



General Assembly

Substitute Bill No. 5030

February Session, 2026



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196 general statutes is repealed and the following is substituted in lieu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

198 (d) No public official or state employee or employee of such public
199 official or state employee shall agree to accept, or be a member or
200 employee of a partnership, association, professional corporation or sole
201 proprietorship which partnership, association, professional corporation
202 or sole proprietorship agrees to accept any employment, fee or other
203 thing of value, or portion thereof, for appearing, agreeing to appear, or
204 taking any other action on behalf of another person before the
205 Department of Banking, the Office of the Claims Commissioner, the
206 Health Systems Planning Unit of the [Office of Health Strategy]
207 Department of Public Health, the Insurance Department, the
208 Department of Consumer Protection, the Department of Motor Vehicles,
209 the State Insurance and Risk Management Board, the Department of
210 Energy and Environmental Protection, the Public Utilities Regulatory
211 Authority, the Connecticut Siting Council or the Connecticut Real Estate
212 Commission; provided this shall not prohibit any such person from
213 making inquiry for information on behalf of another before any of said

214 commissions or commissioners if no fee or reward is given or promised
215 in consequence thereof. For the purpose of this subsection, partnerships,
216 associations, professional corporations or sole proprietorships refer
217 only to such partnerships, associations, professional corporations or sole
218 proprietorships which have been formed to carry on the business or
219 profession directly relating to the employment, appearing, agreeing to
220 appear or taking of action provided for in this subsection. Nothing in
221 this subsection shall prohibit any employment, appearing, agreeing to
222 appear or taking action before any municipal board, commission or
223 council. Nothing in this subsection shall be construed as applying (1) to
224 the actions of any teaching or research professional employee of a public
225 institution of higher education if such actions are not in violation of any
226 other provision of this chapter, (2) to the actions of any other
227 professional employee of a public institution of higher education if such
228 actions are not compensated and are not in violation of any other
229 provision of this chapter, (3) to any member of a board or commission
230 who receives no compensation other than per diem payments or
231 reimbursement for actual or necessary expenses, or both, incurred in the
232 performance of the member's duties, or (4) to any member or director of
233 a quasi-public agency. Notwithstanding the provisions of this
234 subsection to the contrary, a legislator, an officer of the General
235 Assembly or part-time legislative employee may be or become a
236 member or employee of a firm, partnership, association or professional
237 corporation which represents clients for compensation before agencies
238 listed in this subsection, provided the legislator, officer of the General
239 Assembly or part-time legislative employee shall take no part in any
240 matter involving the agency listed in this subsection and shall not
241 receive compensation from any such matter. Receipt of a previously
242 established salary, not based on the current or anticipated business of
243 the firm, partnership, association or professional corporation involving
244 the agencies listed in this subsection, shall be permitted.

245 Sec. 8. Subsection (c) of section 1-84b of the general statutes is
246 repealed and the following is substituted in lieu thereof (*Effective July 1,*
247 *2026*):

248 (c) The provisions of this subsection apply to present or former
249 executive branch public officials or state employees of an agency who
250 hold or formerly held positions which involve significant decision-
251 making or supervisory responsibility. Such positions shall be
252 designated as such by the agency concerned, in consultation with the
253 Office of State Ethics, except that such provisions shall not apply to
254 members or former members of the boards or commissions who serve
255 ex officio, who are required by statute to represent the regulated
256 industry or who are permitted by statute to have a past or present
257 affiliation with the regulated industry. On or before November [1, 2021,
258 and not less than] first annually, [thereafter,] the head of each agency
259 concerned, or his or her designee, shall submit the designation of all
260 positions in existence on such date that are subject to the provisions of
261 this subsection to the office electronically, in a manner prescribed by the
262 Citizen's Ethics Advisory Board. If an agency creates such a position
263 after its annual submission under this subsection, the head of such
264 agency, or his or her designee, shall submit the designation of the newly
265 created position not later than thirty days after the creation of such
266 position. As used in this subsection, "agency" means the Health Systems
267 Planning Unit of the [Office of Health Strategy] Department of Public
268 Health, the Connecticut Siting Council, the Department of Banking, the
269 Insurance Department, the Department of Emergency Services and
270 Public Protection, the office within the Department of Consumer
271 Protection that carries out the duties and responsibilities of sections 30-
272 2 to 30-68m, inclusive, the Public Utilities Regulatory Authority,
273 including the Office of Consumer Counsel, and the Department of
274 Consumer Protection and the term "employment" means professional
275 services or other services rendered as an employee or as an independent
276 contractor.

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

281 (2) No former public official or state employee who held such a

282 position in the executive branch shall, within one year after leaving an
283 agency, accept employment with a business subject to regulation by that
284 agency.

285 (3) No business shall employ a present or former public official or
286 state employee in violation of this subsection.

287 Sec. 9. Subsection (b) of section 2-137 of the 2026 supplement to the
288 general statutes is repealed and the following is substituted in lieu
289 thereof (*Effective July 1, 2026*):

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

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

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

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

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

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

314 (6) One appointed by the majority leader of the Senate, who shall be
315 a representative of public school superintendents in the state;

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

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

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

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

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

332 [(12)] (11) The Child Advocate, or the Child Advocate's designee;

333 [(13)] (12) The Healthcare Advocate and the Behavioral Health
334 Advocate, or their designees;

335 [(14)] (13) The executive director of the Court Support Services
336 Division of the Judicial Branch, or the executive director's designee;

337 [(15)] (14) The executive director of the Commission on Women,
338 Children, Seniors, Equity and Opportunity, or the executive director's
339 designee;

340 [(16)] (15) The Secretary of the Office of Policy and Management, or
341 the secretary's designee; and

342 [(17)] (16) One representative from each administrative services
343 organization under contract with the Department of Social Services to
344 provide such services for recipients of assistance under the HUSKY
345 Health program, who shall be ex-officio, nonvoting members.

346 Sec. 10. Section 4-5 of the general statutes is repealed and the
347 following is substituted in lieu thereof (*Effective July 1, 2026*):

348 As used in sections 4-6, 4-7 and 4-8, the term "department head"
349 means the Secretary of the Office of Policy and Management,
350 Commissioner of Administrative Services, Commissioner of Revenue
351 Services, Banking Commissioner, Commissioner of Children and
352 Families, Commissioner of Consumer Protection, Commissioner of
353 Correction, Commissioner of Economic and Community Development,
354 State Board of Education, Commissioner of Emergency Services and
355 Public Protection, Commissioner of Energy and Environmental
356 Protection, Commissioner of Agriculture, Commissioner of Public
357 Health, Insurance Commissioner, Labor Commissioner, Commissioner
358 of Mental Health and Addiction Services, Commissioner of Social
359 Services, Commissioner of Developmental Services, Commissioner of
360 Motor Vehicles, Commissioner of Transportation, Commissioner of
361 Veterans Affairs, Commissioner of Housing, Commissioner of Aging
362 and Disability Services, Commissioner of Early Childhood,
363 [Commissioner of Health Strategy,] executive director of the Office of
364 Military Affairs, executive director of the Technical Education and
365 Career System, Chief Workforce Officer and Commissioner of Higher
366 Education. As used in sections 4-6 and 4-7, "department head" also
367 means the Commissioner of Education.

368 Sec. 11. Subsection (b) of section 4-101a of the general statutes is
369 repealed and the following is substituted in lieu thereof (*Effective July 1,*
370 *2026*):

371 (b) Grants, technical assistance or consultation services, or any

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

401 Sec. 12. Subsection (b) of section 8-37vvv of the 2026 supplement to
402 the general statutes is repealed and the following is substituted in lieu
403 thereof (*Effective July 1, 2026*):

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

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

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

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

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

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

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

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

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

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

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

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

433 designee;

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

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

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

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

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

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

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

447 [(19)] (18) The chief executive officer of the Connecticut Housing
448 Finance Authority, or the chief executive officer's designee; and

449 [(20)] (19) The Long-Term Care Ombudsman.

450 Sec. 13. Subdivision (8) of subsection (c) of section 10-222tt of the 2026
451 supplement to the general statutes is repealed and the following is
452 substituted in lieu thereof (*Effective July 1, 2026*):

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

457 Sec. 14. Subsections (b) to (d), inclusive, of section 10-532 of the
458 general statutes are repealed and the following is substituted in lieu
459 thereof (*Effective July 1, 2026*):

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

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

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

480 Sec. 15. Subsection (b) of section 12-34h of the 2026 supplement to the
481 general statutes is repealed and the following is substituted in lieu
482 thereof (*Effective July 1, 2026*):

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

489 Sec. 16. Subparagraph (B) of subdivision (1) of subsection (c) of
490 section 12-263q of the 2026 supplement to the general statutes, as
491 amended by section 360 of public act 25-168, is repealed and the

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

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

512 Sec. 17. Section 17b-59a of the 2026 supplement to the general statutes
513 is repealed and the following is substituted in lieu thereof (*Effective July*
514 *1, 2026*):

515 (a) As used in this section:

516 (1) "Electronic health information system" means an information
517 processing system, involving both computer hardware and software
518 that deals with the storage, retrieval, sharing and use of health care
519 information, data and knowledge for communication and decision
520 making, and includes: (A) An electronic health record that provides
521 access in real time to a patient's complete medical record; (B) a personal
522 health record through which an individual, and anyone authorized by
523 such individual, can maintain and manage such individual's health

524 information; (C) computerized order entry technology that permits a
525 health care provider to order diagnostic and treatment services,
526 including prescription drugs electronically; (D) electronic alerts and
527 reminders to health care providers to improve compliance with best
528 practices, promote regular screenings and other preventive practices,
529 and facilitate diagnoses and treatments; (E) error notification
530 procedures that generate a warning if an order is entered that is likely
531 to lead to a significant adverse outcome for a patient; and (F) tools to
532 allow for the collection, analysis and reporting of data on adverse
533 events, near misses, the quality and efficiency of care, patient
534 satisfaction and other healthcare-related performance measures.

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

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

547 (b) The Commissioner of Social Services, in consultation with the
548 [Commissioner of Health Strategy] Secretary of the Office of Policy and
549 Management, shall (1) develop, throughout the Departments of
550 Developmental Services, Public Health, Correction, Children and
551 Families, Veterans Affairs and Mental Health and Addiction Services,
552 uniform management information, uniform statistical information,
553 uniform terminology for similar facilities and uniform electronic health
554 information technology standards, (2) plan for increased participation
555 of the private sector in the delivery of human services, and (3) provide
556 direction and coordination to federally funded programs in the human

557 services agencies and recommend uniform system improvements and
558 reallocation of physical resources and designation of a single
559 responsibility across human services agencies lines to facilitate shared
560 services and eliminate duplication.

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

585 (d) The [Commissioner of Health Strategy] Secretary of the Office of
586 Policy and Management shall, within existing resources and in
587 consultation with the State Health Information Technology Advisory
588 Council: (1) Oversee the development and implementation of the State-
589 wide Health Information Exchange in conformance with section 17b-
590 59d, as amended by this act; (2) coordinate the state's health information

591 technology and health information exchange efforts to ensure consistent
592 and collaborative cross-agency planning and implementation; and (3)
593 serve as the state liaison to, and work collaboratively with, the State-
594 wide Health Information Exchange established pursuant to section 17b-
595 59d, as amended by this act, to ensure consistency between the state-
596 wide health information technology plan and the State-wide Health
597 Information Exchange and to support the state's health information
598 technology and exchange goals.

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

614 (f) Not later than February [1, 2017, and annually thereafter] first
615 annually, the [Commissioner of Health Strategy] Secretary of the Office
616 of Policy and Management, in consultation with the State Health
617 Information Technology Advisory Council, shall report in accordance
618 with the provisions of section 11-4a to the joint standing committees of
619 the General Assembly having cognizance of matters relating to human
620 services and public health concerning: (1) The development and
621 implementation of the state-wide health information technology plan
622 and data standards, established and implemented by the
623 [Commissioner of Health Strategy] secretary pursuant to this section; (2)
624 the establishment of the State-wide Health Information Exchange; and

625 (3) recommendations for policy, regulatory and legislative changes and
626 other initiatives to promote the state's health information technology
627 and exchange goals.

628 Sec. 18. Subsections (d) to (g), inclusive, of section 17b-59d of the
629 general statutes are repealed and the following is substituted in lieu
630 thereof (*Effective July 1, 2026*):

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

649 (2) Such request for proposals may require an eligible organization
650 responding to the request to: (A) Have not less than three years of
651 experience operating either a state-wide health information exchange in
652 any state or a regional exchange serving a population of not less than
653 one million that (i) enables the exchange of patient health information
654 among health care providers, patients and other authorized users
655 without regard to location, source of payment or technology, (ii)
656 includes, with proper consent, behavioral health and substance abuse
657 treatment information, (iii) supports transitions of care and care

658 coordination through real-time health care provider alerts and access to
659 clinical information, (iv) allows health information to follow each
660 patient, (v) allows patients to access and manage their health data, and
661 (vi) has demonstrated success in reducing costs associated with
662 preventable readmissions, duplicative testing or medical errors; (B) be
663 committed to, and demonstrate, a high level of transparency in its
664 governance, decision-making and operations; (C) be capable of
665 providing consulting to ensure effective governance; (D) be regulated or
666 administratively overseen by a state government agency; and (E) have
667 sufficient staff and appropriate expertise and experience to carry out the
668 administrative, operational and financial responsibilities of the State-
669 wide Health Information Exchange.

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

680 (f) The [Commissioner of Health Strategy] Secretary of the Office of
681 Policy and Management shall have administrative authority over the
682 State-wide Health Information Exchange. The [commissioner] secretary
683 shall be responsible for designating, and posting on [its] the Office of
684 Policy and Management's Internet web site, the list of systems,
685 technologies, entities and programs that shall constitute the State-wide
686 Health Information Exchange. Systems, technologies, entities, and
687 programs that have not been so designated shall not be considered part
688 of said exchange.

689 (g) The [Commissioner of Health Strategy] Secretary of the Office of
690 Policy and Management shall adopt regulations in accordance with the

691 provisions of chapter 54 that set forth requirements necessary to
692 implement the provisions of this section. The [commissioner] secretary
693 may implement policies and procedures necessary to administer the
694 provisions of this section while in the process of adopting such policies
695 and procedures in regulation form, provided the [commissioner]
696 secretary holds a public hearing at least thirty days prior to
697 implementing such policies and procedures and publishes notice of
698 intention to adopt the regulations on the Office of [Health Strategy's]
699 Policy and Management's Internet web site and the eRegulations System
700 not later than twenty days after implementing such policies and
701 procedures. Policies and procedures implemented pursuant to this
702 subsection shall be valid until the time such regulations are effective.

