Department
2610 of Public Health, in a form and manner specified by the [office]
2611 department, written notice informing the [office] department that such
2612 sponsor has filed with the federal Food and Drug Administration:

2613 (1) A new drug application or biologics license application for a
2614 pipeline drug, not later than sixty days after such sponsor receives an
2615 action date from the federal Food and Drug Administration regarding
2616 such application; or

2617 (2) A biologics license application for a biosimilar drug, not later than
2618 sixty days after such sponsor's receipt of an action date from the federal
2619 Food and Drug Administration regarding such application.

2620 (c) (1) Beginning on January 1, 2020, the Commissioner of [Health
2621 Strategy] Public Health may conduct a study, with the assistance of the
2622 Comptroller and not more frequently than once annually, of each
2623 pharmaceutical manufacturer of a pipeline drug that, in the opinion of
2624 the commissioner in consultation with the Comptroller and the
2625 Commissioner of Social Services, may have a significant impact on state
2626 expenditures for outpatient prescription drugs. The [office] Department
2627 of Public Health may work with the Comptroller to utilize existing state
2628 resources and contracts, or contract with a third party, including, but
2629 not limited to, an accounting firm, to conduct such study.

2630 (2) Each pharmaceutical manufacturer that is the subject of a study

2631 conducted pursuant to subdivision (1) of this subsection shall submit to
2632 the [office] Department of Public Health, or any contractor engaged by
2633 the [office] department or the Comptroller to perform such study, the
2634 following information for the pipeline drug that is the subject of such
2635 study:

2636 (A) The primary disease, condition or therapeutic area studied in
2637 connection with such drug, and whether such drug is therapeutically
2638 indicated for such disease, condition or therapeutic area;

2639 (B) Each route of administration studied for such drug;

2640 (C) Clinical trial comparators, if applicable, for such drug;

2641 (D) The estimated year of market entry for such drug;

2642 (E) Whether the federal Food and Drug Administration has
2643 designated such drug as an orphan drug, a fast track product or a
2644 breakthrough therapy; and

2645 (F) Whether the federal Food and Drug Administration has
2646 designated such drug for accelerated approval and, if such drug
2647 contains a new molecular entity, for priority review.

2648 (d) (1) [On or before] Not later than March 1, [2020, and] annually,
2649 [thereafter,] the Commissioner of [Health Strategy] Public Health, in
2650 consultation with the Comptroller [] and the Commissioner of Social
2651 Services, [and Commissioner of Public Health,] shall prepare a list of not
2652 more than ten outpatient prescription drugs that the Commissioner of
2653 [Health Strategy] Public Health, in the commissioner's discretion,
2654 determines are (A) provided at substantial cost to the state, considering
2655 the net cost of such drugs, or (B) critical to public health. The list shall
2656 include outpatient prescription drugs from different therapeutic classes
2657 of outpatient prescription drugs and not less than one generic outpatient
2658 prescription drug.

2659 (2) Prior to publishing the annual list pursuant to subdivision (1) of

2660 this subsection, the [commissioner] Commissioner of Public Health
2661 shall prepare a preliminary list that includes outpatient prescription
2662 drugs that the commissioner plans to include on such annual list. The
2663 commissioner shall make such preliminary list available for public
2664 comment for not less than thirty days. During the public comment
2665 period, any manufacturer of an outpatient prescription drug included
2666 on the preliminary list may produce documentation, as permitted by
2667 federal law, to the commissioner to establish that the wholesale
2668 acquisition cost of such drug, less all rebates paid to the state for such
2669 outpatient prescription drug during the immediately preceding
2670 calendar year, does not exceed the limits established in subdivision (3)
2671 of this subsection. If such documentation establishes, to the satisfaction
2672 of the commissioner, that the wholesale acquisition cost of the drug, less
2673 all rebates paid to the state for such drug during the immediately
2674 preceding calendar year, does not exceed the limits established in
2675 subdivision (3) of this subsection, the commissioner shall, not later than
2676 fifteen days after the closing of the public comment period, remove such
2677 drug from the preliminary list before publishing the annual list
2678 pursuant to subdivision (1) of this subsection.

2679 (3) The [commissioner] Commissioner of Public Health shall not list
2680 any outpatient prescription drugs under subdivision (1) or (2) of this
2681 subsection unless the wholesale acquisition cost of such outpatient
2682 prescription drug (A) increased by not less than sixteen per cent
2683 cumulatively during the immediately preceding two calendar years,
2684 and (B) was not less than forty dollars for a course of treatment.

2685 (4) (A) The pharmaceutical manufacturer of an outpatient
2686 prescription drug included on a list prepared by the [commissioner]
2687 Commissioner of Public Health pursuant to subdivision (1) of this
2688 subsection shall provide to the [office] department, in a form and
2689 manner specified by the commissioner, (i) a written, narrative
2690 description, suitable for public release, of all factors that caused the
2691 increase in the wholesale acquisition cost of the listed outpatient
2692 prescription drug, and (ii) aggregate, company-level research and

2693 development costs and such other capital expenditures that the
2694 commissioner, in the commissioner's discretion, deems relevant for the
2695 most recent year for which final audited data are available.

2696 (B) The quality and types of information and data that a
2697 pharmaceutical manufacturer submits to the [office] department under
2698 this subdivision shall be consistent with the quality and types of
2699 information and data that the pharmaceutical manufacturer includes in
2700 (i) such pharmaceutical manufacturer's annual consolidated report on
2701 Securities and Exchange Commission Form 10-K, or (ii) any other public
2702 disclosure.

2703 (5) The [office] Department of Public Health shall establish a
2704 standardized form for reporting information and data pursuant to this
2705 subsection after consulting with pharmaceutical manufacturers. The
2706 form shall be designed to minimize the administrative burden and cost
2707 of reporting on the [office] department and pharmaceutical
2708 manufacturers.

2709 (e) The [office] Department of Public Health may impose a penalty of
2710 not more than seven thousand five hundred dollars on a pharmaceutical
2711 manufacturer or sponsor for each violation of this section by the
2712 pharmaceutical manufacturer or sponsor.

2713 (f) The [office] Department of Public Health may adopt regulations,
2714 in accordance with the provisions of chapter 54, to carry out the
2715 purposes of this section.

2716 Sec. 71. Subsections (a) to (c), inclusive, of section 19a-754c of the
2717 general statutes are repealed and the following is substituted in lieu
2718 thereof (*Effective July 1, 2026*):

2719 (a) For the purposes of this section:

2720 (1) "Affordable Care Act" has the same meaning as provided in
2721 section 38a-1080;

2722 (2) "Covered Connecticut program" means the program established
2723 under subsection (b) of this section;

2724 (3) "Exchange" has the same meaning as provided in section 38a-1080;

2725 (4) "Health carrier" has the same meaning as provided in section 38a-
2726 1080;

2727 (5) "Individual market" has the same meaning as provided in 42 USC
2728 18024(a), as amended from time to time; and

2729 [(6) "Office of Health Strategy" means the Office of Health Strategy
2730 established under section 19a-754a; and]

2731 [(7)] (6) "Silver level" has the same meaning as provided in 42 USC
2732 18022(d), as amended from time to time.

2733 (b) There is established within the Department of Social Services the
2734 Covered Connecticut program for the purpose of reducing the state's
2735 uninsured rate. The Commissioner of Social Services shall administer
2736 said program in consultation with the [Office of Health Strategy,]
2737 Insurance Commissioner and exchange, and, as part of said program,
2738 the Department of Social Services shall:

2739 (1) Provide premium and cost-sharing subsidies that are sufficient to
2740 ensure fully subsidized coverage:

2741 (A) On and after July 1, 2021, for parents and needy caretaker
2742 relatives, and their tax dependents not older than twenty-six years of
2743 age, who (i) are eligible for premium and cost-sharing subsidies for a
2744 qualified health plan, (ii) are ineligible for Medicaid because their
2745 income exceeds the Medicaid income limits under chapter 319v, (iii)
2746 have household income up to one hundred seventy-five per cent of the
2747 federal poverty level, (iv) are receiving coverage under a qualified
2748 health plan offered through the exchange in the individual market at a
2749 silver level of coverage, and (v) are utilizing the full amount of
2750 applicable premium subsidies for such plan;

2751 (B) On and after July 1, 2021, for the following additional family
2752 members of parents and caretaker relatives receiving coverage under
2753 such qualified health plan, provided the requirements of subparagraph
2754 (A) of subdivision (1) of this subsection are met: (i) A child over twenty-
2755 six years of age who is permanently and totally disabled, as defined by
2756 the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who
2757 is over the age of twenty-six and is incapable of self-sustaining
2758 employment by reason of mental or physical handicap and is chiefly
2759 dependent upon the parent or caretaker relative for support and
2760 maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a
2761 child or stepchild receiving coverage under such qualified health plan
2762 as described in sections 38a-497 and 38a-512b;

2763 (C) On and after July 1, 2022, for all parents, needy caretaker relatives
2764 and low-income adults who (i) are at least nineteen but not more than
2765 sixty-four years of age, (ii) are eligible for premium and cost-sharing
2766 subsidies for a qualified health plan, (iii) are ineligible for Medicaid
2767 because their income exceeds the Medicaid income limits under chapter
2768 319v, (iv) have household income up to one hundred seventy-five per
2769 cent of the federal poverty level, (v) are receiving coverage under a
2770 qualified health plan offered through the exchange in the individual
2771 market at a silver level of coverage, and (vi) are utilizing the full amount
2772 of applicable premium subsidies for such plan; and

2773 (D) On and after July 1, 2022, for the following additional family
2774 members of parents, caretaker relatives, and adults receiving coverage
2775 under such qualified health plan, provided the requirements of
2776 subparagraph (C) of subdivision (1) of this subsection are met: (i) A
2777 child over twenty-six years of age who is permanently and totally
2778 disabled, as defined by the Internal Revenue Service pursuant to 26 USC
2779 152, or (ii) a child who is over the age of twenty-six and is incapable of
2780 self-sustaining employment by reason of mental or physical handicap
2781 and is chiefly dependent upon the parent or caretaker relative for
2782 support and maintenance, as described in sections 38a-489 and 38a-512a,
2783 or (iii) a child or stepchild, as described in sections 38a-497 and 38a-512b.

2784 (2) Not earlier than July 1, 2022, provide dental and nonemergency
2785 medical transportation services, as provided under chapter 319v, to all
2786 eligible individuals described in subdivision (1) of this subsection;

2787 (3) Establish procedures to, on a quarterly basis, pay in
2788 reimbursement to each health carrier offering the qualified health plan
2789 described in subparagraph (A) or (B) of subdivision (1) of this
2790 subsection, as applicable, the premium and cost-sharing subsidies
2791 required under subdivision (1) of this subsection to ensure fully
2792 subsidized coverage; and

2793 (4) Consult with the [Office of Health Strategy and] Insurance
2794 Commissioner for the purposes set forth in section 17b-312, as amended
2795 by this act.

2796 (c) (1) The [Office of Health Strategy] Department of Social Services
2797 may, subject to the approval required under subdivision (3) of this
2798 subsection, seek a waiver pursuant to Section 1332 of the Affordable
2799 Care Act, as amended from time to time, to advance the purpose of the
2800 Covered Connecticut program. The [Office of Health Strategy]
2801 department shall implement such waiver if the federal government
2802 issues such waiver.

2803 (2) The [Office of Health Strategy] Commissioner of Social Services
2804 shall submit a report, in accordance with section 11-4a, to the joint
2805 standing committees of the General Assembly having cognizance of
2806 matters relating to appropriations, human services and insurance
2807 containing any proposed waiver described in subdivision (1) of this
2808 subsection before seeking such waiver from the federal government.

2809 (3) Not later than thirty days after the [Office of Health Strategy]
2810 Commissioner of Social Services submits a report under subdivision (2)
2811 of this subsection, the joint standing committees of the General
2812 Assembly having cognizance of matters relating to appropriations,
2813 human services and insurance shall convene a joint public hearing on
2814 the proposed waiver contained in the report submitted pursuant to

2815 subdivision (2) of this subsection, separately vote to approve or reject
2816 such proposed waiver and advise the [Office of Health Strategy]
2817 commissioner of their approval or rejection of such proposed waiver. If
2818 any committee takes no action on such proposed waiver within the
2819 thirty-day period, the proposed waiver shall be deemed rejected.