703 Sec. 19. Subsection (f) of section 17b-59e of the 2026 supplement to the
704 general statutes is repealed and the following is substituted in lieu
705 thereof (*Effective July 1, 2026*):

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

720 Sec. 20. Section 17b-59f of the general statutes is repealed and the
721 following is substituted in lieu thereof (*Effective July 1, 2026*):

722 (a) There shall be a State Health Information Technology Advisory

723 Council to advise the [Commissioner of Health Strategy] Secretary of
724 the Office of Policy and Management and the health information
725 technology officer, designated in accordance with section [19a-754a] 4-
726 66, as amended by this act, in developing priorities and policy
727 recommendations for advancing the state's health information
728 technology and health information exchange efforts and goals and to
729 advise the [commissioner] secretary and officer in the development and
730 implementation of the state-wide health information technology plan
731 and standards and the State-wide Health Information Exchange,
732 established pursuant to section 17b-59d, as amended by this act. The
733 advisory council shall also advise the [commissioner] secretary and
734 officer regarding the development of appropriate governance, oversight
735 and accountability measures to ensure success in achieving the state's
736 health information technology and exchange goals.

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

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

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

744 (3) The Commissioners of Social Services, Mental Health and
745 Addiction Services, Children and Families, Correction, Public Health
746 and Developmental Services, or the commissioners' designees;

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

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

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

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

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

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

756 (10) Five members appointed by the Governor, one each who shall be
757 (A) a representative of a health system that includes more than one
758 hospital, (B) a representative of the health insurance industry, (C) an
759 expert in health information technology, (D) a health care consumer or
760 consumer advocate, and (E) a current or former employee or trustee of
761 a plan established pursuant to subdivision (5) of subsection (c) of 29 USC
762 186;

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

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

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

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

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

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

782 quality analysis;

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

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

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

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

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

794 (d) (1) The health information technology officer, designated in
795 accordance with section [19a-754a] 4-66, as amended by this act, shall
796 serve as a chairperson of the council. The council shall elect a second
797 chairperson from among its members, who shall not be a state official.
798 The chairpersons of the council may establish subcommittees and
799 working groups and may appoint individuals other than members of
800 the council to serve as members of the subcommittees or working
801 groups. The terms of the members shall be coterminous with the terms
802 of the appointing authority for each member and subject to the
803 provisions of section 4-1a. If any vacancy occurs on the council, the
804 appointing authority having the power to make the appointment under
805 the provisions of this section shall appoint a person in accordance with
806 the provisions of this section. A majority of the members of the council
807 shall constitute a quorum. Members of the council shall serve without
808 compensation, but shall be reimbursed for all reasonable expenses
809 incurred in the performance of their duties.

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

812 chairpersons.

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

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

829 (f) Prior to submitting any application, proposal, planning document
830 or other request seeking federal grants, matching funds or other federal
831 support for health information technology or health information
832 exchange, the [Commissioner of Health Strategy] Secretary of the Office
833 of Policy and Management or the Commissioner of Social Services shall
834 present such application, proposal, document or other request to the
835 council for review and comment.

836 Sec. 21. Subsections (a) and (b) of section 17b-59g of the general
837 statutes are repealed and the following is substituted in lieu thereof
838 (*Effective July 1, 2026*):

839 (a) The state, acting by and through the Secretary of the Office of
840 Policy and Management, [in collaboration with the Commissioner of
841 Health Strategy,] shall establish a program to expedite the development
842 of the State-wide Health Information Exchange, established under
843 section 17b-59d, as amended by this act, to assist the state, health care

844 providers, insurance carriers, physicians and all stakeholders in
845 empowering consumers to make effective health care decisions,
846 promote patient-centered care, improve the quality, safety and value of
847 health care, reduce waste and duplication of services, support clinical
848 decision-making, keep confidential health information secure and make
849 progress toward the state's public health goals. The purposes of the
850 program shall be to (1) assist the State-wide Health Information
851 Exchange in establishing and maintaining itself as a neutral and trusted
852 entity that serves the public good for the benefit of all Connecticut
853 residents, including, but not limited to, Connecticut health care
854 consumers and Connecticut health care providers and carriers, and (2)
855 perform, on behalf of the state, the role of intermediary between public
856 and private stakeholders and customers of the State-wide Health
857 Information Exchange, [, and (3) fulfill the responsibilities of the Office
858 of Health Strategy, as described in section 19a-754a.]

859 (b) The [Commissioner of Health Strategy] Secretary of the Office of
860 Policy and Management, in consultation with the health information
861 technology officer, designated in accordance with section [19a-754] 4-66
862 as amended by this act, shall design [, and the Secretary of the Office of
863 Policy and Management, in collaboration with said commissioner,] and
864 may establish or incorporate an entity to implement the program
865 established under subsection (a) of this section. Such entity shall,
866 without limitation, be owned and governed, in whole or in part, by a
867 party or parties other than the state and may be organized as a nonprofit
868 entity.

869 Sec. 22. Section 17b-312 of the general statutes is repealed and the
870 following is substituted in lieu thereof (*Effective July 1, 2026*):

871 The Commissioner of Social Services shall seek, in accordance with
872 the provisions of section 17b-8, [and in consultation with the Insurance
873 Commissioner and the Office of Health Strategy established under
874 section 19a-754a,] a waiver under Section 1115 of the Social Security Act,
875 as amended from time to time, to seek federal funds to support the
876 Covered Connecticut program established under section 19a-754c, as

877 amended by this act. Upon approval by the Centers for Medicare and
878 Medicaid Services, the Commissioner of Social Services shall implement
879 the waiver.

880 Sec. 23. Subsection (c) of section 17b-337 of the general statutes is
881 repealed and the following is substituted in lieu thereof (*Effective July 1,*
882 *2026*):

883 (c) The Long-Term Care Planning Committee shall consist of: (1) The
884 chairpersons and ranking members of the joint standing committees of
885 the General Assembly having cognizance of matters relating to human
886 services, public health, elderly services and long-term care; (2) the
887 Commissioner of Social Services, or the commissioner's designee; (3)
888 one member of the Office of Policy and Management appointed by the
889 Secretary of the Office of Policy and Management; (4) one member from
890 the Department of Public Health appointed by the Commissioner of
891 Public Health; (5) one member from the Department of Housing
892 appointed by the Commissioner of Housing; (6) one member from the
893 Department of Developmental Services appointed by the Commissioner
894 of Developmental Services; (7) one member from the Department of
895 Mental Health and Addiction Services appointed by the Commissioner
896 of Mental Health and Addiction Services; (8) one member from the
897 Department of Transportation appointed by the Commissioner of
898 Transportation; (9) one member from the Department of Children and
899 Families appointed by the Commissioner of Children and Families; [(10)
900 one member from the Health Systems Planning Unit of the Office of
901 Health Strategy appointed by the Commissioner of Health Strategy; and
902 (11)] and (10) one member from the Department of Aging and Disability
903 Services appointed by the Commissioner of Aging and Disability
904 Services. The committee shall convene no later than ninety days after
905 June 4, 1998. Any vacancy shall be filled by the appointing authority.
906 The chairperson shall be elected from among the members of the
907 committee. The committee shall seek the advice and participation of any
908 person, organization or state or federal agency it deems necessary to
909 carry out the provisions of this section.

910 Sec. 24. Subdivision (3) of subsection (f) of section 17b-340 of the 2026
911 supplement to the general statutes is repealed and the following is
912 substituted in lieu thereof (*Effective July 1, 2026*):

913 (3) For the fiscal year ending June 30, 1992, per diem maximum
914 allowable costs for each cost component shall be as follows: For direct
915 costs, the maximum shall be equal to one hundred forty per cent of the
916 median allowable cost of that peer grouping; for indirect costs, the
917 maximum shall be equal to one hundred thirty per cent of the state-wide
918 median allowable cost; for fair rent, the amount shall be calculated
919 utilizing the amount approved by the [Office of Health Care Access]
920 Health Systems Planning Unit of the Department of Public Health
921 pursuant to section 19a-638, as amended by this act; for capital-related
922 costs, there shall be no maximum; and for administrative and general
923 costs, the maximum shall be equal to one hundred twenty-five per cent
924 of the state-wide median allowable cost. For the fiscal year ending June
925 30, 1993, per diem maximum allowable costs for each cost component
926 shall be as follows: For direct costs, the maximum shall be equal to one
927 hundred forty per cent of the median allowable cost of that peer
928 grouping; for indirect costs, the maximum shall be equal to one hundred
929 twenty-five per cent of the state-wide median allowable cost; for fair
930 rent, the amount shall be calculated utilizing the amount approved by
931 the [Office of Health Care Access] Health Systems Planning Unit
932 pursuant to section 19a-638, as amended by this act; for capital-related
933 costs, there shall be no maximum; and for administrative and general
934 costs the maximum shall be equal to one hundred fifteen per cent of the
935 state-wide median allowable cost. For the fiscal year ending June 30,
936 1994, per diem maximum allowable costs for each cost component shall
937 be as follows: For direct costs, the maximum shall be equal to one
938 hundred thirty-five per cent of the median allowable cost of that peer
939 grouping; for indirect costs, the maximum shall be equal to one hundred
940 twenty per cent of the state-wide median allowable cost; for fair rent,
941 the amount shall be calculated utilizing the amount approved by the
942 [Office of Health Care Access] Health Systems Planning Unit pursuant
943 to section 19a-638, as amended by this act; for capital-related costs, there

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

979 be equal to the state-wide median allowable cost and such medians shall
980 be based upon the same cost year used to set rates for facilities with
981 prospective rates. Costs in excess of the maximum amounts established
982 under this subsection shall not be recognized as allowable costs, except
983 that the Commissioner of Social Services (A) may allow costs in excess
984 of maximum amounts for any facility with patient days covered by
985 Medicare, including days requiring coinsurance, in excess of twelve per
986 cent of annual patient days which also has patient days covered by
987 Medicaid in excess of fifty per cent of annual patient days; (B) may
988 establish a pilot program whereby costs in excess of maximum amounts
989 shall be allowed for beds in a nursing home which has a managed care
990 program and is affiliated with a hospital licensed under chapter 368v;
991 and (C) may establish rates whereby allowable costs may exceed such
992 maximum amounts for beds approved on or after July 1, 1991, which are
993 restricted to use by patients with acquired immune deficiency syndrome
994 or traumatic brain injury.

995 Sec. 25. Section 17b-356 of the general statutes is repealed and the
996 following is substituted in lieu thereof (*Effective July 1, 2026*):

997 Any health care facility or institution, as defined in subsection (a) of
998 section 19a-490, except a nursing home, rest home, residential care home
999 or residential facility for persons with intellectual disability licensed
1000 pursuant to section 17a-227 and certified to participate in the Title XIX
1001 Medicaid program as an intermediate care facility for individuals with
1002 intellectual disabilities, proposing to expand its services by adding
1003 nursing home beds shall obtain the approval of the Commissioner of
1004 Social Services in accordance with the procedures established pursuant
1005 to sections 17b-352, 17b-353 and 17b-354 for a facility, as defined in
1006 section 17b-352, prior to obtaining the approval of the Health Systems
1007 Planning Unit of the [Office of Health Strategy] Department of Public
1008 Health pursuant to section 19a-639, as amended by this act.

1009 Sec. 26. Section 19a-6q of the general statutes is repealed and the
1010 following is substituted in lieu thereof (*Effective July 1, 2026*):

1011 The Commissioner of Public Health, in consultation with the
1012 [Commissioner of Health Strategy and] local and regional health
1013 departments, shall, within available resources, develop a plan that is
1014 consistent with the Department of Public Health's Healthy Connecticut
1015 2020 health improvement plan and the state healthcare innovation plan
1016 developed pursuant to the State Innovation Model Initiative by the
1017 Centers for Medicare and Medicaid Services Innovation Center. The
1018 Commissioner of Public Health shall develop and implement such plan
1019 to: (1) Reduce the incidence of tobacco use, high blood pressure, health
1020 care associated infections, asthma, unintended pregnancy and diabetes;
1021 (2) improve chronic disease care coordination in the state; and (3) reduce
1022 the incidence and effects of chronic disease and improve outcomes for
1023 conditions associated with chronic disease in the state. The
1024 Commissioner of Public Health shall post such plan on the Department
1025 of Public Health's Internet web site.

1026 Sec. 27. Subsection (b) of section 19a-7 of the general statutes is
1027 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1028 *2026*):

1029 (b) For the purposes of establishing a state health plan as required by
1030 subsection (a) of this section and consistent with state and federal law
1031 on patient records, the department is entitled to access hospital
1032 discharge data, emergency room and ambulatory surgery encounter
1033 data, data on home health care agency client encounters and services,
1034 data from community health centers on client encounters and services
1035 and all data collected or compiled by the Health Systems Planning Unit
1036 of the [Office of Health Strategy] Department of Public Health pursuant
1037 to section 19a-613, as amended by this act.

1038 Sec. 28. Subsection (l) of section 19a-7h of the general statutes is
1039 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1040 *2026*):

1041 (l) The commissioner shall, in consultation with the [Office of Health
1042 Strategy] Secretary of the Office of Policy and Management, adopt

1043 regulations, in accordance with the provisions of chapter 54, to facilitate
1044 interoperability between the immunization information system and the
1045 State-wide Health Information Exchange established pursuant to
1046 section 17b-59d, as amended by this act. The commissioner may
1047 implement policies and procedures necessary to administer the
1048 provisions of this section while in the process of adopting such policies
1049 and procedures as regulations, provided the department posts such
1050 policies and procedures on the eRegulations System prior to adopting
1051 them. Policies and procedures implemented pursuant to this section
1052 shall be valid until regulations are adopted in accordance with the
1053 provisions of chapter 54.

1054 Sec. 29. Subsection (a) of section 19a-75a of the general statutes is
1055 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1056 *2026*):

1057 (a) On or before January 1, 2023, the Department of Public Health
1058 shall establish and administer a child and adolescent psychiatrist grant
1059 program. The program shall provide incentive grants to employers of
1060 child and adolescent psychiatrists for recruiting and hiring new child
1061 and adolescent psychiatrists and retaining child and adolescent
1062 psychiatrists who are in their employ. The Commissioner of Public
1063 Health shall establish eligibility requirements, priority categories,
1064 funding limitations and the application process for the grant program.
1065 Such priority categories shall include, but need not be limited to,
1066 nonhospital employers. The commissioner [, in consultation with the
1067 Office of Health Strategy,] shall distribute incentive grant funds
1068 equitably with regard to the type of employer and location of such
1069 employer.