2820 Sec. 72. Section 19a-754d of the general statutes is repealed and the
2821 following is substituted in lieu thereof (*Effective July 1, 2026*):

2822 (a) [On and after January 1, 2022, any] Any state agency, board or
2823 commission that directly, or by contract with another entity, collects
2824 demographic data concerning the ancestry or ethnic origin, ethnicity,
2825 race or primary language of residents of the state in the context of health
2826 care or for the provision or receipt of health care services or for any
2827 public health purpose shall:

2828 (1) Collect such data in a manner that allows for aggregation and
2829 disaggregation of data;

2830 (2) Expand race and ethnicity categories to include subgroup
2831 identities as specified by the [Community and Clinical Integration
2832 Program of the Office of Health Strategy] Office of Policy and
2833 Management and follow the hierarchical mapping to align with United
2834 States Office of Management and Budget standards;

2835 (3) Provide the option to individuals of selecting one or more ethnic
2836 or racial designations and include an "other" designation with the ability
2837 to write in identities not represented by other codes;

2838 (4) Provide the option to individuals to refuse to identify with any
2839 ethnic or racial designations;

2840 (5) Collect primary language data employing language codes set by
2841 the International Organization for Standardization; and

2842 (6) Ensure, in cases where data concerning an individual's ethnic
2843 origin, ethnicity or race is reported to any other state agency, board or

2844 commission, that such data is neither tabulated nor reported without all
2845 of the following information: (A) The number or percentage of
2846 individuals who identify with each ethnic or racial designation as their
2847 sole ethnic or racial designation and not in combination with any other
2848 ethnic or racial designation; (B) the number or percentage of individuals
2849 who identify with each ethnic or racial designation, whether as their sole
2850 ethnic or racial designation or in combination with other ethnic or racial
2851 designations; (C) the number or percentage of individuals who identify
2852 with multiple ethnic or racial designations; and (D) the number or
2853 percentage of individuals who do not identify or refuse to identify with
2854 any ethnic or racial designations.

2855 (b) Each health care provider with an electronic health record system
2856 capable of connecting to and participating in the State-wide Health
2857 Information Exchange as specified in section 17b-59e, as amended by
2858 this act, shall, collect and include in its electronic health record system
2859 self-reported patient demographic data including, but not limited to,
2860 race, ethnicity, primary language, insurance status and disability status
2861 based upon the implementation plan developed [under subsection (c) of
2862 this section] in consultation with consumer advocates, health equity
2863 experts, state agencies and health care providers for the changes
2864 required by this section. Race and ethnicity data shall adhere to
2865 standard categories as determined in subsection (a) of this section.

2866 [(c) Not later than August 1, 2021, the Office of Health Strategy shall
2867 consult with consumer advocates, health equity experts, state agencies
2868 and health care providers, to create an implementation plan for the
2869 changes required by this section.]

2870 [(d)] (c) The Office of [Health Strategy] Policy and Management shall
2871 (1) review (A) demographic changes in race and ethnicity, as
2872 determined by the U.S. Census Bureau, and (B) health data collected by
2873 the state, and (2) reevaluate the standard race and ethnicity categories
2874 from time to time, in consultation with health care providers, consumers
2875 and the joint standing committee of the General Assembly having

2876 cognizance of matters relating to public health.

2877 Sec. 73. Section 19a-754f of the general statutes is repealed and the
2878 following is substituted in lieu thereof (*Effective July 1, 2026*):

2879 For the purposes of this section and sections 19a-754g to 19a-754k,
2880 inclusive, as amended by this act:

2881 (1) "Drug manufacturer" means the manufacturer of a drug that is:
2882 (A) Included in the information and data submitted by a health carrier
2883 pursuant to section 38a-479qqq, (B) studied or listed pursuant to
2884 subsection (c) or (d) of section 19a-754b, as amended by this act, or (C)
2885 in a therapeutic class of drugs that the [Commissioner of Health
2886 Strategy] Secretary of the Office of Policy and Management determines,
2887 through public or private reports, has had a substantial impact on
2888 prescription drug expenditures, net of rebates, as a percentage of total
2889 health care expenditures;

2890 [(2) "Commissioner" means the Commissioner of Health Strategy;]

2891 [(3)] (2) "Health care cost growth benchmark" means the annual
2892 benchmark established pursuant to section 19a-754g, as amended by
2893 this act;

2894 [(4)] (3) "Health care quality benchmark" means an annual
2895 benchmark established pursuant to section 19a-754g, as amended by
2896 this act;

2897 [(5)] (4) "Health care provider" has the same meaning as provided in
2898 subdivision (1) of subsection (a) of section 19a-17b;

2899 [(6)] (5) "Net cost of private health insurance" means the difference
2900 between premiums earned and benefits incurred, and includes insurers'
2901 costs of paying bills, advertising, sales commissions, and other
2902 administrative costs, net additions or subtractions from reserves, rate
2903 credits and dividends, premium taxes and profits or losses;

2904 [(7)] (6) "Office" means the Office of [Health Strategy established
2905 under section 19a-754a] Policy and Management;

2906 [(8)] (7) "Other entity" means a drug manufacturer, pharmacy
2907 benefits manager or other health care provider that is not considered a
2908 provider entity;

2909 [(9)] (8) "Payer" means a payer, including Medicaid, Medicare and
2910 governmental and nongovernment health plans, and includes any
2911 organization acting as payer that is a subsidiary, affiliate or business
2912 owned or controlled by a payer that, during a given calendar year, pays
2913 health care providers for health care services or pharmacies or provider
2914 entities for prescription drugs designated by the [Commissioner of
2915 Health Strategy] Secretary of the Office of Policy and Management;

2916 [(10)] (9) "Performance year" means the most recent calendar year for
2917 which data were submitted for the applicable health care cost growth
2918 benchmark, primary care spending target or health care quality
2919 benchmark;

2920 [(11)] (10) "Pharmacy benefits manager" has the same meaning as
2921 provided in subdivision (10) of section 38a-479ooo;

2922 [(12)] (11) "Primary care spending target" means the annual target
2923 established pursuant to section 19a-754g, as amended by this act;

2924 [(13)] (12) "Provider entity" means an organized group of clinicians
2925 that come together for the purposes of contracting, or are an established
2926 billing unit that, at a minimum, includes primary care providers, and
2927 that collectively, during any given calendar year, has enough attributed
2928 lives to participate in total cost of care contracts, even if they are not
2929 engaged in a total cost of care contract;

2930 [(14)] (13) "Potential gross state product" means a forecasted measure
2931 of the economy that equals the sum of the (A) expected growth in
2932 national labor force productivity, (B) expected growth in the state's labor

2933 force, and (C) expected national inflation, minus the expected state
2934 population growth;

2935 (14) "Secretary" means the Secretary of the Office of Policy and
2936 Management;

2937 (15) "Total health care expenditures" means the sum of all health care
2938 expenditures in this state from public and private sources for a given
2939 calendar year, including: (A) All claims-based spending paid to
2940 providers, net of pharmacy rebates, (B) all patient cost-sharing amounts,
2941 and (C) the net cost of private health insurance; and

2942 (16) "Total medical expense" means the total cost of care for the
2943 patient population of a payer or provider entity for a given calendar
2944 year, where cost is calculated for such year as the sum of (A) all claims-
2945 based spending paid to providers by public and private payers, and net
2946 of pharmacy rebates, (B) all nonclaims payments for such year,
2947 including, but not limited to, incentive payments and care coordination
2948 payments, and (C) all patient cost-sharing amounts expressed on a per
2949 capita basis for the patient population of a payer or provider entity in
2950 this state.

2951 Sec. 74. Section 19a-754g of the 2026 supplement to the general
2952 statutes is repealed and the following is substituted in lieu thereof
2953 (*Effective July 1, 2026*):

2954 [(a) Not later than July 1, 2022, the commissioner shall publish (1) the
2955 health care cost growth benchmarks and annual primary care spending
2956 targets as a percentage of total medical expenses for the calendar years
2957 2021 to 2025, inclusive, and (2) the annual health care quality
2958 benchmarks for the calendar years 2022 to 2025, inclusive, on the office's
2959 Internet web site.]

2960 [(b)] (a) (1) (A) Not later than July 1, 2025, and every five years
2961 thereafter, the [commissioner] secretary shall develop and adopt annual
2962 health care cost growth benchmarks and annual primary care spending

2963 targets for the succeeding five calendar years for provider entities and
2964 payers.

2965 (B) In developing the health care cost growth benchmarks and
2966 primary care spending targets pursuant to this subdivision, the
2967 [commissioner] secretary shall consider (i) any historical and forecasted
2968 changes in median income for individuals in the state and the growth
2969 rate of potential gross state product, (ii) the rate of inflation, and (iii) the
2970 most recent report prepared by the [commissioner] secretary pursuant
2971 to subsection (b) of section 19a-754h, as amended by this act.

2972 (C) (i) The [commissioner] secretary shall hold at least one
2973 informational public hearing prior to adopting the health care cost
2974 growth benchmarks and primary care spending targets for each
2975 succeeding five-year period described in this subdivision. The
2976 [commissioner] secretary may hold informational public hearings
2977 concerning any annual health care cost growth benchmark and primary
2978 care spending target set pursuant to [subsection (a) of this section or]
2979 this subdivision, [(1) of subsection (b) of this section.] Such
2980 informational public hearings shall be held at a time and place
2981 designated by the [commissioner] secretary in a notice prominently
2982 posted by the [commissioner] secretary on the office's Internet web site
2983 and in a form and manner prescribed by the [commissioner] secretary.
2984 The [commissioner] secretary shall make available on the office's
2985 Internet web site a summary of any such informational public hearing
2986 and include the [commissioner's] secretary's recommendations, if any,
2987 to modify or not to modify any such annual benchmark or target.

2988 (ii) If the [commissioner] secretary determines, after any
2989 informational public hearing held pursuant to this subparagraph, that a
2990 modification to any health care cost growth benchmark or annual
2991 primary care spending target is, in the [commissioner's] secretary's
2992 discretion, reasonably warranted, the [commissioner] secretary may
2993 modify such benchmark or target.

2994 (iii) The [commissioner] secretary shall annually (I) review the
2995 current and projected rate of inflation, and (II) include on the office's
2996 Internet web site the [commissioner's] secretary's findings of such
2997 review, including the reasons for making or not making a modification
2998 to any applicable health care cost growth benchmark. If the
2999 [commissioner] secretary determines that the rate of inflation requires
3000 modification of any health care cost growth benchmark adopted under
3001 this section, the [commissioner] secretary may modify such benchmark.
3002 In such event, the [commissioner] secretary shall not be required to hold
3003 an informational public hearing concerning such modified health care
3004 cost growth benchmark.

3005 (D) The [commissioner] secretary shall post each adopted health care
3006 cost growth benchmark and annual primary care spending target on the
3007 office's Internet web site.

3008 (E) Notwithstanding the provisions of subparagraphs (A) to (D),
3009 inclusive, of this subdivision, if the average annual health care cost
3010 growth benchmark for a succeeding five-year period described in this
3011 subdivision differs from the average annual health care cost growth
3012 benchmark for the five-year period preceding such succeeding five-year
3013 period by more than one-half of one per cent, the [commissioner]
3014 secretary shall submit the annual health care cost growth benchmarks
3015 developed for such succeeding five-year period to the joint standing
3016 committee of the General Assembly having cognizance of matters
3017 relating to insurance for the committee's review and approval. The
3018 committee shall be deemed to have approved such annual health care
3019 cost growth benchmarks for such succeeding five-year period, except
3020 upon a vote to reject such benchmarks by the majority of committee
3021 members at a meeting of such committee called for the purpose of
3022 reviewing such benchmarks and held not later than thirty days after the
3023 [commissioner] secretary submitted such benchmarks to such
3024 committee. If the committee votes to reject such benchmarks, the
3025 [commissioner] secretary may submit to the committee modified annual
3026 health care cost growth benchmarks for such succeeding five-year

3027 period for the committee's review and approval in accordance with the
3028 provisions of this subparagraph. The [commissioner] secretary shall not
3029 be required to hold an informational public hearing concerning such
3030 modified benchmarks. Until the joint standing committee of the General
3031 Assembly having cognizance of matters relating to insurance approves
3032 annual health care cost growth benchmarks for the succeeding five-year
3033 period, such benchmarks shall be deemed to be equal to the average
3034 annual health care cost growth benchmark for the preceding five-year
3035 period.