1070 Sec. 30. Section 19a-127k of the general statutes is repealed and the
1071 following is substituted in lieu thereof (*Effective July 1, 2026*):

1072 (a) As used in this section:

1073 (1) "Community benefit partners" means federal, state and municipal
1074 government entities and private sector entities, including, but not

1075 limited to, faith-based organizations, businesses, educational and
1076 academic organizations, health care organizations, health departments,
1077 philanthropic organizations, organizations specializing in housing
1078 justice, planning and land use organizations, public safety
1079 organizations, transportation organizations and tribal organizations,
1080 that, in partnership with hospitals, play an essential role with respect to
1081 the policy, system, program and financing solutions necessary to
1082 achieve community benefit program goals;

1083 (2) "Community benefit program" means any voluntary program or
1084 activity to promote preventive health care, protect health and safety,
1085 improve health equity and reduce health disparities, reduce the cost and
1086 economic burden of poor health and improve the health status for all
1087 populations within the geographic service areas of a hospital, regardless
1088 of whether a member of any such population is a patient of such
1089 hospital;

1090 (3) "Community benefit program reporting" means the community
1091 health needs assessment, implementation strategy and annual report
1092 submitted by a hospital to the Office of [Health Strategy] the Healthcare
1093 Advocate pursuant to the provisions of this section;

1094 (4) "Community health needs assessment" means a written
1095 assessment, as described in 26 CFR 1.501(r)-(3);

1096 (5) "Health disparities" means health differences that are closely
1097 linked with social or economic disadvantages that adversely affect one
1098 or more groups of people who have experienced greater systemic social
1099 or economic obstacles to health or a safe environment based on race or
1100 ethnicity, religion, socioeconomic status, gender, age, mental health,
1101 cognitive, sensory or physical disability, sexual orientation, gender
1102 identity, geographic location or other characteristics historically linked
1103 to discrimination or exclusion;

1104 (6) "Health equity" means that every person has a fair and just
1105 opportunity to be as healthy as possible, which encompasses removing
1106 obstacles to health, such as poverty, racism and the adverse

1107 consequences of poverty and racism, including, but not limited to, a lack
1108 of equitable opportunities, access to good jobs with fair pay, quality
1109 education and housing, safe environments and health care;

1110 (7) "Hospital" means a nonprofit entity licensed as a hospital
1111 pursuant to chapter 368v that is required to annually file Internal
1112 Revenue Service form 990. "Hospital" includes a for-profit entity
1113 licensed as an acute care general hospital;

1114 (8) "Implementation strategy" means a written plan, as described in
1115 26 CFR 1.501(r)-(3), that is adopted by an authorized body of a hospital
1116 and documents how such hospital intends to address the needs
1117 identified in the community health needs assessment; and

1118 (9) "Meaningful participation" means that (A) residents of a hospital's
1119 community, including, but not limited to, residents of such community
1120 that experience the greatest health disparities, have an appropriate
1121 opportunity to participate in such hospital's planning and decisions, (B)
1122 community participation influences a hospital's planning, and (C)
1123 participants receive information from a hospital summarizing how their
1124 input was or was not used by such hospital.

1125 (b) On and after January 1, 2023, each hospital shall submit
1126 community benefit program reporting to the Office of [Health Strategy]
1127 the Healthcare Advocate, or to a designee selected by the
1128 [Commissioner of Health Strategy] Healthcare Advocate, in the form
1129 and manner described in subsections (c) to (e), inclusive, of this section.

1130 (c) Each hospital shall submit its community health needs assessment
1131 to the Office of [Health Strategy] the Healthcare Advocate not later than
1132 thirty days after the date on which such assessment is made available to
1133 the public pursuant to 26 CFR 1.501(r)-(3)(b), provided the
1134 [Commissioner of Health Strategy, or the commissioner's] Healthcare
1135 Advocate, or the Healthcare Advocate's designee, may grant an
1136 extension of time to a hospital for the filing of such assessment. Such
1137 submission shall contain the following:

1138 (1) Consistent with the requirements set forth in 26 CFR 1.501(r)-
1139 (3)(b)(6)(i), and as included in a hospital's federal filing submitted to the
1140 Internal Revenue Service:

1141 (A) A definition of the community served by the hospital and a
1142 description of how the community was determined;

1143 (B) A description of the process and methods used to conduct the
1144 community health needs assessment;

1145 (C) A description of how the hospital solicited and took into account
1146 input received from persons who represent the broad interests of the
1147 community it serves;

1148 (D) A prioritized description of the significant health needs of the
1149 community identified through the community health needs assessment,
1150 and a description of the process and criteria used in identifying certain
1151 health needs as significant and prioritizing those significant health
1152 needs;

1153 (E) A description of the resources potentially available to address the
1154 significant health needs identified through the community health needs
1155 assessment;

1156 (F) An evaluation of the impact of any actions that were taken, since
1157 the hospital finished conducting its immediately preceding community
1158 health needs assessment, to address the significant health needs
1159 identified in the hospital's prior community health needs assessment;
1160 and

1161 (2) Additional documentation of the following:

1162 (A) The names of the individuals responsible for developing the
1163 community health needs assessment;

1164 (B) The demographics of the population within the geographic
1165 service area of the hospital and, to the extent feasible, a detailed
1166 description of the health disparities, health risks, insurance status,

1167 service utilization patterns and health care costs within such geographic
1168 service area;

1169 (C) A description of the health status and health disparities affecting
1170 the population within the geographic service area of the hospital,
1171 including, but not limited to, the health status and health disparities
1172 affecting a representative spectrum of age, racial and ethnic groups,
1173 incomes and medically underserved populations;

1174 (D) A description of the meaningful participation afforded to
1175 community benefit partners and diverse community members in
1176 assessing community health needs, priorities and target populations;

1177 (E) A description of the barriers to achieving or maintaining health
1178 and to accessing health care, including, but not limited to, social,
1179 economic and environmental barriers, lack of access to or availability of
1180 sources of health care coverage and services and a lack of access to and
1181 availability of prevention and health promotion services and support;

1182 (F) Recommendations regarding the role that the state and other
1183 community benefit partners could play in removing the barriers
1184 described in subparagraph (E) of this subdivision and enabling effective
1185 solutions; and

1186 (G) Any additional information, data or disclosures that the hospital
1187 voluntarily chooses to include as may be relevant to its community
1188 benefit program.

1189 (d) Each hospital shall submit its implementation strategy to the
1190 Office of [Health Strategy] the Healthcare Advocate not later than thirty
1191 days after the date on which such implementation strategy is adopted
1192 pursuant to 26 CFR 1.501(r)-(3)(c), provided the [Commissioner of
1193 Health Strategy, or the commissioner's] Healthcare Advocate, or the
1194 Healthcare Advocate's designee, may grant an extension to a hospital
1195 for the filing of such implementation strategy. Such submission shall
1196 contain the following:

1197 (1) Consistent with the requirements set forth in 26 CFR 1.501(r)-
1198 (3)(b)(6)(i), and as included in a hospital's federal filing submitted to the
1199 Internal Revenue Service:

1200 (A) With respect to each significant health need identified through
1201 the community health needs assessment, either (i) a description of how
1202 the hospital plans to address the health need, or (ii) identification of the
1203 health need as one which the hospital does not intend to address;

1204 (B) For significant health needs described in subparagraph (A)(i) of
1205 this subdivision, (i) a description of the actions that the hospital intends
1206 to take to address the health need and the anticipated impact of such
1207 actions, (ii) identification of the resources that the hospital plans to
1208 commit to address the health need, and (iii) a description of any planned
1209 collaboration between the hospital and other facilities or organizations
1210 to address the health need;

1211 (C) For significant health needs identified in subparagraph (A)(ii) of
1212 this subdivision, an explanation of why the hospital does not intend to
1213 address such health need; and

1214 (2) Additional documentation of the following:

1215 (A) The names of the individuals responsible for developing the
1216 implementation strategy;

1217 (B) A description of the meaningful participation afforded to
1218 community benefit partners and diverse community members;

1219 (C) A description of the community health needs and health
1220 disparities that were prioritized in developing the implementation
1221 strategy with consideration given to the most recent version of the state
1222 health plan prepared by the Department of Public Health pursuant to
1223 section 19a-7, as amended by this act;

1224 (D) Reference-citing evidence, if available, that shows how the
1225 implementation strategy is intended to address the corresponding
1226 health need or reduction in health disparity;

1227 (E) A description of the planned methods for the ongoing evaluation
1228 of proposed actions and corresponding process or outcome measures
1229 intended for use in assessing progress or impact;

1230 (F) A description of how the hospital solicited commentary on the
1231 implementation strategy from the communities within such hospital's
1232 geographic service area and revisions to such strategy based on such
1233 commentary; and

1234 (G) Any other information that the hospital voluntarily chooses to
1235 include as may be relevant to its implementation strategy, including, but
1236 not limited to, data, disclosures, expected or planned resource outlay,
1237 investments or commitments, including, but not limited to, staff,
1238 financial or in-kind commitments.

1239 (e) On or before October 1, 2023, and annually thereafter, each
1240 hospital shall submit to the Office of [Health Strategy] the Healthcare
1241 Advocate a status report on such hospital's community benefit program,
1242 provided the [Commissioner of Health Strategy, or the commissioner's]
1243 Healthcare Advocate, or the Healthcare Advocate's designee, may grant
1244 an extension to a hospital for the filing of such report. Such report shall
1245 include the following:

1246 (1) A description of major updates regarding community health
1247 needs, priorities and target populations, if any;

1248 (2) A description of progress made regarding the hospital's actions in
1249 support of its implementation strategy;

1250 (3) A description of any major changes to the proposed
1251 implementation strategy and associated hospital actions; and

1252 (4) A description of financial resources and other resources allocated
1253 or expended that supported the actions taken in support of the hospital's
1254 implementation strategy.

1255 (f) Notwithstanding the provisions of section 19a-755a, as amended
1256 by this act, and to the full extent permitted by 45 CFR 164.514(e), the

1257 Office of [Health Strategy] the Healthcare Advocate shall make data in
1258 the all-payer claims database available to hospitals for use in their
1259 community benefit programs and activities solely for the purposes of (1)
1260 preparing the hospital's community health needs assessment, (2)
1261 preparing and executing the hospital's implementation strategy, and (3)
1262 fulfilling community benefit program reporting, as described in
1263 subsections (c) to (e), inclusive, of this section. Any disclosure made by
1264 said office pursuant to this subsection of information other than health
1265 information shall be made in a manner to protect the confidentiality of
1266 such information as may be required by state or federal law.

1267 (g) A hospital shall not be responsible for limitations in its ability to
1268 fulfill community benefit program reporting requirements, as described
1269 in subsections (c) to (e), inclusive, of this section, if the all-payer claims
1270 database data is not provided to such hospital, as required by subsection
1271 (f) of this section.

1272 (h) [On or before April 1, 2024, and annually thereafter, the
1273 Commissioner of Health Strategy] Not later than April first, annually,
1274 the Healthcare Advocate shall develop a summary and analysis of the
1275 community benefit program reporting submitted by hospitals under
1276 this section during the previous calendar year and post such summary
1277 and analysis on its Internet web site and solicit stakeholder input
1278 through a public comment period. The Office of [Health Strategy] the
1279 Healthcare Advocate shall use such reporting and stakeholder input to:

1280 (1) Identify additional stakeholders that may be engaged to address
1281 identified community health needs, including, but not limited to,
1282 federal, state and municipal entities, nonhospital private sector health
1283 care providers and private sector entities that are not health care
1284 providers, including community-based organizations, insurers and
1285 charitable organizations;

1286 (2) Determine how each identified stakeholder could assist in
1287 addressing identified community health needs or augmenting solutions
1288 or approaches reported in the implementation strategies;

1289 (3) Determine whether to make recommendations to the Department
1290 of Public Health in the development of its state health plan; and

1291 (4) Inform the state-wide health care facilities and services plan
1292 established pursuant to section 19a-634, as amended by this act.

1293 (i) Each for-profit entity licensed as an acute care general hospital
1294 shall submit community benefit program reporting consistent with the
1295 reporting schedules of subsections (c) to (e), inclusive, of this section,
1296 and reasonably similar to what would be included on such hospital's
1297 federal filings to the Internal Revenue Service, where applicable.

1298 Sec. 31. Section 19a-486 of the general statutes is repealed and the
1299 following is substituted in lieu thereof (*Effective July 1, 2026*):

1300 For purposes of sections 19a-486 to 19a-486h, inclusive, as amended
1301 by this act:

1302 (1) "Nonprofit hospital" means a nonprofit entity licensed as a
1303 hospital pursuant to this chapter and any entity affiliated with such a
1304 hospital through governance or membership, including, but not limited
1305 to, a holding company or subsidiary.

1306 (2) "Purchaser" means a person acquiring any assets of a nonprofit
1307 hospital through a transfer.

1308 (3) "Person" means any individual, firm, partnership, corporation,
1309 limited liability company, association or other entity.

1310 (4) "Transfer" means to sell, transfer, lease, exchange, option, convey,
1311 give or otherwise dispose of or transfer control over, including, but not
1312 limited to, transfer by way of merger or joint venture not in the ordinary
1313 course of business.

1314 (5) "Control" has the meaning assigned to it in section 36b-41.

1315 (6) "Commissioner" means the Commissioner of [Health Strategy]
1316 Public Health, or the commissioner's designee.

1317 Sec. 32. Section 19a-486g of the general statutes is repealed and the
1318 following is substituted in lieu thereof (*Effective July 1, 2026*):

1319 The Commissioner of Public Health shall refuse to issue a license to,
1320 or if issued shall suspend or revoke the license of, a hospital if the
1321 commissioner finds, after a hearing and opportunity to be heard, that:

1322 (1) There was a transaction described in section 19a-486a that
1323 occurred without the commissioner's approval, [of the Commissioner of
1324 Health Strategy,] if such approval was required by sections 19a-486 to
1325 19a-486h, inclusive, as amended by this act;

1326 (2) There was a transaction described in section 19a-486a without the
1327 approval of the Attorney General, if such approval was required by
1328 sections 19a-486 to 19a-486h, inclusive, as amended by this act, and the
1329 Attorney General certifies to the [Commissioner of Health Strategy]
1330 commissioner that such transaction involved a material amount of the
1331 nonprofit hospital's assets or operations or a change in control of
1332 operations; or

1333 (3) The hospital is not complying with the terms of an agreement
1334 approved by the Attorney General and [Commissioner of Health
1335 Strategy] commissioner pursuant to sections 19a-486 to 19a-486h,
1336 inclusive, as amended by this act.

1337 Sec. 33. Section 19a-486h of the general statutes is repealed and the
1338 following is substituted in lieu thereof (*Effective July 1, 2026*):

1339 Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by
1340 this act, shall be construed to limit: (1) The common law or statutory
1341 authority of the Attorney General; (2) the statutory authority of the
1342 Commissioner of Public Health including, but not limited to, licensing
1343 [; (3) the statutory authority of the Commissioner of Health Strategy,
1344 including, but not limited to, certificate of need authority; or (4)] and
1345 certificate of need authority; or (3) the application of the doctrine of cy
1346 pres or approximation.

1347 Sec. 34. Subsections (d) to (i), inclusive, of section 19a-486i of the
1348 general statutes are repealed and the following is substituted in lieu
1349 thereof (*Effective July 1, 2026*):

1350 (d) (1) The written notice required under subsection (c) of this section
1351 shall identify each party to the transaction and describe the material
1352 change as of the date of such notice to the business or corporate structure
1353 of the group practice, including: (A) A description of the nature of the
1354 proposed relationship among the parties to the proposed transaction;
1355 (B) the names and specialties of each physician that is a member of the
1356 group practice that is the subject of the proposed transaction and who
1357 will practice medicine with the resulting group practice, hospital,
1358 hospital system, captive professional entity, medical foundation or
1359 other entity organized by, controlled by, or otherwise affiliated with
1360 such hospital or hospital system following the effective date of the
1361 transaction; (C) the names of the business entities that are to provide
1362 services following the effective date of the transaction; (D) the address
1363 for each location where such services are to be provided; (E) a
1364 description of the services to be provided at each such location; and (F)
1365 the primary service area to be served by each such location.

1366 (2) Not later than thirty days after the effective date of any transaction
1367 described in subsection (c) of this section, the parties to the transaction
1368 shall submit written notice to the Commissioner of [Health Strategy]
1369 Public Health. Such written notice shall include, but need not be limited
1370 to, the same information described in subdivision (1) of this subsection.
1371 The commissioner shall post a link to such notice on the [Office of Health
1372 Strategy's] Department of Public Health's Internet web site.

1373 (e) Not less than thirty days prior to the effective date of any
1374 transaction that results in an affiliation between one hospital or hospital
1375 system and another hospital or hospital system, the parties to the
1376 affiliation shall submit written notice to the Attorney General of such
1377 affiliation. Such written notice shall identify each party to the affiliation
1378 and describe the affiliation as of the date of such notice, including: (1) A
1379 description of the nature of the proposed relationship among the parties

1380 to the affiliation; (2) the names of the business entities that are to provide
1381 services following the effective date of the affiliation; (3) the address for
1382 each location where such services are to be provided; (4) a description
1383 of the services to be provided at each such location; and (5) the primary
1384 service area to be served by each such location.

1385 (f) Written information submitted to the Attorney General pursuant
1386 to subsections (b) to (e), inclusive, of this section shall be maintained and
1387 used by the Attorney General in the same manner as provided in section
1388 35-42.

1389 (g) Not later than January [15, 2018, and] fifteenth annually,
1390 [thereafter,] each hospital and hospital system shall file with the
1391 Attorney General and the Commissioner of [Health Strategy] Public
1392 Health a written report describing the activities of the group practices
1393 owned or affiliated with such hospital or hospital system. Such report
1394 shall include, for each such group practice: (1) A description of the
1395 nature of the relationship between the hospital or hospital system and
1396 the group practice; (2) the names and specialties of each physician
1397 practicing medicine with the group practice; (3) the names of the
1398 business entities that provide services as part of the group practice and
1399 the address for each location where such services are provided; (4) a
1400 description of the services provided at each such location; and (5) the
1401 primary service area served by each such location.

1402 (h) Not later than January [15, 2018, and] fifteenth annually,
1403 [thereafter,] each group practice comprised of thirty or more physicians
1404 that is not the subject of a report filed under subsection (g) of this section
1405 shall file with the Attorney General and the Commissioner of [Health
1406 Strategy] Public Health a written report concerning the group practice.
1407 Such report shall include, for each such group practice: (1) The names
1408 and specialties of each physician practicing medicine with the group
1409 practice; (2) the names of the business entities that provide services as
1410 part of the group practice and the address for each location where such
1411 services are provided; (3) a description of the services provided at each
1412 such location; and (4) the primary service area served by each such

1413 location.

1414 (i) Not later than January [15, 2018, and] fifteenth annually,
1415 [thereafter,] each hospital and hospital system shall file with the
1416 Attorney General and the Commissioner of [Health Strategy] Public
1417 Health a written report describing each affiliation with another hospital
1418 or hospital system. Such report shall include: (1) The name and address
1419 of each party to the affiliation; (2) a description of the nature of the
1420 relationship among the parties to the affiliation; (3) the names of the
1421 business entities that provide services as part of the affiliation and the
1422 address for each location where such services are provided; (4) a
1423 description of the services provided at each such location; and (5) the
1424 primary service area served by each such location.

1425 Sec. 35. Section 19a-486j of the general statutes is repealed and the
1426 following is substituted in lieu thereof (*Effective July 1, 2026*):

1427 (a) On or before October 31, [2024] 2026, and semiannually thereafter,
1428 each hospital, as defined in section 12-263p, shall submit a semiannual
1429 report to the Commissioner of [Health Strategy] Social Services that
1430 identifies, for each of the two prior calendar quarters, (1) the number of
1431 days of cash on hand, or days cash and cash equivalents otherwise
1432 available to the hospital, and (2) the dollar amount of (A) invoices that
1433 are at least ninety days past due in the reporting period, (B) utility bills
1434 that are at least ninety days past due in the reporting period, (C) fees,
1435 taxes or assessments owed to public entities that are at least ninety days
1436 past due in the reporting period, and (D) unpaid employee health
1437 insurance premiums, including unpaid contributions, claims or other
1438 obligations supporting employees under a self-funded insurance plan
1439 or fully insured plan, that are at least ninety days past due in the
1440 reporting period. The commissioner shall develop a uniform template,
1441 including, but not limited to, definitions of terms used in such template,
1442 to be used by hospitals for the purposes of complying with the
1443 provisions of this subsection and post such template on the [Office of
1444 Health Strategy's] Department of Social Services' Internet web site. A
1445 hospital may request an extension of time to comply with the

1446 requirements of this subsection in a form and manner prescribed by the
1447 commissioner. The commissioner may grant such request for good
1448 cause, as determined by the commissioner. Such template shall be based
1449 on generally accepted accounting principles as prescribed by the
1450 Financial Accounting Standards Board.

1451 (b) If a hospital submits a report pursuant to the provisions of
1452 subsection (a) of this section reflecting two consecutive quarters of sixty
1453 days or less of days of cash on hand, or days cash and cash equivalents
1454 otherwise available to the hospital, the commissioner may require the
1455 hospital to provide the [Office of Health Strategy] Department of Social
1456 Services with additional information that the commissioner deems
1457 relevant to understanding the financial health of the hospital.

1458 (c) If a hospital submits a report pursuant to the provisions of
1459 subsection (a) of this section reflecting two consecutive quarters of forty-
1460 five days or less of cash on hand, or days cash and cash equivalents
1461 otherwise available to the hospital, the [Office of Health Strategy]
1462 Department of Social Services shall contact the hospital to offer
1463 assistance.

1464 (d) If a hospital has multiple consecutive quarters of one hundred or
1465 more days of cash on hand, or days cash and cash equivalents otherwise
1466 available to the hospital, the commissioner may waive one of the
1467 hospital's two semiannual reports required pursuant to the provisions
1468 of subsection (a) of this section.

1469 Sec. 36. Subsection (b) of section 19a-490ii of the 2026 supplement to
1470 the general statutes is repealed and the following is substituted in lieu
1471 thereof (*Effective July 1, 2026*):

1472 (b) Not later than March [1, 2025, and] first annually, [thereafter] until
1473 March 1, 2029, each hospital that conducts an analysis pursuant to
1474 subsection (a) of this section shall submit a report, in accordance with
1475 the provisions of section 11-4a, to the joint standing committee of the
1476 General Assembly having cognizance of matters relating to public
1477 health and, not later than March [1, 2026, and] first annually [thereafter]

1478 until March 1, 2029, shall also submit such report to the
1479 [Commissioners] Commissioner of Public Health [and Health Strategy]
1480 and the Healthcare Advocate, regarding its findings and any
1481 recommendations for achieving the goals described in subparagraphs
1482 (A) to (C), inclusive, of subdivision (4) of subsection (a) of this section.

1483 Sec. 37. Subsections (b) and (c) of section 19a-493b of the general
1484 statutes are repealed and the following is substituted in lieu thereof
1485 (*Effective July 1, 2026*):

1486 (b) No entity, individual, firm, partnership, corporation, limited
1487 liability company or association, other than a hospital, shall individually
1488 or jointly establish or operate an outpatient surgical facility in this state
1489 without complying with chapter 368z, except as otherwise provided by
1490 this section, and obtaining a license within the time specified in this
1491 subsection from the Department of Public Health for such facility
1492 pursuant to the provisions of this chapter, unless such entity, individual,
1493 firm, partnership, corporation, limited liability company or association:
1494 (1) Provides to the Health Systems Planning Unit of the [Office of Health
1495 Strategy] Department of Public Health satisfactory evidence that it was
1496 in operation on or before July 1, 2003, or (2) obtained, on or before July
1497 1, 2003, from the Office of Health Care Access, a determination that a
1498 certificate of need is not required. An entity, individual, firm,
1499 partnership, corporation, limited liability company or association
1500 otherwise in compliance with this section may operate an outpatient
1501 surgical facility without a license through March 30, 2007, and shall have
1502 until March 30, 2007, to obtain a license from the Department of Public
1503 Health.

1504 (c) Notwithstanding the provisions of this section, no outpatient
1505 surgical facility shall be required to comply with section 19a-631, as
1506 amended by this act, 19a-632, 19a-644, as amended by this act, 19a-645,
1507 as amended by this act, 19a-646, as amended by this act, 19a-649, 19a-
1508 664 to 19a-666, inclusive, 19a-673 to 19a-676, inclusive, 19a-678, 19a-681,
1509 as amended by this act, or 19a-683. Each outpatient surgical facility shall
1510 continue to be subject to the obligations and requirements applicable to

1511 such facility, including, but not limited to, any applicable provision of
1512 this chapter and those provisions of chapter 368z not specified in this
1513 subsection, except that a request for permission to undertake a transfer
1514 or change of ownership or control shall not be required pursuant to
1515 subsection (a) of section 19a-638 if the Health Systems Planning Unit of
1516 the [Office of Health Strategy] Department of Public Health determines
1517 that the following conditions are satisfied: (1) Prior to any such transfer
1518 or change of ownership or control, the outpatient surgical facility shall
1519 be owned and controlled exclusively by persons licensed pursuant to
1520 section 20-13 or chapter 375, either directly or through a limited liability
1521 company, formed pursuant to chapter 613, a corporation, formed
1522 pursuant to chapters 601 and 602, or a limited liability partnership,
1523 formed pursuant to chapter 614, that is exclusively owned by persons
1524 licensed pursuant to section 20-13 or chapter 375, or is under the interim
1525 control of an estate executor or conservator pending transfer of an
1526 ownership interest or control to a person licensed under section 20-13 or
1527 chapter 375, and (2) after any such transfer or change of ownership or
1528 control, persons licensed pursuant to section 20-13 or chapter 375, a
1529 limited liability company, formed pursuant to chapter 613, a
1530 corporation, formed pursuant to chapters 601 and 602, or a limited
1531 liability partnership, formed pursuant to chapter 614, that is exclusively
1532 owned by persons licensed pursuant to section 20-13 or chapter 375,
1533 shall own and control no less than a sixty per cent interest in the
1534 outpatient surgical facility.

1535 Sec. 38. Subsection (a) of section 19a-507 of the general statutes is
1536 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1537 *2026*):

1538 (a) Notwithstanding the provisions of chapter 368z, New Horizons,
1539 Inc., a nonprofit, nonsectarian organization, or a subsidiary
1540 organization controlled by New Horizons, Inc., is authorized to
1541 construct and operate an independent living facility for severely
1542 physically disabled adults, in the town of Farmington, provided such
1543 facility shall be constructed in accordance with applicable building
1544 codes. The Farmington Housing Authority, or any issuer acting on

1545 behalf of said authority, subject to the provisions of this section, may
1546 issue tax-exempt revenue bonds on a competitive or negotiated basis for
1547 the purpose of providing construction and permanent mortgage
1548 financing for the facility in accordance with Section 103 of the Internal
1549 Revenue Code. Prior to the issuance of such bonds, plans for the
1550 construction of the facility shall be submitted to and approved by the
1551 Health Systems Planning Unit of the [Office of Health Strategy]
1552 Department of Public Health. The unit shall approve or disapprove such
1553 plans within thirty days of receipt thereof. If the plans are disapproved
1554 they may be resubmitted. Failure of the unit to act on the plans within
1555 such thirty-day period shall be deemed approval thereof. The payments
1556 to residents of the facility who are eligible for assistance under the state
1557 supplement program for room and board and necessary services, shall
1558 be determined annually to be effective July first of each year. Such
1559 payments shall be determined on a basis of a reasonable payment for
1560 necessary services, which basis shall take into account as a factor the
1561 costs of providing those services and such other factors as the
1562 commissioner deems reasonable, including anticipated fluctuations in
1563 the cost of providing services. Such payments shall be calculated in
1564 accordance with the manner in which rates are calculated pursuant to
1565 subsection (i) of section 17b-340 and the cost-related reimbursement
1566 system pursuant to said section except that efficiency incentives shall
1567 not be granted. The commissioner may adjust such rates to account for
1568 the availability of personal care services for residents under the
1569 Medicaid program. The commissioner shall, upon submission of a
1570 request, allow actual debt service, comprised of principal and interest,
1571 in excess of property costs allowed pursuant to section 17-313b-5 of the
1572 regulations of Connecticut state agencies, provided such debt service
1573 terms and amounts are reasonable in relation to the useful life and the
1574 base value of the property. The cost basis for such payment shall be
1575 subject to audit, and a recomputation of the rate shall be made based
1576 upon such audit. The facility shall report on a fiscal year ending on the
1577 thirtieth day of September on forms provided by the commissioner. The
1578 required report shall be received by the commissioner no later than
1579 December thirty-first of each year. The Department of Social Services

1580 may use its existing utilization review procedures to monitor utilization
1581 of the facility. If the facility is aggrieved by any decision of the
1582 commissioner, the facility may, within ten days, after written notice
1583 thereof from the commissioner, obtain by written request to the
1584 commissioner, a hearing on all items of aggrievement. If the facility is
1585 aggrieved by the decision of the commissioner after such hearing, the
1586 facility may appeal to the Superior Court in accordance with the
1587 provisions of section 4-183.