3036 (2) (A) Not later than July 1, 2025, and every five years thereafter, the
3037 [commissioner] secretary shall develop and adopt annual health care
3038 quality benchmarks for the succeeding five calendar years for provider
3039 entities and payers.

3040 (B) In developing annual health care quality benchmarks pursuant to
3041 this subdivision, the [commissioner] secretary shall consider (i) quality
3042 measures endorsed by nationally recognized organizations, including,
3043 but not limited to, the National Quality Forum, the National Committee
3044 for Quality Assurance, the Centers for Medicare and Medicaid Services,
3045 the National Centers for Disease Control and Prevention, the Joint
3046 Commission and expert organizations that develop health equity
3047 measures, and (ii) measures that: (I) Concern health outcomes,
3048 overutilization, underutilization and patient safety, (II) meet standards
3049 of patient-centeredness and ensure consideration of differences in
3050 preferences and clinical characteristics within patient subpopulations,
3051 and (III) concern community health or population health.

3052 (C) (i) The [commissioner] secretary shall hold at least one
3053 informational public hearing prior to adopting the health care quality
3054 benchmarks for each succeeding five-year period described in this
3055 subdivision. The [commissioner] secretary may hold informational
3056 public hearings concerning the quality measures the [commissioner]
3057 secretary proposes to adopt as health care quality benchmarks. Such
3058 informational public hearings shall be held at a time and place

3059 designated by the [commissioner] secretary in a notice prominently
3060 posted by the [commissioner] secretary on the office's Internet web site
3061 and in a form and manner prescribed by the [commissioner] secretary.
3062 The [commissioner] secretary shall make available on the office's
3063 Internet web site a summary of any such informational public hearing
3064 and include the recommendations, if any, to modify or not modify any
3065 such health care quality benchmark.

3066 (ii) If the [commissioner] secretary determines, after any
3067 informational public hearing held pursuant to this subparagraph, that
3068 modifications to any health care quality benchmarks are, in the
3069 [commissioner's] secretary's discretion, reasonably warranted, the
3070 [commissioner] secretary may modify such quality benchmarks. The
3071 [commissioner] secretary shall not be required to hold an additional
3072 informational public hearing concerning such modified quality
3073 benchmarks.

3074 (D) The [commissioner] secretary shall post each adopted health care
3075 quality benchmark on the office's Internet web site.

3076 (c) The [commissioner] secretary may enter into such contractual
3077 agreements as may be necessary to carry out the purposes of this section,
3078 including, but not limited to, contractual agreements with actuarial,
3079 economic and other experts and consultants.

3080 Sec. 75. Section 19a-754h of the general statutes is repealed and the
3081 following is substituted in lieu thereof (*Effective July 1, 2026*):

3082 (a) Not later than August [15, 2022, and] fifteenth annually,
3083 [thereafter,] each payer shall report to the [commissioner] secretary, in
3084 a form and manner prescribed by the [commissioner] secretary, for the
3085 preceding or prior years, if the [commissioner] secretary so requests
3086 based on material changes to data previously submitted, aggregated
3087 data, including aggregated self-funded data as applicable, necessary for
3088 the [commissioner] secretary to calculate total health care expenditures,
3089 primary care spending as a percentage of total medical expenses and net

3090 cost of private health insurance. Each payer shall also disclose, as
3091 requested by the [commissioner] secretary, payer data required for
3092 adjusting total medical expense calculations to reflect changes in the
3093 patient population.

3094 (b) Not later than March [31, 2023, and] thirty-first annually,
3095 [thereafter,] the [commissioner] secretary shall prepare and post on the
3096 office's Internet web site, a report concerning the total health care
3097 expenditures utilizing the total aggregate medical expenses reported by
3098 payers pursuant to subsection (a) of this section, including, but not
3099 limited to, a breakdown of such population-adjusted total medical
3100 expenses by payer and provider entities. The report may include, but
3101 [shall] need not be limited to, information regarding the following:

3102 (1) Trends in major service category spending;

3103 (2) Primary care spending as a percentage of total medical expenses;

3104 (3) The net cost of private health insurance by payer by market
3105 segment, including individual, small group, large group, self-insured,
3106 student and Medicare Advantage markets; and

3107 (4) Any other factors the [commissioner] secretary deems relevant to
3108 providing context on such data, which shall include, but not be limited
3109 to, the following factors: (A) The impact of the rate of inflation and rate
3110 of medical inflation; (B) impacts, if any, on access to care; and (C)
3111 responses to public health crises or similar emergencies.

3112 (c) The [commissioner] secretary shall annually submit a request to
3113 the federal Centers for Medicare and Medicaid Services for the
3114 unadjusted total medical expenses of Connecticut residents.

3115 (d) Not later than August [15, 2023, and] fifteenth annually,
3116 [thereafter,] each payer or provider entity shall report to the
3117 [commissioner] secretary, in a form and manner prescribed by the
3118 [commissioner] secretary, for the preceding year, and for prior years if

3119 the [commissioner] secretary so requests based on material changes to
3120 data previously submitted, on the health care quality benchmarks
3121 adopted pursuant to section 19a-754g, as amended by this act.

3122 (e) Not later than March [31, 2024, and] thirty-first annually,
3123 [thereafter,] the [commissioner] secretary shall prepare and post on the
3124 office's Internet web site, a report concerning health care quality
3125 benchmarks reported by payers and provider entities pursuant to
3126 subsection (d) of this section.

3127 (f) The commissioner may enter into such contractual agreements as
3128 may be necessary to carry out the purposes of this section, including,
3129 but not limited to, contractual agreements with actuarial, economic and
3130 other experts and consultants.

3131 Sec. 76. Section 19a-754i of the general statutes is repealed and the
3132 following is substituted in lieu thereof (*Effective July 1, 2026*):

3133 (a) (1) For each calendar year, beginning on January 1, 2023, the
3134 [commissioner] secretary shall, if the payer or provider entity subject to
3135 the cost growth benchmark or primary care spending target [so]
3136 requests [J] a meeting, the secretary shall meet with such payer or
3137 provider entity to review and validate the total medical expenses data
3138 collected pursuant to section 19a-754h, as amended by this act, for such
3139 payer or provider entity. The [commissioner] secretary shall review
3140 information provided by the payer or provider entity and, if deemed
3141 necessary, amend findings for such payer or provider prior to the
3142 identification of payer or provider entities that exceeded the health care
3143 cost growth benchmark or failed to meet the primary care spending
3144 target for the performance year as set forth in section 19a-754h, as
3145 amended by this act. The [commissioner] secretary shall identify, not
3146 later than May first of such calendar year, each payer or provider entity
3147 that exceeded the health care cost growth benchmark or failed to meet
3148 the primary care spending target for the performance year.

3149 (2) For each calendar year beginning on or after January 1, 2024, the

3150 [commissioner] secretary shall, if the payer or provider entity subject to
3151 the health care quality benchmarks for the performance year [so]
3152 requests [,] a meeting, the secretary shall meet with such payer or
3153 provider entity to review and validate the quality data collected
3154 pursuant to section 19a-754h, as amended by this act, for such payer or
3155 provider entity. The [commissioner] secretary shall review information
3156 provided by the payer or provider entity and, if deemed necessary,
3157 amend findings for such payer or provider prior to the identification of
3158 payer or provider entities that exceeded the health care quality
3159 benchmark as set forth in section 19a-754h, as amended by this act. The
3160 [commissioner] secretary shall identify, not later than May first of such
3161 calendar year, each payer or provider entity that exceeded the health
3162 care quality benchmark for the performance year.

3163 (3) Not later than thirty days after the [commissioner] secretary
3164 identifies each payer or provider entity pursuant to subdivisions (1) and
3165 (2) of this subsection, the [commissioner] secretary shall send a notice to
3166 each such payer or provider entity. Such notice shall be in a form and
3167 manner prescribed by the [commissioner] secretary, and shall disclose
3168 to each such payer or provider entity:

3169 (A) That the [commissioner] secretary has identified such payer or
3170 provider entity pursuant to subdivision (1) or (2) of this subsection; and

3171 (B) The factual basis for the [commissioner's] secretary's
3172 identification of such payer or provider entity pursuant to subdivision
3173 (1) or (2) of this subsection.

3174 (b) (1) For each calendar year beginning on and after January 1, 2023,
3175 if the [commissioner] secretary determines that the annual percentage
3176 change in total health care expenditures for the performance year
3177 exceeded the health care cost growth benchmark for such year, the
3178 [commissioner] secretary shall identify, not later than May first of such
3179 calendar year, any other entity that significantly contributed to
3180 exceeding such benchmark. Each identification shall be based on:

3181 (A) The report prepared by the [commissioner] secretary pursuant to
3182 subsection (b) of section 19a-754h, as amended by this act, for such
3183 calendar year;

3184 (B) The report filed pursuant to section 38a-479ppp for such calendar
3185 year;

3186 (C) The information and data reported to the office pursuant to
3187 subsection (d) of section 19a-754b, as amended by this act, for such
3188 calendar year;

3189 (D) Information obtained from the all-payer claims database
3190 established under section 19a-755a, as amended by this act; and

3191 (E) Any other information that the [commissioner] secretary, in the
3192 [commissioner's] secretary's discretion, deems relevant for the purposes
3193 of this section.

3194 (2) The [commissioner] secretary shall account for costs, net of rebates
3195 and discounts, when identifying other entities pursuant to this section.

3196 Sec. 77. Section 19a-754j of the general statutes is repealed and the
3197 following is substituted in lieu thereof (*Effective July 1, 2026*):

3198 (a) (1) Not later than June [30, 2023, and] thirtieth annually,
3199 [thereafter,] the [commissioner] secretary shall hold an informational
3200 public hearing to compare the growth in total health care expenditures
3201 in the performance year to the health care cost growth benchmark
3202 established pursuant to section 19a-754g, as amended by this act, for
3203 such year. Such hearing shall involve an examination of:

3204 (A) The report most recently prepared by the [commissioner]
3205 secretary pursuant to subsection (b) of section 19a-754h, as amended by
3206 this act;

3207 (B) The expenditures of provider entities and payers, including, but
3208 not limited to, health care cost trends, primary care spending as a

3209 percentage of total medical expenses and the factors contributing to
3210 such costs and expenditures; and

3211 (C) Any other matters that the [commissioner] secretary, in the
3212 [commissioner's] secretary's discretion, deems relevant for the purposes
3213 of this section.

3214 (2) The [commissioner] secretary may require any payer or provider
3215 entity that, for the performance year, is found to be a significant
3216 contributor to health care cost growth in the state or has failed to meet
3217 the primary care spending target, to participate in such hearing. Each
3218 such payer or provider entity that is required to participate in such
3219 hearing shall provide testimony on issues identified by the
3220 [commissioner] secretary and provide additional information on actions
3221 taken to reduce such payer's or entity's contribution to future state-wide
3222 health care costs and expenditures or to increase such payer's or
3223 provider entity's primary care spending as a percentage of total medical
3224 expenses.

3225 (3) The [commissioner] secretary may require that any other entity
3226 that is found to be a significant contributor to health care cost growth in
3227 this state during the performance year participate in such hearing. Any
3228 other entity that is required to participate in such hearing shall provide
3229 testimony on issues identified by the [commissioner] secretary and
3230 provide additional information on actions taken to reduce such other
3231 entity's contribution to future state-wide health care costs. If such other
3232 entity is a drug manufacturer, and the [commissioner] secretary requires
3233 that such drug manufacturer participate in such hearing with respect to
3234 a specific drug or class of drugs, such hearing may, to the extent
3235 possible, include representatives from at least one brand-name
3236 manufacturer, one generic manufacturer and one innovator company
3237 that is less than ten years old.

3238 (4) Not later than October [15, 2023, and] fifteenth annually,
3239 [thereafter,] the [commissioner] secretary shall prepare and submit a

3240 report, in accordance with section 11-4a, to the joint standing
3241 committees of the General Assembly having cognizance of matters
3242 relating to insurance and public health. Such report shall be based on
3243 the [commissioner's] secretary's analysis of the information submitted
3244 during the most recent informational public hearing conducted
3245 pursuant to this subsection and any other information that the
3246 [commissioner] secretary, in the [commissioner's] secretary's discretion,
3247 deems relevant for the purposes of this section, and shall:

3248 (A) Describe health care spending trends in this state, including, but
3249 not limited to, trends in primary care spending as a percentage of total
3250 medical expense, and the factors underlying such trends;

3251 (B) Include the findings from the report prepared pursuant to
3252 subsection (b) of section 19a-754h, as amended by this act;

3253 (C) Describe a plan for monitoring any unintended adverse
3254 consequences resulting from the adoption of cost growth benchmarks
3255 and primary care spending targets and the results of any findings from
3256 the implementation of such plan; and

3257 (D) Disclose the [commissioner's] secretary's recommendations, if
3258 any, concerning strategies to increase the efficiency of the state's health
3259 care system, including, but not limited to, any recommended legislation
3260 concerning the state's health care system.