1588 Sec. 39. Subsections (d) to (m), inclusive, of section 19a-508c of the
1589 2026 supplement to the general statutes are repealed and the following
1590 is substituted in lieu thereof (*Effective July 1, 2026*):

1591 (d) Each initial billing statement that includes a facility fee shall: (1)
1592 Clearly identify the fee as a facility fee that is billed in addition to, or
1593 separately from, any professional fee billed by the provider; (2) provide
1594 the corresponding Medicare facility fee reimbursement rate for the same
1595 service as a comparison or, if there is no corresponding Medicare facility
1596 fee for such service, (A) the approximate amount Medicare would have
1597 paid the hospital for the facility fee on the billing statement, or (B) the
1598 percentage of the hospital's charges that Medicare would have paid the
1599 hospital for the facility fee; (3) include a statement that the facility fee is
1600 intended to cover the hospital's or health system's operational expenses;
1601 (4) inform the patient that the patient's financial liability may have been
1602 less if the services had been provided at a facility not owned or operated
1603 by the hospital or health system; and (5) include written notice of the
1604 patient's right to request a reduction in the facility fee or any other
1605 portion of the bill and a telephone number that the patient may use to
1606 request such a reduction without regard to whether such patient
1607 qualifies for, or is likely to be granted, any reduction. Not later than
1608 October 15, 2022, and annually thereafter, each hospital, health system
1609 and hospital-based facility shall submit to the Health Systems Planning
1610 Unit of the [Office of Health Strategy] Department of Public Health,
1611 established pursuant to section 19a-612, as amended by this act, a
1612 sample of a billing statement issued by such hospital, health system or
1613 hospital-based facility that complies with the provisions of this

1614 subsection and [which] represents the format of billing statements
1615 received by patients. Such billing statement shall not contain patient
1616 identifying information.

1617 (e) The written notice described in subsections (b) to (d), inclusive,
1618 and (h) to (j), inclusive, of this section shall be in plain language and in
1619 a form that may be reasonably understood by a patient who does not
1620 possess special knowledge regarding hospital or health system facility
1621 fee charges. On and after October 1, 2022, such notices shall include tag
1622 lines in at least the top fifteen languages spoken in the state indicating
1623 that the notice is available in each of those top fifteen languages. The
1624 fifteen languages shall be either the languages in the list published by
1625 the Department of Health and Human Services in connection with
1626 section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-
1627 148, or, as determined by the hospital or health system, the top fifteen
1628 languages in the geographic area of the hospital-based facility.

1629 (f) (1) For nonemergency care, if a patient's appointment is scheduled
1630 to occur ten or more days after the appointment is made, such written
1631 notice shall be sent to the patient by first class mail, encrypted electronic
1632 mail or a secure patient Internet portal not less than three days after the
1633 appointment is made. If an appointment is scheduled to occur less than
1634 ten days after the appointment is made or if the patient arrives without
1635 an appointment, such notice shall be hand-delivered to the patient when
1636 the patient arrives at the hospital-based facility.

1637 (2) For emergency care, such written notice shall be provided to the
1638 patient as soon as practicable after the patient is stabilized in accordance
1639 with the federal Emergency Medical Treatment and Active Labor Act,
1640 42 USC 1395dd, as amended from time to time, or is determined not to
1641 have an emergency medical condition and before the patient leaves the
1642 hospital-based facility. If the patient is unconscious, under great duress
1643 or for any other reason unable to read the notice and understand and
1644 act on his or her rights, the notice shall be provided to the patient's
1645 representative as soon as practicable.

1646 (g) Subsections (b) to (f), inclusive, and (l) of this section shall not
1647 apply if a patient is insured by Medicare or Medicaid or is receiving
1648 services under a workers' compensation plan established to provide
1649 medical services pursuant to chapter 568.

1650 (h) A hospital-based facility shall prominently display written notice
1651 in locations that are readily accessible to and visible by patients,
1652 including patient waiting or appointment check-in areas, stating: (1)
1653 That the hospital-based facility is part of a hospital or health system, (2)
1654 the name of the hospital or health system, and (3) that if the hospital-
1655 based facility charges a facility fee, the patient may incur a financial
1656 liability greater than the patient would incur if the hospital-based
1657 facility was not hospital-based. On and after October 1, 2022, such
1658 notices shall include tag lines in at least the top fifteen languages spoken
1659 in the state indicating that the notice is available in each of those top
1660 fifteen languages. The fifteen languages shall be either the languages in
1661 the list published by the Department of Health and Human Services in
1662 connection with section 1557 of the Patient Protection and Affordable
1663 Care Act, P.L. 111-148, or, as determined by the hospital or health
1664 system, the top fifteen languages in the geographic area of the hospital-
1665 based facility. Not later than October 1, 2022, and annually thereafter,
1666 each hospital-based facility shall submit a copy of the written notice
1667 required by this subsection to the Health Systems Planning Unit of the
1668 [Office of Health Strategy] Department of Public Health.

1669 (i) A hospital-based facility shall clearly hold itself out to the public
1670 and payers as being hospital-based, including, at a minimum, by stating
1671 the name of the hospital or health system in its signage, marketing
1672 materials, Internet web sites and stationery.

1673 (j) A hospital-based facility shall, when scheduling services for which
1674 a facility fee may be charged, inform the patient (1) that the hospital-
1675 based facility is part of a hospital or health system, (2) of the name of the
1676 hospital or health system, (3) that the hospital or health system may
1677 charge a facility fee in addition to and separate from the professional fee
1678 charged by the provider, and (4) of the telephone number the patient

1679 may call for additional information regarding such patient's potential
1680 financial liability.

1681 (k) (1) If any transaction described in subsection (c) of section 19a-
1682 486i results in the establishment of a hospital-based facility at which
1683 facility fees may be billed, the hospital or health system, that is the
1684 purchaser in such transaction shall, not later than thirty days after such
1685 transaction, provide written notice, by first class mail, of the transaction
1686 to each patient served within the three years preceding the date of the
1687 transaction by the health care facility that has been purchased as part of
1688 such transaction.

1689 (2) Such notice shall include the following information:

1690 (A) A statement that the health care facility is now a hospital-based
1691 facility and is part of a hospital or health system, the health care facility's
1692 full legal and business name and the date of such facility's acquisition
1693 by a hospital or health system;

1694 (B) The name, business address and phone number of the hospital or
1695 health system that is the purchaser of the health care facility;

1696 (C) A statement that the hospital-based facility bills, or is likely to bill,
1697 patients a facility fee that may be in addition to, and separate from, any
1698 professional fee billed by a health care provider at the hospital-based
1699 facility;

1700 (D) (i) A statement that the patient's actual financial liability will
1701 depend on the professional medical services actually provided to the
1702 patient, and (ii) an explanation that the patient may incur financial
1703 liability that is greater than the patient would incur if the hospital-based
1704 facility were not a hospital-based facility;

1705 (E) The estimated amount or range of amounts the hospital-based
1706 facility may bill for a facility fee or an example of the average facility fee
1707 billed at such hospital-based facility for the most common services
1708 provided at such hospital-based facility; and

1709 (F) A statement that, prior to seeking services at such hospital-based
1710 facility, a patient covered by a health insurance policy should contact
1711 the patient's health insurer for additional information regarding the
1712 hospital-based facility fees, including the patient's potential financial
1713 liability, if any, for such fees.

1714 (3) A copy of the written notice provided to patients in accordance
1715 with this subsection shall be filed with the Health Systems Planning
1716 Unit of the [Office of Health Strategy] Department of Public Health,
1717 established under section 19a-612, as amended by this act. Said unit
1718 shall post a link to such notice on its Internet web site.

1719 (4) A hospital, health system or hospital-based facility shall not collect
1720 a facility fee for services provided at a hospital-based facility that is
1721 subject to the provisions of this subsection from the date of the
1722 transaction until at least thirty days after the written notice required
1723 pursuant to this subsection is mailed to the patient or a copy of such
1724 notice is filed with the Health Systems Planning Unit of the [Office of
1725 Health Strategy] Department of Public Health, whichever is later. A
1726 violation of this subsection shall be considered an unfair trade practice
1727 pursuant to section 42-110b.

1728 (5) Not later than July [1, 2023, and] first annually, [thereafter,] each
1729 hospital-based facility that was the subject of a transaction, as described
1730 in subsection (c) of section 19a-486i, during the preceding calendar year
1731 shall report to the Health Systems Planning Unit of the [Office of Health
1732 Strategy] Department of Public Health the number of patients served by
1733 such hospital-based facility in the preceding three years.

1734 (l) (1) Notwithstanding the provisions of this section, no hospital,
1735 health system or hospital-based facility shall collect a facility fee for (A)
1736 outpatient health care services that use a current procedural
1737 terminology evaluation and management (CPT E/M) code or
1738 assessment and management (CPT A/M) code and are provided at a
1739 hospital-based facility located off-site from a hospital campus, or (B)
1740 outpatient health care services provided at a hospital-based facility

1741 located off-site from a hospital campus received by a patient who is
1742 uninsured of more than the Medicare rate.

1743 (2) Notwithstanding the provisions of this section, on and after July
1744 1, 2024, no hospital or health system shall collect a facility fee for
1745 outpatient health care services that use a current procedural
1746 terminology evaluation and management (CPT E/M) code or
1747 assessment and management (CPT A/M) code and are provided on the
1748 hospital campus. The provisions of this subdivision shall not apply to
1749 (A) an emergency department located on a hospital campus, or (B)
1750 observation stays on a hospital campus and (CPT E/M) and (CPT A/M)
1751 codes when billed for the following services: (i) Wound care, (ii)
1752 orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi)
1753 solid organ transplant.

1754 (3) Notwithstanding the provisions of subdivisions (1) and (2) of this
1755 subsection, in circumstances when an insurance contract that is in effect
1756 on July 1, 2016, provides reimbursement for facility fees prohibited
1757 under the provisions of subdivision (1) of this subsection, and in
1758 circumstances when an insurance contract that is in effect on July 1,
1759 2024, provides reimbursement for facility fees prohibited under the
1760 provisions of subdivision (2) of this subsection, a hospital or health
1761 system may continue to collect reimbursement from the health insurer
1762 for such facility fees until the applicable date of expiration, renewal or
1763 amendment of such contract, whichever such date is the earliest.

1764 (4) The provisions of this subsection shall not apply to a freestanding
1765 emergency department. As used in this subdivision, "freestanding
1766 emergency department" means a freestanding facility that (A) is
1767 structurally separate and distinct from a hospital, (B) provides
1768 emergency care, (C) is a department of a hospital licensed under chapter
1769 368v, and (D) has been issued a certificate of need to operate as a
1770 freestanding emergency department pursuant to chapter 368z.

1771 (5) (A) On and after July 1, 2024, if the Commissioner of [Health
1772 Strategy] Public Health receives information and has a reasonable belief,

1773 after evaluating such information, that any hospital, health system or
1774 hospital-based facility charged facility fees, other than through isolated
1775 clerical or electronic billing errors, in violation of any provision of this
1776 section, or rule or regulation adopted thereunder, such hospital, health
1777 system or hospital-based facility shall be subject to a civil penalty of up
1778 to one thousand dollars. The commissioner may issue a notice of
1779 violation and civil penalty by first class mail or personal service. Such
1780 notice shall include: (i) A reference to the section of the general statutes,
1781 rule or section of the regulations of Connecticut state agencies believed
1782 or alleged to have been violated; (ii) a short and plain language
1783 statement of the matters asserted or charged; (iii) a description of the
1784 activity to cease; (iv) a statement of the amount of the civil penalty or
1785 penalties that may be imposed; (v) a statement concerning the right to a
1786 hearing; and (vi) a statement that such hospital, health system or
1787 hospital-based facility may, not later than ten business days after receipt
1788 of such notice, make a request for a hearing on the matters asserted.

1789 (B) The hospital, health system or hospital-based facility to whom
1790 such notice is provided pursuant to subparagraph (A) of this
1791 subdivision may, not later than ten business days after receipt of such
1792 notice, make written application to the [Office of Health Strategy]
1793 Department of Public Health to request a hearing to demonstrate that
1794 such violation did not occur. The failure to make a timely request for a
1795 hearing shall result in the issuance of a cease and desist order or civil
1796 penalty. All hearings held under this subsection shall be conducted in
1797 accordance with the provisions of chapter 54.

1798 (C) Following any hearing before the [Office of Health Strategy]
1799 Department of Public Health pursuant to this subdivision, if said [office]
1800 department finds, by a preponderance of the evidence, that such
1801 hospital, health system or hospital-based facility violated or is violating
1802 any provision of this subsection, any rule or regulation adopted
1803 thereunder or any order issued by said [office] department, said [office]
1804 department shall issue a final cease and desist order in addition to any
1805 civil penalty said [office] department imposes.

1806 (6) A violation of this subsection shall be considered an unfair trade
1807 practice pursuant to section 42-110b.

1808 (m) (1) Each hospital and health system shall report not later than
1809 October 1, 2023, and thereafter not later than July 1, 2024, and annually
1810 thereafter, to the Commissioner of [Health Strategy] Public Health, on a
1811 form prescribed by the commissioner, concerning facility fees charged
1812 or billed during the preceding calendar year. Such report shall include,
1813 but need not be limited to, (A) the name and address of each facility
1814 owned or operated by the hospital or health system that provides
1815 services for which a facility fee is charged or billed, and an indication as
1816 to whether each facility is located on or outside of the hospital or health
1817 system campus, (B) the number of patient visits at each such facility for
1818 which a facility fee was charged or billed, (C) the number, total amount
1819 and range of allowable facility fees paid at each such facility
1820 disaggregated by payer mix, (D) for each facility, the total amount of
1821 facility fees charged and the total amount of revenue received by the
1822 hospital or health system derived from facility fees, (E) the total amount
1823 of facility fees charged and the total amount of revenue received by the
1824 hospital or health system from all facilities derived from facility fees, (F)
1825 a description of the ten procedures or services that generated the
1826 greatest amount of facility fee gross revenue, disaggregated by current
1827 procedural terminology (CPT) category code for each such procedure or
1828 service and, for each such procedure or service, patient volume and the
1829 total amount of gross and net revenue received by the hospital or health
1830 system derived from facility fees, disaggregated by on-campus and off-
1831 campus, and (G) the top ten procedures or services for which facility
1832 fees are charged based on patient volume and the gross and net revenue
1833 received by the hospital or health system for each such procedure or
1834 service, disaggregated by on-campus and off-campus. For purposes of
1835 this subsection, "facility" means a hospital-based facility that is located
1836 on a hospital campus or outside a hospital campus.