3261 (b) (1) Not later than June [30, 2024, and] thirtieth annually,
3262 [thereafter,] the [commissioner] secretary shall hold an informational
3263 public hearing to compare the performance of payers and provider
3264 entities in the performance year to the quality benchmarks established
3265 for such year pursuant to section 19a-754g, as amended by this act. Such
3266 hearing shall include an examination of:

3267 (A) The report most recently prepared by the [commissioner]
3268 secretary pursuant to subsection (e) of section 19a-754h, as amended by
3269 this act; and

3270 (B) Any other matters that the [commissioner] secretary, in the
3271 [commissioner's] secretary's discretion, deems relevant for the purposes
3272 of this section.

3273 (2) The [commissioner] secretary may require any payer or provider
3274 entity that failed to meet any health care quality benchmarks in this state
3275 during the performance year to participate in such hearing. Each such
3276 payer or provider entity that is required to participate in such hearing
3277 shall provide testimony on issues identified by the [commissioner]
3278 secretary and provide additional information on actions taken to
3279 improve such payer's or provider entity's quality benchmark
3280 performance.

3281 (3) Not later than October [15, 2024, and] fifteenth annually,
3282 [thereafter,] the [commissioner] secretary shall prepare and submit a
3283 report, in accordance with section 11-4a, to the joint standing
3284 committees of the General Assembly having cognizance of matters
3285 relating to insurance and public health. Such report shall be based on
3286 the [commissioner's] secretary's analysis of the information submitted
3287 during the most recent informational public hearing conducted
3288 pursuant to this subsection and any other information that the
3289 [commissioner] secretary, in the [commissioner's] secretary's discretion,
3290 deems relevant for the purposes of this section, and shall:

3291 (A) Describe health care quality trends in this state and the factors
3292 underlying such trends;

3293 (B) Include the findings from the report prepared pursuant to
3294 subsection (e) of section 19a-754h, as amended by this act; and

3295 (C) Disclose the [commissioner's] secretary's recommendations, if
3296 any, concerning strategies to improve the quality of the state's health
3297 care system, including, but not limited to, any recommended legislation
3298 concerning the state's health care system.

3299 Sec. 78. Section 19a-754k of the general statutes is repealed and the

3300 following is substituted in lieu thereof (*Effective July 1, 2026*):

3301 The [Commissioner of Health Strategy] Secretary of the Office of
3302 Policy and Management may adopt regulations, in accordance with
3303 chapter 54, to implement the provisions of [section 19a-754a and]
3304 sections 19a-754f to 19a-754j, inclusive, as amended by this act.

3305 Sec. 79. Section 19a-755a of the general statutes is repealed and the
3306 following is substituted in lieu thereof (*Effective July 1, 2026*):

3307 (a) As used in this section:

3308 (1) "All-payer claims database" means a database that receives and
3309 stores data from a reporting entity relating to medical insurance claims,
3310 dental insurance claims, pharmacy claims and other insurance claims
3311 information from enrollment and eligibility files.

3312 (2) (A) "Reporting entity" means:

3313 (i) An insurer, as described in section 38a-1, licensed to do health
3314 insurance business in this state;

3315 (ii) A health care center, as defined in section 38a-175;

3316 (iii) An insurer or health care center that provides coverage under
3317 Part C or Part D of Title XVIII of the Social Security Act, as amended
3318 from time to time, to residents of this state;

3319 (iv) A third-party administrator, as defined in section 38a-720;

3320 (v) A pharmacy benefits manager, as defined in section 38a-479aaa;

3321 (vi) A hospital service corporation, as defined in section 38a-199;

3322 (vii) A nonprofit medical service corporation, as defined in section
3323 38a-214;

3324 (viii) A fraternal benefit society, as described in section 38a-595, that

3325 transacts health insurance business in this state;

3326 (ix) A dental plan organization, as defined in section 38a-577;

3327 (x) A preferred provider network, as defined in section 38a-479aa;
3328 and

3329 (xi) Any other person that administers health care claims and
3330 payments pursuant to a contract or agreement or is required by statute
3331 to administer such claims and payments.

3332 (B) "Reporting entity" does not include an employee welfare benefit
3333 plan, as defined in the federal Employee Retirement Income Security
3334 Act of 1974, as amended from time to time, that is also a trust established
3335 pursuant to collective bargaining subject to the federal Labor
3336 Management Relations Act.

3337 (3) "Medicaid data" means the Medicaid provider registry, health
3338 claims data and Medicaid recipient data maintained by the Department
3339 of Social Services.

3340 (4) "CHIP data" means the provider registry, health claims data and
3341 recipient data maintained by the Department of Social Services to
3342 administer the Children's Health Insurance Program.

3343 (b) (1) There is established an all-payer claims database program. The
3344 Office of [Health Strategy] Policy and Management shall: (A) Oversee
3345 the planning, implementation and administration of the all-payer claims
3346 database program for the purpose of collecting, assessing and reporting
3347 health care information relating to safety, quality, cost-effectiveness,
3348 access and efficiency for all levels of health care; (B) ensure that data
3349 received is securely collected, compiled and stored in accordance with
3350 state and federal law; (C) conduct audits of data submitted by reporting
3351 entities in order to verify its accuracy; and (D) in consultation with the
3352 Health Information Technology Advisory Council established under
3353 section 17b-59f, as amended by this act, maintain written procedures for

3354 the administration of such all-payer claims database. Any such written
3355 procedures shall include (i) reporting requirements for reporting
3356 entities, and (ii) requirements for providing notice to a reporting entity
3357 regarding any alleged failure on the part of such reporting entity to
3358 comply with such reporting requirements.

3359 (2) The [Commissioner of Health Strategy] Secretary of the Office of
3360 Policy and Management shall seek funding from the federal
3361 government, other public sources and other private sources to cover
3362 costs associated with the planning, implementation and administration
3363 of the all-payer claims database program.

3364 (3) (A) Upon the adoption of reporting requirements as set forth in
3365 subdivision (1) of this subsection, a reporting entity shall report health
3366 care information for inclusion in the all-payer claims database in a form
3367 and manner prescribed by the [Commissioner of Health Strategy] Secretary of the Office of Policy and Management. The [commissioner]
3368 secretary may, after notice and hearing, impose a civil penalty on any
3369 reporting entity that fails to report health care information as prescribed.
3370 Such civil penalty shall not exceed one thousand dollars per day for each
3371 day of violation and shall not be imposed as a cost for the purpose of
3372 rate determination or reimbursement by a third-party payer.

3374 (B) The [Commissioner of Health Strategy] Secretary of the Office of
3375 Policy and Management may provide the name of any reporting entity
3376 on which such penalty has been imposed to the Insurance
3377 Commissioner. After consultation with the [Commissioner of Health
3378 Strategy] secretary, the Insurance Commissioner may request the
3379 Attorney General to bring an action in the superior court for the judicial
3380 district of Hartford to recover any penalty imposed pursuant to
3381 subparagraph (A) of this subdivision.

3382 (4) The Commissioner of Social Services shall submit Medicaid and
3383 CHIP data to the [Commissioner of Health Strategy] Secretary of the
3384 Office of Policy and Management for inclusion in the all-payer claims

3385 database only for purposes related to administration of the State
3386 Medicaid and CHIP Plans, in accordance with 42 CFR 431.301 to 42 CFR
3387 431.306, inclusive.

3388 (5) The [Commissioner of Health Strategy] Secretary of the Office of
3389 Policy and Management shall: (A) Utilize data in the all-payer claims
3390 database to provide health care consumers in the state with information
3391 concerning the cost and quality of health care services for the purpose
3392 of allowing such consumers to make economically sound and medically
3393 appropriate health care decisions; and (B) make data in the all-payer
3394 claims database available to any state agency, insurer, employer, health
3395 care provider, consumer of health care services or researcher for the
3396 purpose of allowing such person or entity to review such data as it
3397 relates to health care utilization, costs or quality of health care services.
3398 If health information, as defined in 45 CFR 160.103, as amended from
3399 time to time, is permitted to be disclosed under the Health Insurance
3400 Portability and Accountability Act of 1996, P.L. 104-191, as amended
3401 from time to time, or regulations adopted thereunder, any disclosure
3402 thereof made pursuant to this subdivision shall have identifiers
3403 removed, as set forth in 45 CFR 164.514, as amended from time to time.
3404 Any disclosure made pursuant to this subdivision of information other
3405 than health information shall be made in a manner to protect the
3406 confidentiality of such other information as required by state and
3407 federal law. The [Commissioner of Health Strategy] secretary may set a
3408 fee to be charged to each person or entity requesting access to data
3409 stored in the all-payer claims database.

3410 (6) The [Commissioner of Health Strategy] Secretary of the Office of
3411 Policy and Management may (A) in consultation with the All-Payer
3412 Claims Database Advisory Group set forth in section 17b-59f, as
3413 amended by this act, enter into a contract with a person or entity to plan,
3414 implement or administer the all-payer claims database program, (B)
3415 enter into a contract or take any action that is necessary to obtain data
3416 that is the same data required to be submitted by reporting entities
3417 under Medicare Part A or Part B, (C) enter into a contract for the

3418 collection, management or analysis of data received from reporting
3419 entities, and (D) in accordance with subdivision (4) of this subsection,
3420 enter into a contract or take any action that is necessary to obtain
3421 Medicaid and CHIP data. Any such contract for the collection,
3422 management or analysis of such data shall expressly prohibit the
3423 disclosure of such data for purposes other than the purposes described
3424 in this subsection.

3425 (c) Unless otherwise specified, nothing in this section and no action
3426 taken by the [Commissioner of Health Strategy] Secretary of the Office
3427 of Policy and Management pursuant to this section or section 19a-755b,
3428 as amended by this act shall be construed to preempt, supersede or
3429 affect the authority of the Insurance Commissioner to regulate the
3430 business of insurance in the state.

3431 Sec. 80. Section 19a-755b of the general statutes is repealed and the
3432 following is substituted in lieu thereof (*Effective July 1, 2026*):

3433 (a) For purposes of this section and sections 19a-904a, 19a-904b and
3434 38a-477d to 38a-477f, inclusive:

3435 (1) "Allowed amount" means the maximum reimbursement dollar
3436 amount that an insured's health insurance policy allows for a specific
3437 procedure or service;

3438 (2) "Consumer health information Internet web site" means an
3439 Internet web site developed and operated by the Office of [Health
3440 Strategy] Policy and Management to assist consumers in making
3441 informed decisions concerning their health care and informed choices
3442 among health care providers;

3443 (3) "Episode of care" means all health care services related to the
3444 treatment of a condition or a service category for such treatment and,
3445 for acute conditions, includes health care services and treatment
3446 provided from the onset of the condition to its resolution or a service
3447 category for such treatment and, for chronic conditions, includes health

3448 care services and treatment provided over a given period of time or a
3449 service category for such treatment;

3450 [(4) "Commissioner" means the Commissioner of Health Strategy;]

3451 [(5)] (4) "Health care provider" means any individual, corporation,
3452 facility or institution licensed by this state to provide health care
3453 services;

3454 [(6)] (5) "Health carrier" means any insurer, health care center,
3455 hospital service corporation, medical service corporation, fraternal
3456 benefit society or other entity delivering, issuing for delivery, renewing,
3457 amending or continuing any individual or group health insurance
3458 policy in this state providing coverage of the type specified in
3459 subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

3460 [(7)] (6) "Hospital" has the same meaning as provided in section 19a-
3461 490;

3462 [(8)] (7) "Out-of-pocket costs" means costs that are not reimbursed by
3463 a health insurance policy and includes deductibles, coinsurance and
3464 copayments for covered services and other costs to the consumer
3465 associated with a procedure or service;

3466 [(9)] (8) "Outpatient surgical facility" has the same meaning as
3467 provided in section 19a-493b, as amended by this act; [and]

3468 [(10)] (9) "Public or private third party" means the state, the federal
3469 government, employers, a health carrier, third-party administrator, as
3470 defined in section 38a-720, or managed care organization; and

3471 (10) "Secretary" means the Secretary of the Office of Policy and
3472 Management.

3473 (b) (1) Within available resources, the consumer health information
3474 Internet web site shall: (A) Contain information comparing the quality,
3475 price and cost of health care services, including, to the extent practicable,

3476 (i) comparative price and cost information for the health care services
3477 and procedures reported pursuant to subsection (c) of this section
3478 categorized by payer or listed by health care provider, (ii) links to
3479 Internet web sites and consumer tools where consumers may obtain
3480 comparative cost and quality information, including The Joint
3481 Commission and Medicare hospital compare tool, (iii) definitions of
3482 common health insurance and medical terms so consumers may
3483 compare health coverage and understand the terms of their coverage,
3484 and (iv) factors consumers should consider when choosing an insurance
3485 product or provider group, including provider network, premium, cost
3486 sharing, covered services and tier information; (B) be designed to assist
3487 consumers and institutional purchasers in making informed decisions
3488 regarding their health care and informed choices among health care
3489 providers and, to the extent practicable, provide reference pricing for
3490 services paid by various health carriers to health care providers; (C)
3491 present information in language and a format that is understandable to
3492 the average consumer; and (D) be publicized to the general public. All
3493 information outlined in this section shall be posted on an Internet web
3494 site established, or to be established, by the [Commissioner of Health
3495 Strategy] secretary in a manner and time frame as may be
3496 organizationally and financially reasonable in [his or her] the secretary's
3497 sole discretion.

3498 (2) Information collected, stored and published by the Office of
3499 [Health Strategy] Policy and Management pursuant to this section is
3500 subject to the federal Health Insurance Portability and Accountability
3501 Act of 1996, P.L. 104-191, as amended from time to time.

3502 (3) The [Commissioner of Health Strategy] secretary may consider
3503 adding quality measures to the consumer health information Internet
3504 web site.

3505 (c) Not later than January [1, 2018, and] first annually, [thereafter],
3506 the [Commissioner of Health Strategy] secretary shall, to the extent the
3507 information is available, make available to the public on the consumer

3508 health information Internet web site a list of: (1) The fifty most
3509 frequently occurring inpatient services or procedures in the state; (2) the
3510 fifty most frequently provided outpatient services or procedures in the
3511 state; (3) the twenty-five most frequent surgical services or procedures
3512 in the state; (4) the twenty-five most frequent imaging services or
3513 procedures in the state; and (5) the twenty-five most frequently used
3514 pharmaceutical products and medical devices in the state. Such lists
3515 may (A) be expanded to include additional admissions and procedures,
3516 (B) be based upon those services and procedures that are most
3517 commonly performed by volume or that represent the greatest
3518 percentage of related health care expenditures, or (C) be designed to
3519 include those services and procedures most likely to result in out-of-
3520 pocket costs to consumers or include bundled episodes of care.

3521 (d) Not later than January [1, 2018, and] first annually, [thereafter,] to
3522 the extent practicable, the [Commissioner of Health Strategy] secretary
3523 shall issue a report, in a form and manner prescribed by the
3524 [commissioner] secretary, that includes the (1) billed and allowed
3525 amounts paid to health care providers in each health carrier's network
3526 for each service and procedure included pursuant to subsection (c) of
3527 this section, and (2) out-of-pocket costs for each such service and
3528 procedure.

3529 (e) (1) [On and after January 1, 2018, each] Each hospital shall, at the
3530 time of scheduling a service or procedure for nonemergency care that is
3531 included in the report prepared by the [Commissioner of Health
3532 Strategy] secretary pursuant to subsection (d) of this section, regardless
3533 of the location or setting where such services are delivered, notify the
3534 patient of the patient's right to make a request for cost and quality
3535 information. Upon the request of a patient for a diagnosis or procedure
3536 included in such report, the hospital shall, not later than three business
3537 days after scheduling such service or procedure, provide written notice,
3538 electronically or by mail, to the patient who is the subject of the service
3539 or procedure concerning: (A) If the patient is uninsured, the amount to
3540 be charged for the service or procedure if all charges are paid in full

3541 without a public or private third party paying any portion of the
3542 charges, including the amount of any facility fee, or, if the hospital is not
3543 able to provide a specific amount due to an inability to predict the
3544 specific treatment or diagnostic code, the estimated maximum allowed
3545 amount or charge for the service or procedure, including the amount of
3546 any facility fee; (B) the corresponding Medicare reimbursement amount
3547 or, if there is no corresponding Medicare reimbursement amount for
3548 such diagnosis or procedure, (i) the approximate amount Medicare
3549 would have paid the hospital for the services on the billing statement,
3550 or (ii) the percentage of the hospital's charges that Medicare would have
3551 paid the hospital for the services; (C) if the patient is insured, the
3552 allowed amount, the toll-free telephone number and the Internet web
3553 site address of the patient's health carrier where the patient can obtain
3554 information concerning charges and out-of-pocket costs; (D) The Joint
3555 Commission's composite accountability rating and the Medicare
3556 hospital compare star rating for the hospital, as applicable; and (E) the
3557 Internet web site addresses for The Joint Commission and the Medicare
3558 hospital compare tool where the patient may obtain information
3559 concerning the hospital.

3560 (2) If the patient is insured and the hospital is out-of-network under
3561 the patient's health insurance policy, such written notice shall include a
3562 statement that the service or procedure will likely be deemed out-of-
3563 network and that any out-of-network applicable rates under such policy
3564 may apply.

3565 Sec. 81. Subsection (b) of section 19a-911 of the general statutes is
3566 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3567 2026):

3568 (b) The Council on Protecting Women's Health shall be comprised of
3569 (1) the following ex-officio voting members: (A) The Commissioner of
3570 Public Health, or the commissioner's designee; (B) the Commissioner of
3571 Mental Health and Addiction Services, or the commissioner's designee;
3572 (C) the Insurance Commissioner, or the commissioner's designee; (D)

3573 [the Commissioner of Health Strategy, or the commissioner's designee;
3574 (E)] the Healthcare Advocate, or the Healthcare Advocate's designee;
3575 and [(F)] (E) the Secretary of the Office of Policy and Management, or
3576 the secretary's designee; and (2) fourteen public members, three of
3577 whom shall be appointed by the president pro tempore of the Senate,
3578 three of whom shall be appointed by the speaker of the House of
3579 Representatives, two of whom shall be appointed by the majority leader
3580 of the Senate, two of whom shall be appointed by the majority leader of
3581 the House of Representatives, two of whom shall be appointed by the
3582 minority leader of the Senate and two of whom shall be appointed by
3583 the minority leader of the House of Representatives, and all of whom
3584 shall be knowledgeable on issues relative to women's health care in the
3585 state. The membership of the council shall fairly and adequately
3586 represent women who have had issues accessing quality health care in
3587 the state.

3588 Sec. 82. Subsections (b) and (c) of section 20-195ttt of the 2026
3589 supplement to the general statutes are repealed and the following is
3590 substituted in lieu thereof (*Effective July 1, 2026*):

3591 (b) There is established within the [Office of Health Strategy]
3592 Department of Social Services a Community Health Worker Advisory
3593 Body. Said body shall (1) advise [said office and the Department of
3594 Public Health] the department on matters relating to the educational
3595 and certification requirements for training programs for community
3596 health workers, including the minimum number of hours and
3597 internship requirements for certification of community health workers,
3598 (2) conduct a continuous review of such educational and certification
3599 programs, and (3) provide the department with a list of approved
3600 educational and certification programs for community health workers.

3601 (c) The Commissioner [of Health Strategy] Social Services, or the
3602 commissioner's designee, shall act as the chair of the Community Health
3603 Worker Advisory Body and shall appoint the following members to said
3604 body:

3605 (1) Six members who are actively practicing as community health
3606 workers in the state;

3607 (2) A member of the Community Health Workers Association of
3608 Connecticut;

3609 (3) A representative of a community-based community health worker
3610 training organization;

3611 (4) A representative of the Connecticut State Community College;

3612 (5) An employer of community health workers;

3613 (6) A representative of a health care organization that employs
3614 community health workers;

3615 (7) A health care provider who works directly with community health
3616 workers; and

3617 (8) The Commissioner of Public Health, or the commissioner's
3618 designee.

3619 Sec. 83. Subsection (b) of section 28-33 of the 2026 supplement to the
3620 general statutes is repealed and the following is substituted in lieu
3621 thereof (*Effective July 1, 2026*):

3622 (b) The task force shall consist of the following members:

3623 (1) Two appointed by the speaker of the House of Representatives,
3624 one of whom has expertise in prescription drug supply chains and one
3625 of whom has expertise in federal law concerning prescription drug
3626 shortages;

3627 (2) Two appointed by the president pro tempore of the Senate, one of
3628 whom represents hospitals and one of whom represents health care
3629 providers who treat patients with rare diseases;

3630 (3) One appointed by the majority leader of the House of

3631 Representatives, who represents one of the two federally recognized
3632 Indian tribes in the state;

3633 (4) One appointed by the majority leader of the Senate, who
3634 represents one of the two federally recognized Indian tribes in the state;

3635 (5) One appointed by the minority leader of the House of
3636 Representatives, who represents health insurance companies;

3637 (6) One appointed by the minority leader of the Senate, who is a
3638 representative of the Connecticut Health Insurance Exchange;

3639 [(7) The Commissioner of Health Strategy, or the commissioner's
3640 designee;]

3641 [(8)] (7) The Commissioner of Consumer Protection, or the
3642 commissioner's designee;

3643 [(9)] (8) The Commissioner of Social Services, or the commissioner's
3644 designee;

3645 [(10)] (9) The Commissioner of Public Health, or the commissioner's
3646 designee;

3647 [(11)] (10) The chief executive officer of The University of Connecticut
3648 Health Center, or the chief executive officer's designee;

3649 [(12)] (11) The Insurance Commissioner, or the commissioner's
3650 designee;

3651 [(13)] (12) The Commissioner of Economic and Community
3652 Development, or the commissioner's designee; and

3653 [(14)] (13) Any other members as deemed necessary by the
3654 chairpersons of the task force.

3655 Sec. 84. Subsections (e) to (g), inclusive, of section 33-182bb of the
3656 general statutes are repealed and the following is substituted in lieu

3657 thereof (*Effective July 1, 2026*):

3658 (e) Any medical foundation organized on or after July 1, 2009, shall
3659 file a copy of its certificate of incorporation and any amendments to its
3660 certificate of incorporation with the Health Systems Planning Unit of the
3661 [Office of Health Strategy] Department of Public Health not later than
3662 ten business days after the medical foundation files such certificate of
3663 incorporation or amendment with the Secretary of the State pursuant to
3664 chapter 602.

3665 (f) Any medical group clinic corporation formed under chapter 594
3666 of the general statutes, revision of 1958, revised to 1995, which amends
3667 its certificate of incorporation pursuant to subsection (a) of section 33-
3668 182cc, shall file with the Health Systems Planning Unit of the [Office of
3669 Health Strategy] Department of Public Health a copy of its certificate of
3670 incorporation and any amendments to its certificate of incorporation,
3671 including any amendment to its certificate of incorporation that
3672 complies with the requirements of subsection (a) of section 33-182cc, not
3673 later than ten business days after the medical foundation files its
3674 certificate of incorporation or any amendments to its certificate of
3675 incorporation with the Secretary of the State.

3676 (g) Any medical foundation, regardless of when organized, shall file
3677 notice with the Health Systems Planning Unit of the [Office of Health
3678 Strategy] Department of Public Health and the Secretary of the State of
3679 its liquidation, termination, dissolution or cessation of operations not
3680 later than ten business days after a vote by its board of directors or
3681 members to take such action. A medical foundation shall, annually,
3682 provide the office with (1) a statement of its mission, (2) the name and
3683 address of the organizing members, (3) the name and specialty of each
3684 physician employed by or acting as an agent of the medical foundation,
3685 (4) the location or locations where each such physician practices, (5) a
3686 description of the services provided at each such location, (6) a
3687 description of any significant change in its services during the preceding
3688 year, (7) a copy of the medical foundation's governing documents and

3689 bylaws, (8) the name and employer of each member of the board of
3690 directors, and (9) other financial information as reported on the medical
3691 foundation's most recently filed Internal Revenue Service return of
3692 organization exempt from income tax form, or any replacement form
3693 adopted by the Internal Revenue Service, or, if such medical foundation
3694 is not required to file such form, information substantially similar to that
3695 required by such form. The Health Systems Planning Unit shall make
3696 such forms and information available to members of the public and
3697 accessible on said unit's Internet web site.