1837 (2) The commissioner shall publish the information reported
1838 pursuant to subdivision (1) of this subsection, or post a link to such
1839 information, on the Internet web site of the [Office of Health Strategy]

1840 Department of Public Health.

1841 Sec. 40. Subsection (c) of section 19a-509b of the general statutes is
1842 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1843 *2026*):

1844 (c) Each hospital that holds or administers one or more hospital bed
1845 funds shall make available in a place and manner allowing individual
1846 members of the public to easily obtain it, a one-page summary in
1847 English and Spanish describing hospital bed funds and how to apply for
1848 them. The summary shall also describe any other policies regarding the
1849 provision of charity care and reduced cost services for the indigent as
1850 reported by the hospital to the Health Systems Planning Unit of the
1851 [Office of Health Strategy] Department of Public Health pursuant to
1852 section 19a-649 and shall clearly distinguish hospital bed funds from
1853 other sources of financial assistance. The summary shall include
1854 notification that the patient is entitled to reapply upon rejection, and
1855 that additional funds may become available on an annual basis. The
1856 summary shall be available in the patient admissions office, emergency
1857 room, social services department and patient accounts or billing office,
1858 and from any collection agent. If during the admission process or during
1859 its review of the financial resources of the patient, the hospital
1860 reasonably believes the patient will have limited funds to pay for any
1861 portion of the patient's hospitalization not covered by insurance, the
1862 hospital shall provide the summary to each such patient.

1863 Sec. 41. Section 19a-612 of the general statutes is repealed and the
1864 following is substituted in lieu thereof (*Effective July 1, 2026*):

1865 [(a)] There is established, within the [Office of Health Strategy,
1866 established under section 19a-754a] Department of Public Health, a unit
1867 to be known as the Health Systems Planning Unit [. The unit, under]
1868 that shall be under the direction of the Commissioner of [Health
1869 Strategy, shall constitute a successor to the former Office of Health Care
1870 Access, in accordance with the provisions of sections 4-38d and 4-39]
1871 Public Health.

1872 [(b) Any order, decision, agreed settlement or regulation of the
1873 former Office of Health Care Access which is in force on July 1, 2018,
1874 shall continue in force and effect as an order or regulation of the Office
1875 of Health Strategy until amended, repealed or superseded pursuant to
1876 law.

1877 (c) If the words "Office of Health Care Access" are used or referred to
1878 in any public or special act of 2009 or in any section of the general
1879 statutes which is amended in 2009, such words shall be deemed to mean
1880 or refer to the Office of Health Care Access division within the
1881 Department of Public Health. If the words "Office of Health Care
1882 Access" are used or referred to in any public or special act of 2018 or in
1883 any section of the general statutes which is amended in 2018, such
1884 words shall be deemed to mean or refer to the Health Systems Planning
1885 Unit within the Office of Health Strategy.]

1886 Sec. 42. Section 19a-612d of the general statutes is repealed and the
1887 following is substituted in lieu thereof (*Effective July 1, 2026*):

1888 [(a)] The Commissioner of [Health Strategy] Public Health shall
1889 oversee the Health Systems Planning Unit and shall exercise
1890 independent decision-making authority over all certificate of need
1891 decisions.

1892 [(b) Notwithstanding the provisions of subsection (a) of this section,
1893 the Deputy Commissioner of Public Health shall retain independent
1894 decision-making authority over only the certificate of need applications
1895 that are pending before the Office of Health Care Access and have been
1896 deemed completed by said office on or before May 14, 2018. Following
1897 the issuance by the Deputy Commissioner of Public Health of a final
1898 decision on any such certificate of need application, the Commissioner
1899 of Health Strategy shall exercise independent authority on any further
1900 action required on such certificate of need application or the certificate
1901 of need issued pursuant to such application.]

1902 Sec. 43. Subsection (c) of section 19a-613 of the general statutes is
1903 repealed and the following is substituted in lieu thereof (*Effective July 1,*

1904 2026):

1905 (c) The Commissioner of [Health Strategy] Public Health, or any
1906 person the commissioner designates, may conduct a hearing and render
1907 a final decision in any case when a hearing is required or authorized
1908 under the provisions of any statute dealing with the Health Systems
1909 Planning Unit.

1910 Sec. 44. Section 19a-614 of the general statutes is repealed and the
1911 following is substituted in lieu thereof (*Effective July 1, 2026*):

1912 The Commissioner of [Health Strategy] Public Health may employ
1913 and pay professional and support staff subject to the provisions of
1914 chapter 67 and contract with and engage consultants and other
1915 independent professionals as may be necessary or desirable to carry out
1916 the functions of the Health Systems Planning Unit.

1917 Sec. 45. Section 19a-630 of the 2026 supplement to the general statutes
1918 is repealed and the following is substituted in lieu thereof (*Effective July*
1919 *1, 2026*):

1920 As used in this chapter, unless the context otherwise requires:

1921 (1) "Affiliate" means a person, entity or organization controlling,
1922 controlled by or under common control with another person, entity or
1923 organization. Affiliate does not include a medical foundation organized
1924 under chapter 594b.

1925 (2) "Applicant" means any person or health care facility that applies
1926 for a certificate of need pursuant to section 19a-639a, as amended by this
1927 act.

1928 (3) "Bed capacity" means the total number of inpatient beds in a
1929 facility licensed by the Department of Public Health under sections 19a-
1930 490 to 19a-503, inclusive.

1931 (4) "Capital expenditure" means an expenditure that under generally
1932 accepted accounting principles consistently applied is not properly

1933 chargeable as an expense of operation or maintenance and includes
1934 acquisition by purchase, transfer, lease or comparable arrangement, or
1935 through donation, if the expenditure would have been considered a
1936 capital expenditure had the acquisition been by purchase.

1937 (5) "Certificate of need" means a certificate issued by the unit.

1938 (6) "Days" means calendar days.

1939 (7) "Commissioner" means the Commissioner of [Health Strategy]
1940 Public Health.

1941 (8) "Free clinic" means a private, nonprofit community-based
1942 organization that provides medical, dental, pharmaceutical or mental
1943 health services at reduced cost or no cost to low-income, uninsured and
1944 underinsured individuals.

1945 (9) "Large group practice" means eight or more full-time equivalent
1946 physicians, legally organized in a partnership, professional corporation,
1947 limited liability company formed to render professional services,
1948 medical foundation, not-for-profit corporation, faculty practice plan or
1949 other similar entity (A) in which each physician who is a member of the
1950 group provides substantially the full range of services that the physician
1951 routinely provides, including, but not limited to, medical care,
1952 consultation, diagnosis or treatment, through the joint use of shared
1953 office space, facilities, equipment or personnel; (B) for which
1954 substantially all of the services of the physicians who are members of
1955 the group are provided through the group and are billed in the name of
1956 the group practice and amounts so received are treated as receipts of the
1957 group; or (C) in which the overhead expenses of, and the income from,
1958 the group are distributed in accordance with methods previously
1959 determined by members of the group. An entity that otherwise meets
1960 the definition of group practice under this section shall be considered a
1961 group practice although its shareholders, partners or owners of the
1962 group practice include single-physician professional corporations,
1963 limited liability companies formed to render professional services or
1964 other entities in which beneficial owners are individual physicians.

1965 (10) "Health care facility" means (A) hospitals licensed by the
1966 Department of Public Health under chapter 368v; (B) specialty hospitals;
1967 (C) freestanding emergency departments; (D) outpatient surgical
1968 facilities, as defined in section 19a-493b, as amended by this act, and
1969 licensed under chapter 368v; (E) a hospital or other facility or institution
1970 operated by the state that provides services that are eligible for
1971 reimbursement under Title XVIII or XIX of the federal Social Security
1972 Act, 42 USC 301, as amended; (F) a central service facility; (G) mental
1973 health facilities; (H) substance abuse treatment facilities; and (I) any
1974 other facility requiring certificate of need review pursuant to subsection
1975 (a) of section 19a-638. "Health care facility" includes any parent
1976 company, subsidiary, affiliate or joint venture, or any combination
1977 thereof, of any such facility.

1978 (11) "Nonhospital based" means located at a site other than the main
1979 campus of the hospital.

1980 (12) ["Office" means the Office of Health Strategy] "Department"
1981 means the Department of Public Health.

1982 (13) "Person" means any individual, partnership, corporation, limited
1983 liability company, association, governmental subdivision, agency or
1984 public or private organization of any character, but does not include the
1985 agency conducting the proceeding.

1986 (14) "Physician" has the same meaning as provided in section 20-13a.

1987 (15) "Termination of services" means the cessation of any services for
1988 a combined total of greater than one hundred eighty days within any
1989 consecutive two-year period.

1990 (16) "Transfer of ownership" means a transfer that impacts or changes
1991 the governance or controlling body of a health care facility, institution
1992 or large group practice, including, but not limited to, all affiliations,
1993 mergers or any sale or transfer of net assets of a health care facility.

1994 (17) "Unit" means the Health Systems Planning Unit.

1995 Sec. 46. Subsection (b) of section 19a-631 of the general statutes is
1996 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1997 *2026*):

1998 (b) Each hospital shall annually pay to the Commissioner of [Health
1999 Strategy] Public Health, for deposit in the General Fund, an amount
2000 equal to its share of the actual expenditures made by the unit during
2001 each fiscal year including the cost of fringe benefits for unit personnel
2002 as estimated by the Comptroller, the amount of expenses for central
2003 state services attributable to the unit for the fiscal year as estimated by
2004 the Comptroller, plus the expenditures made on behalf of the unit from
2005 the Capital Equipment Purchase Fund pursuant to section 4a-9 for such
2006 year. Payments shall be made by assessment of all hospitals of the costs
2007 calculated and collected in accordance with the provisions of this section
2008 and section 19a-632. If for any reason a hospital ceases operation, any
2009 unpaid assessment for the operations of the unit shall be reapportioned
2010 among the remaining hospitals to be paid in addition to any other
2011 assessment.

2012 Sec. 47. Section 19a-632a of the general statutes is repealed and the
2013 following is substituted in lieu thereof (*Effective July 1, 2026*):

2014 (a) For purposes of this section, "electronic funds transfer" has the
2015 same meaning as provided in section 12-685.

2016 (b) The [Office of Health Strategy] Department of Public Health may
2017 require a hospital to pay an assessment levied pursuant to section 19a-
2018 632 by way of an approved method of electronic funds transfer.

2019 (c) A hospital making an electronic funds transfer pursuant to this
2020 section shall initiate such transfer in a timely fashion to ensure that a
2021 bank account designated by the department is credited by electronic
2022 funds transfer for the amount of the assessment required to be made by
2023 such method on or before the date such assessment is due.

2024 (d) Where an assessment is required to be made by electronic funds
2025 transfer, any payment made by a method other than electronic funds

2026 transfer shall be treated as an assessment not made in a timely manner,
2027 and any payment made by electronic funds transfer, where the bank
2028 account designated by the department is not credited for the amount of
2029 the assessment on or before the date such assessment is due, shall be
2030 treated as an assessment not made in a timely manner. Any assessment
2031 treated under this subsection as an assessment not made in a timely
2032 manner shall be subject to a penalty in accordance with subsection (e) of
2033 this section.

2034 (e) Where any assessment is treated under subsection (d) of this
2035 section as an assessment not made in a timely manner because it is made
2036 by means other than electronic funds transfer, [there shall be imposed]
2037 the department shall impose a penalty equal to ten per cent of the
2038 assessment required to be made by electronic funds transfer. Where any
2039 assessment made by electronic funds transfer is treated under
2040 subsection (d) of this section as an assessment not made in a timely
2041 manner because the bank account designated by the department is not
2042 credited by electronic funds transfer for the amount of the assessment
2043 on or before the date such assessment is due, [there shall be imposed]
2044 the department shall impose a penalty equal to (1) two per cent of the
2045 assessment required to be made by electronic funds transfer, if such
2046 failure to pay by electronic funds transfer is for not more than five days;
2047 (2) five per cent of the assessment required to be made by electronic
2048 funds transfer, if such failure to pay by electronic funds transfer is for
2049 more than five days but not more than fifteen days; or (3) ten per cent of
2050 the assessment required to be made by electronic funds transfer, if such
2051 failure to pay by electronic funds transfer is for more than fifteen days.

2052 (f) The [office] department shall deposit all payments received
2053 pursuant to this section with the State Treasurer. The moneys so
2054 deposited shall be credited to the General Fund and shall be accounted
2055 for as expenses recovered from hospitals.

2056 Sec. 48. Subsection (a) of section 19a-634 of the 2026 supplement to
2057 the general statutes is repealed and the following is substituted in lieu
2058 thereof (*Effective July 1, 2026*):

2059 (a) The Health Systems Planning Unit shall conduct, on a biennial
2060 basis, within available appropriations, a state-wide health care facility
2061 utilization study. Such study may include an assessment of: (1) Current
2062 availability and utilization of acute hospital care, hospital emergency
2063 care, specialty hospital care, outpatient surgical care, primary care and
2064 clinic care; (2) geographic areas and subpopulations that may be
2065 underserved or have reduced access to specific types of health care
2066 services; and (3) other factors that the unit deems pertinent to health care
2067 facility utilization. Not later than June thirtieth of the year in which the
2068 biennial study is conducted, the Commissioner of [Health Strategy]
2069 Public Health shall report, in accordance with section 11-4a, to the
2070 Governor and the joint standing committees of the General Assembly
2071 having cognizance of matters relating to public health and human
2072 services on the findings of the study. Such report may also include the
2073 unit's recommendations for addressing identified gaps in the provision
2074 of health care services and recommendations concerning a lack of access
2075 to health care services.

2076 Sec. 49. Subsections (d) and (e) of section 19a-638 of the general
2077 statutes are repealed and the following is substituted in lieu thereof
2078 (*Effective July 1, 2026*):

2079 (d) The Commissioner of [Health Strategy] Public Health may
2080 implement policies and procedures necessary to administer the
2081 provisions of this section while in the process of adopting such policies
2082 and procedures as regulation, provided the commissioner holds a
2083 public hearing prior to implementing the policies and procedures and
2084 posts notice of intent to adopt regulations on the [office's] department's
2085 Internet web site and the eRegulations System not later than twenty
2086 days after the date of implementation. Policies and procedures
2087 implemented pursuant to this section shall be valid until the time final
2088 regulations are adopted.

2089 (e) On or before June 30, 2026, a mental health facility seeking to
2090 increase licensed bed capacity without applying for a certificate of need,
2091 as permitted pursuant to subdivision (23) of subsection (b) of this

2092 section, shall notify the [Office of Health Strategy] Department of Public
2093 Health, in a form and manner prescribed by the commissioner,
2094 regarding (1) such facility's intent to increase licensed bed capacity, (2)
2095 the address of such facility, and (3) a description of all services that are
2096 being or will be provided at such facility.