3698 Sec. 85. Subdivisions (2) and (3) of subsection (a) of section 38a-47 of
3699 the general statutes are repealed and the following is substituted in lieu
3700 thereof (*Effective July 1, 2026*):

3701 (2) The amount appropriated to the Office of Health Strategy Policy
3702 and Management from the Insurance Fund for the fiscal year, including
3703 the cost of fringe benefits for office personnel as estimated by the
3704 Comptroller, which shall be reduced by the amount of federal
3705 reimbursement received for allowable Medicaid administrative
3706 expenses;

3707 (3) The expenditures made on behalf of the department and said
3708 offices from the Capital Equipment Purchase Fund pursuant to section
3709 4a-9 for such year, but excluding such estimated expenditures made on
3710 behalf of the Health Systems Planning Unit of the Office of Health
3711 Strategy Department of Public Health; and

3712 Sec. 86. Subsections (b) to (f), inclusive, of section 38a-48 of the
3713 general statutes are repealed and the following is substituted in lieu
3714 thereof (*Effective July 1, 2026*):

3715 (b) On or before July thirty-first, annually, the Insurance
3716 Commissioner shall render to each domestic insurance company or
3717 other domestic entity liable for payment under section 38a-47, as
3718 amended by this act:

3719 (1) A statement that includes (A) the amount appropriated to the
3720 Insurance Department [,] and the Office of the Healthcare Advocate
3721 [and the Office of Health Strategy] from the Insurance Fund established
3722 under section 38a-52a for the fiscal year beginning July first of the same
3723 year, (B) the cost of fringe benefits for department and office personnel
3724 for such year, as estimated by the Comptroller, (C) the estimated
3725 expenditures on behalf of the department and the offices from the
3726 Capital Equipment Purchase Fund pursuant to section 4a-9 for such
3727 year, not including such estimated expenditures made on behalf of the
3728 Health Systems Planning Unit of the [Office of Health Strategy]
3729 Department of Public Health, and (D) the amount appropriated to the
3730 Department of Aging and Disability Services for the fall prevention
3731 program established in section 17a-859 from the Insurance Fund for the
3732 fiscal year;

3733 (2) A statement of the total amount of taxes reported in the annual
3734 statement rendered to the Insurance Commissioner pursuant to
3735 subsection (a) of this section; and

3736 (3) The proposed assessment against that company or entity,
3737 calculated in accordance with the provisions of subsection (c) of this
3738 section, provided for the purposes of this calculation the amount
3739 appropriated to the Insurance Department [,] and the Office of the
3740 Healthcare Advocate [and the Office of Health Strategy] from the
3741 Insurance Fund plus the cost of fringe benefits for department and office
3742 personnel and the estimated expenditures on behalf of the department
3743 and said offices from the Capital Equipment Purchase Fund pursuant to
3744 section 4a-9, not including such expenditures made on behalf of the
3745 Health Systems Planning Unit of the [Office of Health Strategy]
3746 Department of Public Health shall be deemed to be the actual
3747 expenditures of the department and said offices, and the amount
3748 appropriated to the Department of Aging and Disability Services from
3749 the Insurance Fund for the fiscal year for the fall prevention program
3750 established in section 17a-859 shall be deemed to be the actual
3751 expenditures for the program.

3752 (c) (1) The proposed assessments for each domestic insurance
3753 company or other domestic entity shall be calculated by (A) allocating
3754 twenty per cent of the amount to be paid under section 38a-47, as
3755 amended by this act, among the domestic entities organized under
3756 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,
3757 in proportion to their respective shares of the total amount of taxes
3758 reported in the annual statement rendered to the Insurance
3759 Commissioner pursuant to subsection (a) of this section, and (B)
3760 allocating eighty per cent of the amount to be paid under section 38a-47,
3761 as amended by this act, among all domestic insurance companies and
3762 domestic entities other than those organized under sections 38a-199 to
3763 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to
3764 their respective shares of the total amount of taxes reported in the
3765 annual statement rendered to the Insurance Commissioner pursuant to
3766 subsection (a) of this section, provided if there are no domestic entities
3767 organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to
3768 38a-225, inclusive, at the time of assessment, one hundred per cent of
3769 the amount to be paid under section 38a-47, as amended by this act, shall
3770 be allocated among such domestic insurance companies and domestic
3771 entities.

3772 (2) When the amount any such company or entity is assessed
3773 pursuant to this section exceeds twenty-five per cent of the actual
3774 expenditures of the Insurance Department [,] and the Office of the
3775 Healthcare Advocate [and the Office of Health Strategy] from the
3776 Insurance Fund, such excess amount shall not be paid by such company
3777 or entity but rather shall be assessed against and paid by all other such
3778 companies and entities in proportion to their respective shares of the
3779 total amount of taxes reported in the annual statement rendered to the
3780 Insurance Commissioner pursuant to subsection (a) of this section,
3781 except that for purposes of any assessment made to fund payments to
3782 the Department of Public Health to purchase vaccines, such company or
3783 entity shall be responsible for its share of the costs, notwithstanding
3784 whether its assessment exceeds twenty-five per cent of the actual

3785 expenditures of the Insurance Department [,] and the Office of the
3786 Healthcare Advocate [and the Office of Health Strategy] from the
3787 Insurance Fund. The provisions of this subdivision shall not be
3788 applicable to any corporation that has converted to a domestic mutual
3789 insurance company pursuant to section 38a-155 upon the effective date
3790 of any public act that amends said section to modify or remove any
3791 restriction on the business such a company may engage in, for purposes
3792 of any assessment due from such company on and after such effective
3793 date.

3794 (d) Each annual payment determined under section 38a-47, as
3795 amended by this act, and each annual assessment determined under this
3796 section shall be calculated based on the total amount of taxes reported
3797 in the annual statement rendered to the Insurance Commissioner
3798 pursuant to subsection (a) of this section.

3799 (e) On or before September first, annually, for each fiscal year, the
3800 Insurance Commissioner, after receiving any objections to the proposed
3801 assessments and making such adjustments as in the commissioner's
3802 opinion may be indicated, shall assess each such domestic insurance
3803 company or other domestic entity an amount equal to its proposed
3804 assessment as so adjusted. Each domestic insurance company or other
3805 domestic entity shall pay to the Insurance Commissioner (1) on or before
3806 June thirtieth, annually, an estimated payment against its assessment for
3807 the following year equal to twenty-five per cent of its assessment for the
3808 fiscal year ending such June thirtieth, (2) on or before September
3809 thirtieth, annually, twenty-five per cent of its assessment adjusted to
3810 reflect any credit or amount due from the preceding fiscal year as
3811 determined by the commissioner under subsection (f) of this section,
3812 and (3) on or before the following December thirty-first and March
3813 thirty-first, annually, each domestic insurance company or other
3814 domestic entity shall pay to the Insurance Commissioner the remaining
3815 fifty per cent of its proposed assessment to the department in two equal
3816 installments.

3817 (f) If the actual expenditures for the fall prevention program
3818 established in section 17a-859 are less than the amount allocated, the
3819 Commissioner of Aging and Disability Services shall notify the
3820 Insurance Commissioner. Immediately following the close of the fiscal
3821 year, the Insurance Commissioner shall recalculate the proposed
3822 assessment for each domestic insurance company or other domestic
3823 entity in accordance with subsection (c) of this section using the actual
3824 expenditures made during the fiscal year by the Insurance Department
3825 [l] and the Office of the Healthcare Advocate [and the Office of Health
3826 Strategy] from the Insurance Fund, the actual expenditures made on
3827 behalf of the department and said offices from the Capital Equipment
3828 Purchase Fund pursuant to section 4a-9, not including such
3829 expenditures made on behalf of the Health Systems Planning Unit of the
3830 [Office of Health Strategy] Department of Public Health, and the actual
3831 expenditures for the fall prevention program. On or before July thirty-
3832 first, annually, the Insurance Commissioner shall render to each such
3833 domestic insurance company and other domestic entity a statement
3834 showing the difference between their respective recalculated
3835 assessments and the amount they have previously paid. On or before
3836 August thirty-first, the Insurance Commissioner, after receiving any
3837 objections to such statements, shall make such adjustments that in the
3838 commissioner's opinion may be indicated, and shall render an adjusted
3839 assessment, if any, to the affected companies. Any such domestic
3840 insurance company or other domestic entity may pay to the Insurance
3841 Commissioner the entire assessment required under this subsection in
3842 one payment when the first installment of such assessment is due.

3843 Sec. 87. Subsection (a) of section 38a-477e of the general statutes is
3844 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3845 *2026*):

3846 (a) [On and after January 1, 2017, each] Each health carrier, as defined
3847 in section 19a-755b, as amended by this act, shall maintain an Internet
3848 web site and toll-free telephone number that enables consumers to
3849 request and obtain: (1) Information on in-network costs for inpatient

3850 admissions, health care procedures and services, including (A) the
3851 allowed amount for, at a minimum, admissions and procedures
3852 reported to the [Commissioner of Health Strategy] Secretary of the
3853 Office of Policy and Management pursuant to section 19a-755b, as
3854 amended by this act, for each health care provider in the state; (B) the
3855 estimated out-of-pocket costs that a consumer would be responsible for
3856 paying for any such admission or procedure that is medically necessary,
3857 including any facility fee, coinsurance, copayment, deductible or other
3858 out-of-pocket expense; and (C) data or other information concerning (i)
3859 quality measures for the health care provider, (ii) patient satisfaction, to
3860 the extent such information is available, (iii) a directory of participating
3861 providers, as defined in section 38a-472f, in accordance with the
3862 provisions of section 38a-477h; and (2) information on out-of-network
3863 costs for inpatient admissions, health care procedures and services.

3864 Sec. 88. Subdivision (2) of subsection (c) of section 38a-477ee of the
3865 2026 supplement to the general statutes is repealed and the following is
3866 substituted in lieu thereof (*Effective July 1, 2026*):

3867 (2) The Attorney General [] and Healthcare Advocate, [and
3868 Commissioner of Health Strategy.]

3869 Sec. 89. Subdivisions (13) to (17), inclusive, of subsection (c) of section
3870 38a-1083 of the general statutes are repealed and the following is
3871 substituted in lieu thereof (*Effective July 1, 2026*):

3872 (13) Make and enter into any contract or agreement necessary or
3873 incidental to the performance of its duties and execution of its powers,
3874 including, but not limited to, an agreement with the Office of [Health
3875 Strategy] Policy and Management to use funds collected under this
3876 section for the operation of the all-payer claims database established
3877 under section 19a-755a, as amended by this act, and to receive data from
3878 such database. The contracts entered into by the exchange shall not be
3879 subject to the approval of any other state department, office or agency,
3880 provided copies of all contracts of the exchange shall be maintained by

3881 the exchange as public records, subject to the proprietary rights of any
3882 party to the contract, except any agreement with the Office of [Health
3883 Strategy] Policy and Management shall be subject to approval by said
3884 office [and the Office of Policy and Management] and no portion of such
3885 agreement shall be considered proprietary;

3886 (14) To the extent permitted under its contract with other persons,
3887 consent to any termination, modification, forgiveness or other change of
3888 any term of any contractual right, payment, royalty, contract or
3889 agreement of any kind to which the exchange is a party;

3890 (15) Award grants to trained and certified individuals and
3891 institutions that will assist individuals, families and small employers
3892 and their employees in enrolling in appropriate coverage through the
3893 exchange. Applications for grants from the exchange shall be made on
3894 a form prescribed by the board;

3895 (16) Limit the number of plans offered, and use selective criteria in
3896 determining which plans to offer, through the exchange, provided
3897 individuals and employers have an adequate number and selection of
3898 choices;

3899 (17) Evaluate [jointly with the Health Care Cabinet established
3900 pursuant to section 19a-725] the feasibility of implementing a basic
3901 health program option as set forth in Section 1331 of the Affordable Care
3902 Act;

3903 Sec. 90. Subdivision (26) of section 38a-1084 of the general statutes is
3904 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3905 *2026*):

3906 (26) Consult with the Commissioner of Social Services, Insurance
3907 Commissioner and Office of [Health Strategy, established under section
3908 19a-754a] Policy and Management for the purposes set forth in section
3909 19a-754c, as amended by this act;

3910 Sec. 91. Subsection (d) of section 3-123ddd of the general statutes is
3911 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3912 2026):

3913 (d) Nothing in sections 3-123aaa to 3-123hhh, inclusive, 19a-654, as
3914 amended by this act, [19a-725,] 19a-755a, as amended by this act, 38a-
3915 513f or 38a-513g shall diminish any right to retiree health insurance
3916 pursuant to a collective bargaining agreement or any other provision of
3917 the general statutes.

3918 Sec. 92. Subsection (b) of section 3-123hhh of the general statutes is
3919 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3920 2026):

3921 (b) Nothing in this section or sections 3-123aaa to 3-123ggg, inclusive,
3922 19a-654, as amended by this act, [19a-725,] 19a-755a, as amended by this
3923 act, 38a-513f or 38a-513g shall modify the state employee plan in any
3924 way without the written consent of the State Employees Bargaining
3925 Agent Coalition and the Secretary of the Office of Policy and
3926 Management.

3927 Sec. 93. (NEW) (*Effective July 1, 2026*) (a) The Department of Public
3928 Health shall constitute a successor agency, in accordance with the
3929 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
3930 Office of Health Strategy with respect to all functions, powers and
3931 duties of the Office of Health Strategy concerning (1) the Health Systems
3932 Planning Unit established pursuant to section 19a-612 of the general
3933 statutes, as amended by this act, and (2) the certificate of need process
3934 set forth in sections 19a-638 to 19a-641, inclusive, of the general statutes,
3935 as amended by this act. Any order, decision, agreed settlement or
3936 regulation of the former Office of Health Strategy concerning any of the
3937 functions described in subdivisions (1) and (2) of this subsection that is
3938 in force on July 1, 2026, shall continue in force and effect as an order,
3939 decision, agreed settlement or regulation of the Department of Public
3940 Health until amended, repealed or superseded pursuant to law. Where

3941 any order, decision, agreed settlement or regulation of said department
3942 and said former office conflict, the Commissioner of Public Health may
3943 implement policies and procedures consistent with the provisions of
3944 chapters 368v and 368z of the general statutes while in the process of
3945 adopting the policies or procedures in regulation form, provided the
3946 commissioner shall publish notice of intention to adopt regulations on
3947 the Department of Public Health's Internet web site and the
3948 eRegulations System not later than twenty days after implementation of
3949 such policies and procedures. Any such policies or procedures shall be
3950 valid until such regulations are adopted.

3951 (b) If the words "Office of Health Strategy" or "Commissioner of
3952 Health Strategy" are used or referred to in any public or special act of
3953 2026, or in any section of the general statutes that is amended in 2026
3954 that concerns said office's or commissioner's functions with regard to (1)
3955 the Health Systems Planning Unit established pursuant to section 19a-
3956 612 of the general statutes, as amended by this act, or (2) the certificate
3957 of need process set forth in sections 19a-638 to 19a-641, inclusive, of the
3958 general statutes, as amended by this act, such words shall be deemed to
3959 mean or refer to the Department of Public Health or the Commissioner
3960 of Public Health, respectively.

3961 Sec. 94. (NEW) (*Effective July 1, 2026*) (a) The Office of Policy and
3962 Management shall constitute a successor agency, in accordance with the
3963 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
3964 Office of Health Strategy with respect to all functions, powers and
3965 duties of the Office of Health Strategy concerning (1) the State-wide
3966 Health Information Exchange, established pursuant to section 17b-59d
3967 of the general statutes, as amended by this act, (2) the all-payer claims
3968 database program, established pursuant to section 19a-755a of the
3969 general statutes, as amended by this act, and (3) the development,
3970 publication and modification of health care cost growth benchmarks
3971 and health care quality benchmarks required pursuant to sections 19a-
3972 754f to 19a-754k, inclusive, of the general statutes, as amended by this
3973 act. Any order, decision, agreed settlement or regulation of the former

3974 Office of Health Strategy concerning any of the functions described in
3975 subdivisions (1) to (3), inclusive, of this subsection that is in force on July
3976 1, 2026, shall continue in force and effect as an order, decision, agreed
3977 settlement or regulation of the Office of Policy and Management until
3978 amended, repealed or superseded pursuant to law. Where any order,
3979 decision, agreed settlement or regulation of said offices conflict, the
3980 Secretary of the Office of Policy and Management may implement
3981 policies and procedures consistent with the provisions of part III of
3982 chapter 319o and chapter 368ee of the general statutes while in the
3983 process of adopting the policies or procedures in regulation form,
3984 provided the secretary shall publish notice of intention to adopt
3985 regulations on the Office of Policy and Management's Internet web site
3986 and the eRegulations System not later than twenty days after
3987 implementation of such policies and procedures. Any such policy or
3988 procedure shall be valid until such regulations are adopted.

3989 (b) If the words "Office of Health Strategy" or "Commissioner of
3990 Health Strategy" are used or referred to in any public or special act of
3991 2026, or in any section of the general statutes that is amended in 2026
3992 that concerns said office's or commissioner's functions with regard to (1)
3993 the State-wide Health Information Exchange, established pursuant to
3994 section 17b-59d of the general statutes, as amended by this act, (2) the
3995 all-payer claims database program, established pursuant to section 19a-
3996 755a of the general statutes, as amended by this act, or (3) the
3997 development, publication and modification of health care cost growth
3998 benchmarks and health care quality benchmarks required pursuant to
3999 sections 19a-754f to 19a-754k, inclusive, of the general statutes, as
4000 amended by this act, such words shall be deemed to mean or refer to the
4001 Office of Policy and Management or the Secretary of the Office of Policy
4002 and Management, respectively.

4003 Sec. 95. (NEW) (*Effective July 1, 2026*) (a) The Department of Social
4004 Services shall constitute a successor agency, in accordance with the
4005 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
4006 Office of Health Strategy with respect to all functions, powers and

4007 duties of the Office of Health Strategy concerning (1) community benefit
4008 program reporting by hospitals pursuant to section 19a-127k of the
4009 general statutes, as amended by this act, and (2) hospital financial health
4010 reporting by hospitals pursuant to section 19a-486j, as amended by this
4011 act. Any order, decision, agreed settlement or regulation of the former
4012 Office of Health Strategy concerning any of the functions described in
4013 subdivisions (1) and (2) of this subsection that is in force on July 1, 2026,
4014 shall continue in force and effect as an order, decision, agreed settlement
4015 or regulation of the Department of Social Services until amended,
4016 repealed or superseded pursuant to law. Where any order, decision,
4017 agreed settlement or regulation of said offices conflict, the
4018 Commissioner of Social Services may implement policies and
4019 procedures consistent with the provisions of part III of chapter 319o and
4020 chapter 368ee of the general statutes while in the process of adopting the
4021 policies or procedures in regulation form, provided the secretary shall
4022 publish notice of intention to adopt regulations on the Department of
4023 Social Services' Internet web site and the eRegulations System not later
4024 than twenty days after implementation of such policies and procedures.
4025 Any such policy or procedure shall be valid until such regulations are
4026 adopted.

4027 (b) If the words "Office of Health Strategy" or "Commissioner of
4028 Health Strategy" are used or referred to in any public or special act of
4029 2026, or in any section of the general statutes that is amended in 2026
4030 that concerns said office's or commissioner's functions with regard to (1)
4031 community benefit program reporting by hospitals pursuant to section
4032 19a-127k of the general statutes, as amended by this act, and (2) hospital
4033 financial health reporting by hospitals pursuant to section 19a-486j, as
4034 amended by this act, such terms shall be deemed to mean or refer to the
4035 Department of Social Services or the Commissioner of Social Services,
4036 respectively.

4037 Sec. 96. Section 19a-2a of the 2026 supplement to the general statutes
4038 is repealed and the following is substituted in lieu thereof (*Effective July
4039 1, 2026*):

4040 The Commissioner of Public Health shall employ the most efficient
4041 and practical means for the prevention and suppression of disease and
4042 shall administer all laws under the jurisdiction of the Department of
4043 Public Health and the Public Health Code. The commissioner shall have
4044 responsibility for the overall operation and administration of the
4045 Department of Public Health. The commissioner shall have the power
4046 and duty to: (1) Administer, coordinate and direct the operation of the
4047 department; (2) adopt and enforce regulations, in accordance with
4048 chapter 54, as are necessary to carry out the purposes of the department
4049 as established by statute; (3) establish rules for the internal operation
4050 and administration of the department; (4) establish and develop
4051 programs and administer services to achieve the purposes of the
4052 department as established by statute; (5) enter into a contract, including,
4053 but not limited to, a contract with another state, for facilities, services
4054 and programs to implement the purposes of the department as
4055 established by statute; (6) designate a deputy commissioner or other
4056 employee of the department to sign any license, certificate or permit
4057 issued by said department; (7) conduct a hearing, issue subpoenas,
4058 administer oaths, compel testimony and render a final decision in any
4059 case when a hearing is required or authorized under the provisions of
4060 any statute dealing with the Department of Public Health; (8) with the
4061 health authorities of this and other states, secure information and data
4062 concerning the prevention and control of epidemics and conditions
4063 affecting or endangering the public health, and compile such
4064 information and statistics and shall disseminate among health
4065 authorities and the people of the state such information as may be of
4066 value to them; (9) annually issue a list of reportable diseases, emergency
4067 illnesses and health conditions and a list of reportable laboratory
4068 findings and amend such lists as the commissioner deems necessary and
4069 distribute such lists as well as any necessary forms to each licensed
4070 physician, licensed physician assistant, licensed advanced practice
4071 registered nurse and clinical laboratory in this state. The commissioner
4072 shall prepare printed forms for reports and returns, with such
4073 instructions as may be necessary, for the use of directors of health,

4074 boards of health and registrars of vital statistics; [and] (10) specify
4075 uniform methods of keeping statistical information by public and
4076 private agencies, organizations and individuals, including a client
4077 identifier system, and collect and make available relevant statistical
4078 information, including the number of persons treated, frequency of
4079 admission and readmission, and frequency and duration of treatment.
4080 The client identifier system shall be subject to the confidentiality
4081 requirements set forth in section 17a-688 and regulations adopted
4082 thereunder; and (11) direct and oversee the Health Systems Planning
4083 Unit, established under section 19a-612, as amended by this act, and all
4084 of its duties and responsibilities concerning the certificate of need
4085 process as set forth in chapter 368z. The commissioner may designate
4086 any person to perform any of the duties listed in subdivision (7) of this
4087 section. The commissioner shall have authority over directors of health
4088 and may, for cause, remove any such director; but any person claiming
4089 to be aggrieved by such removal may appeal to the Superior Court
4090 which may affirm or reverse the action of the commissioner as the public
4091 interest requires. The commissioner shall assist and advise local
4092 directors of health and district directors of health in the performance of
4093 their duties, and may require the enforcement of any law, regulation or
4094 ordinance relating to public health. In the event the commissioner
4095 reasonably suspects impropriety on the part of a local director of health
4096 or district director of health, or employee of such director, in the
4097 performance of his or her duties, the commissioner shall provide
4098 notification and any evidence of such impropriety to the appropriate
4099 governing authority of the municipal health authority, established
4100 pursuant to section 19a-200, or the district department of health,
4101 established pursuant to section 19a-244, for purposes of reviewing and
4102 assessing a director's or an employee's compliance with such duties.
4103 Such governing authority shall provide a written report of its findings
4104 from the review and assessment to the commissioner not later than
4105 ninety days after such review and assessment. When requested by local
4106 directors of health or district directors of health, the commissioner shall
4107 consult with them and investigate and advise concerning any condition

4108 affecting public health within their jurisdiction. The commissioner shall
4109 investigate nuisances and conditions affecting, or that he or she has
4110 reason to suspect may affect, the security of life and health in any
4111 locality and, for that purpose, the commissioner, or any person
4112 authorized by the commissioner, may enter and examine any ground,
4113 vehicle, apartment, building or place, and any person designated by the
4114 commissioner shall have the authority conferred by law upon
4115 constables. Whenever the commissioner determines that any provision
4116 of the general statutes or regulation of the Public Health Code is not
4117 being enforced effectively by a local health department or health district,
4118 he or she shall forthwith take such measures, including the performance
4119 of any act required of the local health department or health district, to
4120 ensure enforcement of such statute or regulation and shall inform the
4121 local health department or health district of such measures. In
4122 September of each year the commissioner shall certify to the Secretary
4123 of the Office of Policy and Management the population of each
4124 municipality. The commissioner may solicit and accept for use any gift
4125 of money or property made by will or otherwise, and any grant of or
4126 contract for money, services or property from the federal government,
4127 the state, any political subdivision thereof, any other state or any private
4128 source, and do all things necessary to cooperate with the federal
4129 government or any of its agencies in making an application for any grant
4130 or contract. The commissioner may enter into any contracts or
4131 agreements, in accordance with any established procedures, as may be
4132 necessary for the distribution or use of such money, services or property
4133 in accordance with any requirements to fulfill any conditions of a gift,
4134 grant or contract. The commissioner may establish state-wide and
4135 regional advisory councils. For purposes of this section, "employee of
4136 such director" means an employee of, a consultant employed or retained
4137 by or an independent contractor retained by a local director of health, a
4138 district director of health, a local health department or a health district.