2097 Sec. 50. Subdivision (1) of subsection (a) of section 19a-639 of the 2026
2098 supplement to the general statutes is repealed and the following is
2099 substituted in lieu thereof (*Effective July 1, 2026*):

2100 (1) Whether the proposed project is consistent with any applicable
2101 policies and standards adopted in regulations by the [Office of Health
2102 Strategy] Department of Public Health;

2103 Sec. 51. Subsection (a) of section 19a-639a of the general statutes is
2104 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2105 *2026*):

2106 (a) An application for a certificate of need shall be filed with the unit
2107 in accordance with the provisions of this section and any regulations
2108 adopted by the [Office of Health Strategy] Department of Public Health.
2109 The application shall address the guidelines and principles set forth in
2110 (1) subsection (a) of section 19a-639, as amended by this act, and (2)
2111 regulations adopted by the department. The applicant shall include
2112 with the application a nonrefundable application fee based on the cost
2113 of the project. The amount of the fee shall be as follows: (A) One
2114 thousand dollars for a project that will cost not greater than fifty
2115 thousand dollars; (B) two thousand dollars for a project that will cost
2116 greater than fifty thousand dollars but not greater than one hundred
2117 thousand dollars; (C) three thousand dollars for a project that will cost
2118 greater than one hundred thousand dollars but not greater than five
2119 hundred thousand dollars; (D) four thousand dollars for a project that
2120 will cost greater than five hundred thousand dollars but not greater than
2121 one million dollars; (E) five thousand dollars for a project that will cost
2122 greater than one million dollars but not greater than five million dollars;
2123 (F) eight thousand dollars for a project that will cost greater than five

2124 million dollars but not greater than ten million dollars; and (G) ten
2125 thousand dollars for a project that will cost greater than ten million
2126 dollars.

2127 Sec. 52. Subsection (h) of section 19a-639a of the general statutes is
2128 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2129 *2026*):

2130 (h) The Commissioner of [Health Strategy] Public Health may
2131 implement policies and procedures necessary to administer the
2132 provisions of this section while in the process of adopting such policies
2133 and procedures as regulation, provided the commissioner holds a
2134 public hearing prior to implementing the policies and procedures and
2135 posts notice of intent to adopt regulations on the [office's] Department
2136 of Public Health's Internet web site and the eRegulations System not
2137 later than twenty days after the date of implementation. Policies and
2138 procedures implemented pursuant to this section shall be valid until the
2139 time final regulations are adopted.

2140 Sec. 53. Subsection (e) of section 19a-639b of the general statutes is
2141 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2142 *2026*):

2143 (e) The Commissioner of [Health Strategy] Public Health may
2144 implement policies and procedures necessary to administer the
2145 provisions of this section while in the process of adopting such policies
2146 and procedures as regulation, provided the commissioner holds a
2147 public hearing prior to implementing the policies and procedures and
2148 posts notice of intent to adopt regulations on the [office's] Department
2149 of Public Health's Internet web site and the eRegulations System not
2150 later than twenty days after the date of implementation. Policies and
2151 procedures implemented pursuant to this section shall be valid until the
2152 time final regulations are adopted.

2153 Sec. 54. Subsection (b) of section 19a-639c of the general statutes is
2154 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2155 *2026*):

2156 (b) The Commissioner of [Health Strategy] Public Health may
2157 implement policies and procedures necessary to administer the
2158 provisions of this section while in the process of adopting such policies
2159 and procedures as regulation, provided the commissioner holds a
2160 public hearing prior to implementing the policies and procedures and
2161 posts notice of intent to adopt regulations on the [office's] Department
2162 of Public Health's Internet web site and the eRegulations System not
2163 later than twenty days after the date of implementation. Policies and
2164 procedures implemented pursuant to this section shall be valid until the
2165 time final regulations are adopted.

2166 Sec. 55. Subsection (d) of section 19a-639e of the general statutes is
2167 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2168 *2026*):

2169 (d) The Commissioner of [Health Strategy] Public Health may
2170 implement policies and procedures necessary to administer the
2171 provisions of this section while in the process of adopting such policies
2172 and procedures as regulation, provided the commissioner holds a
2173 public hearing prior to implementing the policies and procedures and
2174 posts notice of intent to adopt regulations on the [office's] Department
2175 of Public Health's Internet web site and the eRegulations System not
2176 later than twenty days after the date of implementation. Policies and
2177 procedures implemented pursuant to this section shall be valid until the
2178 time final regulations are adopted.

2179 Sec. 56. Subsection (a) of section 19a-639f of the general statutes is
2180 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2181 *2026*):

2182 (a) The Health Systems Planning Unit of the [Office of Health
2183 Strategy] Department of Public Health shall conduct a cost and market
2184 impact review in each case where (1) an application for a certificate of
2185 need filed pursuant to section 19a-638, as amended by this act, involves
2186 the transfer of ownership of a hospital, as defined in section 19a-639, as
2187 amended by this act, and (2) the purchaser is a hospital, as defined in

2188 section 19a-490, whether located within or outside the state, that had net
2189 patient revenue for fiscal year 2013 in an amount greater than one billion
2190 five hundred million dollars, or a hospital system, as defined in section
2191 19a-486i, as amended by this act, whether located within or outside the
2192 state, that had net patient revenue for fiscal year 2013 in an amount
2193 greater than one billion five hundred million dollars or any person that
2194 is organized or operated for profit.

2195 Sec. 57. Subsection (l) 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 (l) The Commissioner of [Health Strategy] Public Health shall adopt
2199 regulations, in accordance with the provisions of chapter 54, concerning
2200 cost and market impact reviews and to administer the provisions of this
2201 section. Such regulations shall include definitions of the following
2202 terms: "Dispersed service area", "health status adjusted total medical
2203 expense", "major service category", "relative prices", "total health care
2204 spending" and "health care services". The commissioner may implement
2205 policies and procedures necessary to administer the provisions of this
2206 section while in the process of adopting such policies and procedures in
2207 regulation form, provided the commissioner publishes notice of
2208 intention to adopt the regulations on the [office's] Department of Public
2209 Health's Internet web site and the eRegulations System not later than
2210 twenty days after implementing such policies and procedures. Policies
2211 and procedures implemented pursuant to this subsection shall be valid
2212 until the time such regulations are effective.

2213 Sec. 58. Subsections (a) and (b) of section 19a-639g of the 2026
2214 supplement to the general statutes are repealed and the following is
2215 substituted in lieu thereof (*Effective July 1, 2026*):

2216 (a) Notwithstanding any provision of sections 19a-630 to 19a-639f,
2217 inclusive, as amended by this act, any transacting parties involved in
2218 any transfer of ownership, as defined in section 19a-630, as amended by
2219 this act, of a hospital requiring a certificate of need pursuant to section

2220 19a-638, as amended by this act, in which (1) the hospital subject to the
2221 transfer of ownership has filed for bankruptcy protection in any court
2222 of competent jurisdiction, and (2) a potential purchaser for such hospital
2223 has been or is required to be approved by a bankruptcy court, may, at
2224 the discretion of the Commissioner of [Health Strategy] Public Health,
2225 apply for an emergency certificate of need through the emergency
2226 certificate of need application process described in this section. An
2227 emergency certificate of need issued by the Health Systems Planning
2228 Unit of the [Office of Health Strategy] Department of Public Health
2229 pursuant to the provisions of this section and any conditions imposed
2230 on such issuance shall apply to the applicant applying for the
2231 emergency certificate of need, the hospital subject to the transfer of
2232 ownership and any subsidiary or group practice that would otherwise
2233 require a certificate of need pursuant to the provisions of section 19a-
2234 638, as amended by this act, and that is also subject to the transfer of
2235 ownership as part of the bankruptcy proceeding. The availability of the
2236 emergency certificate of need application process described in this
2237 section shall not affect any existing certificate of need issued pursuant
2238 to the provisions of sections 19a-630 to 19a-639f, inclusive, as amended
2239 by this act.

2240 (b) (1) The unit shall develop an emergency certificate of need
2241 application, which shall identify any data required to be submitted with
2242 such application that the unit deems necessary to analyze the effects of
2243 a hospital's transfer of ownership on health care costs, quality and access
2244 in the affected market. If a potential purchaser of a hospital, described
2245 in subsection (a) of this section, is a for-profit entity, the unit's
2246 emergency certificate of need application may require additional
2247 information or data intended to ensure that the ongoing operation of the
2248 hospital after the transfer of ownership will be maintained in the public
2249 interest. The commissioner shall post any emergency certificate of need
2250 application developed pursuant to the provisions of this subdivision on
2251 the [Office of Health Strategy's] Department of Public Health's Internet
2252 web site and may modify any data required to be submitted with an
2253 emergency certificate of need application, provided the commissioner

2254 posts any such modification to the [office's] department's Internet web
2255 site not later than fifteen days before such a modification becomes
2256 effective.

2257 (2) An applicant seeking an emergency certificate of need shall
2258 submit an emergency certificate of need application to the unit in a form
2259 and manner prescribed by the commissioner.

2260 (3) An emergency certificate of need application shall be deemed
2261 complete on the date the unit determines that an applicant has
2262 submitted a complete application, including data required by the unit
2263 pursuant to subdivision (1) of this subsection. The unit shall determine
2264 whether an application is complete not later than three business days
2265 after an applicant submits an application. If, after making such a
2266 determination, the unit deems an application incomplete, the unit shall,
2267 not more than three business days after deeming such application
2268 incomplete, notify the applicant that such application is incomplete and
2269 identify any application or data elements that were not adequately
2270 addressed by the applicant. The unit shall not review such an
2271 application until the applicant submits any such application or data
2272 elements to the unit.

2273 (4) The unit may hold a public hearing on an emergency certificate of
2274 need application, provided (A) the unit holds such public hearing not
2275 later than thirty days after such application is deemed complete, and (B)
2276 the unit notifies the applicant of such public hearing not less than five
2277 days before the date of the public hearing. Any such public hearing or
2278 any other proceeding related to the emergency certificate of need
2279 application process described in this section shall not be considered a
2280 contested case pursuant to the provisions of chapter 54. Members of the
2281 public may submit public comments at any time during the emergency
2282 certificate of need application process and may request the unit to
2283 exercise its discretion to hold a public hearing pursuant to the
2284 provisions of this subdivision.

2285 (5) When evaluating an emergency certificate of need application, the

2286 unit may consult any person and consider any relevant information,
2287 provided, unless prohibited by federal or state law, the unit includes
2288 any opinion or information gathered from consulting any such person
2289 and any such relevant information considered in the record relating to
2290 the emergency certificate of need application and cites any such opinion
2291 or information and any such relevant information considered in its final
2292 decision on the emergency certificate of need application. The unit may
2293 contract with one or more third-party consultants, at the expense of the
2294 applicant, to analyze (A) the anticipated effect of the hospital's transfer
2295 of ownership on access, cost and quality of health care in the affected
2296 community, and (B) any other issue arising from the application review
2297 process. The aggregate cost of any such third-party consultations shall
2298 not exceed two hundred thousand dollars. Any reports or analyses
2299 generated by any such third-party consultant that the unit considers in
2300 issuing its final decision on an emergency certificate of need application
2301 shall, unless otherwise prohibited by federal or state law, be included in
2302 the record relating to the emergency certificate of need application. The
2303 provisions of chapter 57 and sections 4-212 to 4-219, inclusive, and 4e-
2304 19 shall not apply to any retainer agreement executed pursuant to this
2305 subsection.

2306 Sec. 59. Section 19a-643 of the general statutes is repealed and the
2307 following is substituted in lieu thereof (*Effective July 1, 2026*):

2308 (a) The [Office of Health Strategy] Department of Public Health shall
2309 adopt regulations, in accordance with the provisions of chapter 54, to
2310 carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as
2311 amended by this act, and sections 19a-644, as amended by this act, and
2312 19a-645, as amended by this act, concerning the submission of data by
2313 health care facilities and institutions, including data on dealings
2314 between health care facilities and institutions and their affiliates, and,
2315 with regard to requests or proposals pursuant to sections 19a-638 to 19a-
2316 639e, inclusive, as amended by this act, by state health care facilities and
2317 institutions, the ongoing inspections by the unit of operating budgets
2318 that have been approved by the health care facilities and institutions,
2319 standard reporting forms and standard accounting procedures to be

2320 utilized by health care facilities and institutions and the transferability
2321 of line items in the approved operating budgets of the health care
2322 facilities and institutions, except that any health care facility or
2323 institution may transfer any amounts among items in its operating
2324 budget. All such transfers shall be reported to the unit not later than
2325 thirty days after the transfer or transfers.

2326 (b) The [Office of Health Strategy] Department of Public Health may
2327 adopt such regulations, in accordance with the provisions of chapter 54,
2328 as are necessary to implement this chapter.

2329 Sec. 60. Subsections (a) and (b) of section 19a-644 of the general
2330 statutes are repealed and the following is substituted in lieu thereof
2331 (*Effective July 1, 2026*):

2332 (a) On or before February twenty-eighth annually, for the fiscal year
2333 ending on September thirtieth of the immediately preceding year, each
2334 short-term acute care general or children's hospital shall report to the
2335 unit with respect to its operations in such fiscal year, in such form as the
2336 unit may by regulation require. Such report shall include: (1) Salaries
2337 and fringe benefits for the ten highest paid hospital and health system
2338 employees; (2) the name of each joint venture, partnership, subsidiary
2339 and corporation related to the hospital; (3) the salaries paid to hospital
2340 and health system employees by each such joint venture, partnership,
2341 subsidiary and related corporation and by the hospital to the employees
2342 of related corporations; and (4) information and data prescribed by the
2343 [Office of Health Strategy] Department of Public Health concerning
2344 charges for trauma activation fees. For purposes of this subsection,
2345 "health system" has the same meaning as provided in section 33-182aa.

2346 (b) The [Office of Health Strategy] Commissioner of Public Health
2347 shall adopt regulations in accordance with chapter 54 to provide for the
2348 collection of data and information in addition to the annual report
2349 required in subsection (a) of this section. Such regulations shall provide
2350 for the submission of information about the operations of the following
2351 entities: Persons or parent corporations that own or control the health

2352 care facility, institution or provider; corporations, including limited
2353 liability corporations, in which the health care facility, institution,
2354 provider, its parent, any type of affiliate or any combination thereof,
2355 owns more than an aggregate of fifty per cent of the stock or, in the case
2356 of nonstock corporations, is the sole member; and any partnerships in
2357 which the person, health care facility, institution, provider, its parent or
2358 an affiliate or any combination thereof, or any combination of health
2359 care providers or related persons, owns a greater than fifty per cent
2360 interest. For purposes of this subsection, "affiliate" means any person
2361 that directly or indirectly through one or more intermediaries, controls
2362 or is controlled by or is under common control with any health care
2363 facility, institution, provider or person that is regulated in any way
2364 under this chapter. A person is deemed controlled by another person if
2365 the other person, or one of that other person's affiliates, officers, agents
2366 or management employees, acts as a general partner or manager of the
2367 person in question.