4139 Sec. 97. Section 4-66 of the general statutes is repealed and the
4140 following is substituted in lieu thereof (*Effective July 1, 2026*):

4141 The Secretary of the Office of Policy and Management shall have the
4142 following functions and powers:

4143 (1) To keep on file information concerning the state's general
4144 accounts;

4145 (2) To furnish all accounting statements relating to the financial
4146 condition of the state as a whole, to the condition and operation of state
4147 funds, to appropriations, to reserves and to costs of operations;

4148 (3) To furnish such statements as and when they are required for
4149 administrative purposes and, at the end of each fiscal period, to prepare
4150 and publish such financial statements and data as will convey to the
4151 General Assembly the essential facts as to the financial condition, the
4152 revenues and expenditures and the costs of operations of the state
4153 government;

4154 (4) To furnish to the State Comptroller on or before the twentieth day
4155 of each month cumulative monthly statements of revenues and
4156 expenditures to the end of the last-completed month together with (A)
4157 a statement of estimated revenue by source to the end of the fiscal year,
4158 at least in the same detail as appears in the budget act, and (B) a
4159 statement of appropriation requirements of the state's General Fund to
4160 the end of the fiscal year itemized as far as practicable for each budgeted
4161 agency, including estimates of lapsing appropriations, unallocated
4162 lapsing balances and unallocated appropriation requirements;

4163 (5) To transmit to the Office of Fiscal Analysis a copy of monthly
4164 position data and monthly bond project run;

4165 (6) To inquire into the operation of, and make or recommend
4166 improvement in, the methods employed in the preparation of the
4167 budget and the procedure followed in determining whether the funds
4168 expended by the departments, boards, commissions and institutions
4169 supported in whole or in part by the state are wisely, judiciously and
4170 economically expended and to submit such findings and

4171 recommendations to the General Assembly at each regular session,
4172 together with drafts of proposed legislation, if any;

4173 (7) To examine each department, state college, state hospital, state-
4174 aided hospital, reformatory and prison and each other institution or
4175 other agency supported in whole or in part by the state, except public
4176 schools, for the purpose of determining the effectiveness of its policies,
4177 management, internal organization and operating procedures and the
4178 character, amount, quality and cost of the service rendered by each such
4179 department, institution or agency;

4180 (8) To recommend, and to assist any such department, institution or
4181 agency to effect, improvements in organization, management methods
4182 and procedures and to report its findings and recommendations and
4183 submit drafts of proposed legislation, if any, to the General Assembly at
4184 each regular session;

4185 (9) To consider and devise ways and means whereby comprehensive
4186 plans and designs to meet the needs of the several departments and
4187 institutions with respect to physical plant and equipment and whereby
4188 financial plans and programs for the capital expenditures involved may
4189 be made in advance and to make or assist in making such plans;

4190 (10) To devise and prescribe the form of operating reports that shall
4191 be periodically required from the several departments, boards,
4192 commissions, institutions and agencies supported in whole or in part by
4193 the state;

4194 (11) To require the several departments, boards, commissions,
4195 institutions and agencies to make such reports for such periods as said
4196 secretary may determine; [and]

4197 (12) To verify the correctness of, and to analyze, all such reports and
4198 to take such action as may be deemed necessary to remedy
4199 unsatisfactory conditions disclosed by such reports;

4200 (13) To (A) coordinate the state's health information technology
4201 initiatives, (B) seek funding for and oversee the planning,
4202 implementation and development of policies and procedures for the
4203 administration of the all-payer claims database program established
4204 under section 19a-775a, (C) establish and maintain a consumer health
4205 information Internet web site under section 19a-755b, as amended by
4206 this act, and (D) designate an unclassified individual from the office to
4207 perform the duties of a health information technology officer as set forth
4208 in sections 17b-59f and 17b-59g, as amended by this act; and

4209 (14) To (A) set an annual health care cost growth benchmark and
4210 primary care spending target pursuant to section 19a-754g, as amended
4211 by this act, (B) develop and adopt health care quality benchmarks
4212 pursuant to section 19a-754g, as amended by this act, (C) develop
4213 strategies, in consultation with stakeholders, to meet such benchmarks
4214 and targets developed pursuant to section 19a-754g, as amended by this
4215 act, (D) enhance the transparency of provider entities, as defined in
4216 subdivision (13) of section 19a-754f, as amended by this act, (E) monitor
4217 the development of accountable care organizations and patient-centered
4218 medical homes in the state, and (F) monitor the adoption of alternative
4219 payment methodologies in the state.

4220 Sec. 98. Subsection (a) of section 17b-3 of the general statutes is
4221 repealed and the following is substituted in lieu thereof (*Effective July 1,*
4222 2026):

4223 (a) The Commissioner of Social Services shall administer all law
4224 under the jurisdiction of the Department of Social Services. The
4225 commissioner shall have the power and duty to do the following: (1)
4226 Administer, coordinate and direct the operation of the department; (2)
4227 adopt and enforce such regulations, in accordance with chapter 54, as
4228 are necessary to implement the purposes of the department as
4229 established by statute; (3) establish rules for the internal operation and
4230 administration of the department; (4) establish and develop programs
4231 and administer services to achieve the purposes of the department as

4232 established by statute; (5) enter into a contract, including, but not limited
4233 to, up to five contracts with other states, for facilities, services and
4234 programs to implement the purposes of the department as established
4235 by statute; (6) process applications and requests for services promptly;
4236 (7) with the approval of the Comptroller and in accordance with such
4237 procedures as may be specified by the Comptroller, make payments to
4238 providers of services for individuals who are eligible for benefits from
4239 the department as appropriate; (8) make no duplicate awards for items
4240 of assistance once granted, except for replacement of lost or stolen
4241 checks on which payment has been stopped; (9) promote economic self-
4242 sufficiency where appropriate in the department's programs, policies,
4243 practices and staff interactions with recipients; (10) act as advocate for
4244 the need of more comprehensive and coordinated programs for persons
4245 served by the department; (11) plan services and programs for persons
4246 served by the department; (12) coordinate outreach activities by public
4247 and private agencies assisting persons served by the department; (13)
4248 consult and cooperate with area and private planning agencies; (14)
4249 advise and inform municipal officials and officials of social service
4250 agencies about social service programs and collect and disseminate
4251 information pertaining thereto, including information about federal,
4252 state, municipal and private assistance programs and services; (15)
4253 encourage and facilitate effective communication and coordination
4254 among federal, state, municipal and private agencies; (16) inquire into
4255 the utilization of state and federal government resources which offer
4256 solutions to problems of the delivery of social services; (17) conduct,
4257 encourage and maintain research and studies relating to social services
4258 development; (18) prepare, review and encourage model
4259 comprehensive social service programs; (19) maintain an inventory of
4260 data and information and act as a clearing house and referral agency for
4261 information on state and federal programs and services; [and] (20)
4262 conduct, encourage and maintain research and studies and advise
4263 municipal officials and officials of social service agencies about forms of
4264 intergovernmental cooperation and coordination between public and
4265 private agencies designed to advance social service programs; (21)

4266 develop an annual summary and analysis of community benefit
4267 reporting by hospitals pursuant to section 19a-127k, as amended by this
4268 act, and (22) receive reports from each hospital regarding its financial
4269 health pursuant to section 19a-486j, as amended by this act. The
4270 commissioner may require notice of the submission of all applications
4271 by municipalities, any agency thereof, and social service agencies, for
4272 federal and state financial assistance to carry out social services. The
4273 commissioner shall establish state-wide and regional advisory councils.

4274 Sec. 99. Subsection (a) of section 19a-7p of the general statutes is
4275 repealed and the following is substituted in lieu thereof (*Effective July 1,*
4276 2026):

4277 (a) Not later than September first, annually, the Secretary of the Office
4278 of Policy and Management, in consultation with the Commissioner of
4279 Public Health, shall (1) determine the amounts appropriated from the
4280 Insurance Fund for the Health Systems Planning Unit, established
4281 pursuant to section 19a-612, as amended by this act, syringe services
4282 program, AIDS services, breast and cervical cancer detection and
4283 treatment, x-ray screening and tuberculosis care, sexually transmitted
4284 disease control and children's health initiatives; and (2) inform the
4285 Insurance Commissioner of such amounts.

4286 Sec. 100. Sections 19a-754a and 19a-754e of the 2026 supplement to
4287 the general statutes are repealed. (*Effective July 1, 2026*)

4288 Sec. 101. Sections 19a-725, 20-195sss and 38a-477jj of the general
4289 statutes are repealed. (*Effective July 1, 2026*)

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

Sec. 6	<i>July 1, 2026</i>	46a-52
Sec. 7	<i>from passage</i>	10-76000
Sec. 8	<i>from passage</i>	Repealer section
Sec. 9	<i>July 1, 2026</i>	1-84(d)
Sec. 10	<i>July 1, 2026</i>	1-84b(c)
Sec. 11	<i>July 1, 2026</i>	2-137(b)
Sec. 12	<i>July 1, 2026</i>	4-5
Sec. 13	<i>July 1, 2026</i>	4-101a(b)
Sec. 14	<i>July 1, 2026</i>	8-37vvv(b)
Sec. 15	<i>July 1, 2026</i>	10-222tt(c)(8)
Sec. 16	<i>July 1, 2026</i>	10-532(b) to (d)
Sec. 17	<i>July 1, 2026</i>	12-34h(b)
Sec. 18	<i>July 1, 2026</i>	12-263q(c)(1)(B)
Sec. 19	<i>July 1, 2026</i>	17b-59a
Sec. 20	<i>July 1, 2026</i>	17b-59d(d) to (g)
Sec. 21	<i>July 1, 2026</i>	17b-59e(f)
Sec. 22	<i>July 1, 2026</i>	17b-59f
Sec. 23	<i>July 1, 2026</i>	17b-59g(a) and (b)
Sec. 24	<i>July 1, 2026</i>	17b-312
Sec. 25	<i>July 1, 2026</i>	17b-337(c)
Sec. 26	<i>July 1, 2026</i>	17b-340(f)(3)
Sec. 27	<i>July 1, 2026</i>	17b-356
Sec. 28	<i>July 1, 2026</i>	19a-6q
Sec. 29	<i>July 1, 2026</i>	19a-7(b)
Sec. 30	<i>July 1, 2026</i>	19a-7h(l)
Sec. 31	<i>July 1, 2026</i>	19a-75a(a)
Sec. 32	<i>July 1, 2026</i>	19a-127k
Sec. 33	<i>July 1, 2026</i>	19a-486
Sec. 34	<i>July 1, 2026</i>	19a-486g
Sec. 35	<i>July 1, 2026</i>	19a-486h
Sec. 36	<i>July 1, 2026</i>	19a-486i(d) to (i)
Sec. 37	<i>July 1, 2026</i>	19a-486j
Sec. 38	<i>July 1, 2026</i>	19a-490ii(b)
Sec. 39	<i>July 1, 2026</i>	19a-493b(b) and (c)
Sec. 40	<i>July 1, 2026</i>	19a-507(a)
Sec. 41	<i>July 1, 2026</i>	19a-508c(d) to (m)
Sec. 42	<i>July 1, 2026</i>	19a-509b(c)
Sec. 43	<i>July 1, 2026</i>	19a-612
Sec. 44	<i>July 1, 2026</i>	19a-612d

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

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