2368 Sec. 61. Section 19a-645 of the general statutes is repealed and the
2369 following is substituted in lieu thereof (*Effective July 1, 2026*):

2370 A nonprofit hospital, licensed by the Department of Public Health,
2371 [which] that provides lodging, care and treatment to members of the
2372 public, and [which] that wishes to enlarge its public facilities by adding
2373 contiguous land and buildings thereon, if any, the title to which it
2374 cannot otherwise acquire, may prefer a complaint for the right to take
2375 such land to the superior court for the judicial district in which such land
2376 is located, provided such hospital shall have received the approval of
2377 the Health Systems Planning Unit of the [Office of Health Strategy]
2378 Department of Public Health in accordance with the provisions of this
2379 chapter. Said court shall appoint a committee of three disinterested
2380 persons, who, after examining the premises and hearing the parties,
2381 shall report to the court as to the necessity and propriety of such
2382 enlargement and as to the quantity, boundaries and value of the land
2383 and buildings thereon, if any, [which] that they deem proper to be taken
2384 for such purpose and the damages resulting from such taking. If such
2385 committee reports that such enlargement is necessary and proper and

2386 the court accepts such report, the decision of said court thereon shall
2387 have the effect of a judgment and execution may be issued thereon
2388 accordingly, in favor of the person to whom damages may be assessed,
2389 for the amount thereof; and, on payment thereof, the title to the land and
2390 buildings thereon, if any, for such purpose shall be vested in the
2391 complainant, but such land and buildings thereon, if any, shall not be
2392 taken until such damages are paid to such owner or deposited with said
2393 court, for such owner's use, [within] not later than thirty days after such
2394 report is accepted. If such application is denied, the owner of the land
2395 shall recover costs of the applicant, to be taxed by said court, which may
2396 issue execution therefor. Land so taken shall be held by such hospital
2397 and used only for the public purpose stated in its complaint to the
2398 superior court. No land dedicated or otherwise reserved as open space
2399 or park land or for other recreational purposes and no land belonging
2400 to any town, city or borough shall be taken under the provisions of this
2401 section.

2402 Sec. 62. Subdivision (1) of subsection (a) of section 19a-646 of the
2403 general statutes is repealed and the following is substituted in lieu
2404 thereof (*Effective July 1, 2026*):

2405 (1) "Unit" means the Health Systems Planning Unit within the [Office
2406 of Health Strategy] Department of Public Health, established under
2407 section 19a-612, as amended by this act;

2408 Sec. 63. Subsections (a) to (d), inclusive, of section 19a-653 of the
2409 general statutes are repealed and the following is substituted in lieu
2410 thereof (*Effective July 1, 2026*):

2411 (a) Any person or health care facility or institution that is required to
2412 file a certificate of need for any of the activities described in section 19a-
2413 638, and any person or health care facility or institution that is required
2414 to file data or information under any public or special act or under this
2415 chapter or sections 19a-486 to 19a-486h, inclusive, as amended by this
2416 act, or any regulation adopted or order issued under this chapter or said
2417 sections, and negligently fails to seek certificate of need approval for any

2418 of the activities described in section 19a-638, or to so file within
2419 prescribed time periods, and any person or health care facility or
2420 institution that has agreed to fully resolve a certificate of need
2421 application through settlement and negligently fails to comply with any
2422 term or condition enumerated in the settlement agreement, shall be
2423 subject to a civil penalty of up to one thousand dollars a day for each
2424 day such person or health care facility or institution conducts any of the
2425 described activities without certificate of need approval as required by
2426 section 19a-638, for each day such information is missing, incomplete or
2427 inaccurate or for each day any condition of a settlement agreement is
2428 not met. Any civil penalty authorized by this section shall be imposed
2429 by the [Office of Health Strategy] Department of Public Health in
2430 accordance with subsections (b) to (e), inclusive, of this section.

2431 (b) If the [Office of Health Strategy] Department of Public Health has
2432 reason to believe that a violation has occurred for which a civil penalty
2433 is authorized by subsection (a) of this section or subsection (e) of section
2434 19a-632, [it] the department shall notify the person or health care facility
2435 or institution by first-class mail or personal service. The notice shall
2436 include: (1) A reference to the sections of the statute, regulation or
2437 settlement agreement involved; (2) a short and plain statement of the
2438 matters asserted or charged; (3) a statement of the amount of the civil
2439 penalty or penalties to be imposed; (4) the initial date of the imposition
2440 of the penalty; and (5) a statement of the party's right to a hearing.

2441 (c) The person or health care facility or institution to whom the notice
2442 is addressed shall have fifteen business days [from] after the date of
2443 mailing of the notice to make written application to the unit to (1)
2444 request a hearing to contest the imposition of the penalty, (2) request an
2445 extension of time to file the required data, or (3) comply with
2446 enumerated conditions of an agreed settlement. A failure to make a
2447 timely request for a hearing or an extension of time to file the required
2448 data or a denial of a request for an extension of time shall result in a final
2449 order for the imposition of the penalty. All hearings under this section
2450 shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The
2451 [Office of Health Strategy] Department of Public Health may grant an

2452 extension of time for filing the required data or mitigate or waive the
2453 penalty upon such terms and conditions as, in its discretion, it deems
2454 proper or necessary upon consideration of any extenuating factors or
2455 circumstances.

2456 (d) A final order of the [Office of Health Strategy] Department of
2457 Public Health assessing a civil penalty shall be subject to appeal as set
2458 forth in section 4-183 after a hearing before the unit pursuant to
2459 subsection (c) of this section, except that any such appeal shall be taken
2460 to the superior court for the judicial district of New Britain. Such final
2461 order shall not be subject to appeal under any other provision of the
2462 general statutes. No challenge to any such final order shall be allowed
2463 as to any issue [which] that could have been raised by an appeal of an
2464 earlier order, denial or other final decision by the [office] department.

2465 Sec. 64. Subsections (b) to (g), inclusive, of section 19a-654 of the
2466 general statutes are repealed and the following is substituted in lieu
2467 thereof (*Effective July 1, 2026*):

2468 (b) Each short-term acute care general or children's hospital shall
2469 submit patient-identifiable inpatient discharge data and emergency
2470 department data to the [Health Systems Planning Unit of the Office of
2471 Health Strategy to fulfill the responsibilities of the unit] Department of
2472 Public Health (1) to assist the department in fulfilling its responsibilities
2473 under chapter 368z, and (2) for the purposes set forth in section 19a-25
2474 and the regulations promulgated thereunder. Such data shall include
2475 data taken from patient medical record abstracts and bills. The [unit]
2476 department shall specify the timing and format of such submissions.
2477 Data submitted pursuant to this section may be submitted through a
2478 contractual arrangement with an intermediary and such contractual
2479 arrangement shall [(1)] (A) comply with the provisions of the Health
2480 Insurance Portability and Accountability Act of 1996 P.L. 104-191
2481 (HIPAA), and [(2)] (B) ensure that such submission of data is timely and
2482 accurate. The [unit] department may conduct an audit of the data
2483 submitted through such intermediary in order to verify its accuracy.

2484 (c) An outpatient surgical facility, as defined in section 19a-493b, as
2485 amended by this act, a short-term acute care general or children's
2486 hospital, or a facility that provides outpatient surgical services as part of
2487 the outpatient surgery department of a short-term acute care hospital
2488 shall submit to the [unit] department the data identified in subsection
2489 (c) of section 19a-634. The [unit] department shall convene a working
2490 group consisting of representatives of outpatient surgical facilities,
2491 hospitals and other individuals necessary to develop recommendations
2492 that address current obstacles to, and proposed requirements for,
2493 patient-identifiable data reporting in the outpatient setting. [On or
2494 before February 1, 2012, the] The working group shall report, in
2495 accordance with the provisions of section 11-4a, on its findings and
2496 recommendations to the joint standing committees of the General
2497 Assembly having cognizance of matters relating to public health and
2498 insurance and real estate [. Additional reporting of] regarding such
2499 outpatient data as the [unit] department deems necessary. [shall begin
2500 not later than July 1, 2015. On or before July 1, 2018, and annually
2501 thereafter,] Not later than July first annually, the Connecticut
2502 Association of Ambulatory Surgery Centers shall provide a progress
2503 report to the [Office of Health Strategy] Department of Public Health,
2504 until such time as all ambulatory surgery centers are in full compliance
2505 with the implementation of systems that allow for the reporting of
2506 outpatient data as required by the [commissioner] Commissioner of
2507 Public Health. Until such additional reporting requirements take effect
2508 on July 1, 2015, the department may work with the Connecticut
2509 Association of Ambulatory Surgery Centers and the Connecticut
2510 Hospital Association on specific data reporting initiatives provided that
2511 no penalties shall be assessed under this chapter or any other provision
2512 of law with respect to the failure to submit such data.

2513 (d) Except as provided in this subsection and section 19a-25, and the
2514 regulations promulgated thereunder, patient-identifiable data received
2515 by the [unit] department shall be kept confidential by the department
2516 and shall not be considered public records or files subject to disclosure
2517 under the Freedom of Information Act, as defined in section 1-200. The

2518 [unit] department may release de-identified patient data or aggregate
2519 patient data to the public in a manner consistent with the provisions of
2520 45 CFR 164.514. [Any de-identified patient data released by the unit
2521 shall exclude provider, physician and payer organization names or
2522 codes and shall be kept confidential by the recipient. The unit] The
2523 department may release patient-identifiable data (1) for [medical and
2524 scientific research as provided for in section 19a-25-3 of the regulations
2525 of Connecticut state agencies, and (2) to (A) a state agency for the
2526 purpose of improving health care service delivery, (B)] the purposes set
2527 forth in and pursuant to section 19a-25 and the regulations promulgated
2528 thereunder, and (2) to (A) a federal agency or the office of the Attorney
2529 General for the purpose of investigating hospital mergers and
2530 acquisitions, [(C)] (B) another state's health data collection agency with
2531 which the [unit] department has entered into a reciprocal data-sharing
2532 agreement for the purpose of certificate of need review or evaluation of
2533 health care services, upon receipt of a request from such agency,
2534 provided, prior to the release of such patient-identifiable data, such
2535 agency enters into a written agreement with the [unit] department
2536 pursuant to which such agency agrees to protect the confidentiality of
2537 such patient-identifiable data and not to use such patient-identifiable
2538 data as a basis for any decision concerning a patient, or [(D)] (C) a
2539 consultant or independent professional contracted by the [Office of
2540 Health Strategy] Department of Public Health pursuant to section 19a-
2541 614, as amended by this act, to carry out the functions of the [unit]
2542 department, including collecting, managing or organizing such patient-
2543 identifiable data. [No] Except as provided under section 19a-25 and the
2544 regulations promulgated thereunder, no individual or entity receiving
2545 patient-identifiable data may release such data in any manner that may
2546 result in an individual patient, physician, provider or payer being
2547 identified. The [unit] department shall impose a reasonable, cost-based
2548 fee for any patient data provided to a nongovernmental entity.

2549 (e) Not later than October 1, 2018, the [Health Systems Planning Unit]
2550 department shall enter into a memorandum of understanding with the
2551 Comptroller that shall permit the Comptroller to access the data set forth

2552 in subsections (b) and (c) of this section, provided the Comptroller
2553 agrees, in writing, to keep individual patient and provider data
2554 identified by proper name or personal identification code and submitted
2555 pursuant to this section confidential.

2556 (f) The Commissioner of [Health Strategy] Public Health shall adopt
2557 regulations, in accordance with the provisions of chapter 54, to carry out
2558 the provisions of this section.

2559 (g) The duties assigned to the [Office of Health Strategy] Department
2560 of Public Health under the provisions of this section shall be
2561 implemented within available appropriations.

2562 Sec. 65. Subdivision (1) of section 19a-659 of the general statutes is
2563 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2564 *2026*):

2565 (1) "Unit" means the Health Systems Planning Unit within the [Office
2566 of Health Strategy] Department of Public Health, established under
2567 section 19a-612, as amended by this act;

2568 Sec. 66. Section 19a-673a of the general statutes is repealed and the
2569 following is substituted in lieu thereof (*Effective July 1, 2026*):

2570 The Commissioner of [Health Strategy] Public Health shall adopt
2571 regulations, in accordance with chapter 54, to establish uniform debt
2572 collection standards for hospitals.

2573 Sec. 67. Subsection (c) of section 19a-681 of the general statutes is
2574 repealed and the following is substituted in lieu thereof (*Effective July 1,*
2575 *2026*):

2576 (c) Upon the request of the [Office of Health Strategy, established
2577 under section 19a-754a] Department of Public Health, or a patient, a
2578 hospital shall provide to the [office] department or the patient a detailed
2579 patient bill. If the billing detail by line item on a detailed patient bill does
2580 not agree with the detailed schedule of charges on file with the unit for
2581 the date of service specified on the bill, the hospital shall be subject to a

2582 civil penalty of five hundred dollars per occurrence payable to the state
2583 not later than fourteen days after the date of notification. The penalty
2584 shall be imposed in accordance with section 19a-653, as amended by this
2585 act. The unit may issue an order requiring such hospital, not later than
2586 fourteen days after the date of notification of an overcharge to a patient,
2587 to adjust the bill to be consistent with the detailed schedule of charges
2588 on file with the unit for the date of service specified on the detailed
2589 patient bill.

2590 Sec. 68. Subsections (b) to (f), inclusive, of section 19a-754b of the
2591 general statutes are repealed and the following is substituted in lieu
2592 thereof (*Effective July 1, 2026*):

2593 (b) [Beginning on] On and after January 1, 2020, each sponsor shall
2594 submit to the [Office of Health Strategy, established in section 19a-754a]
2595 Department of Public Health, in a form and manner specified by the
2596 [office] department, written notice informing the [office] department
2597 that such sponsor has filed with the federal Food and Drug
2598 Administration:

2599 (1) A new drug application or biologics license application for a
2600 pipeline drug, not later than sixty days after such sponsor receives an
2601 action date from the federal Food and Drug Administration regarding
2602 such application; or

2603 (2) A biologics license application for a biosimilar drug, not later than
2604 sixty days after such sponsor's receipt of an action date from the federal
2605 Food and Drug Administration regarding such application.

2606 (c) (1) Beginning on January 1, 2020, the Commissioner of [Health
2607 Strategy] Public Health may conduct a study, with the assistance of the
2608 Comptroller and not more frequently than once annually, of each
2609 pharmaceutical manufacturer of a pipeline drug that, in the opinion of
2610 the commissioner in consultation with the Comptroller and the
2611 Commissioner of Social Services, may have a significant impact on state
2612 expenditures for outpatient prescription drugs. The [office] Department
2613 of Public Health may work with the Comptroller to utilize existing state

2614 resources and contracts, or contract with a third party, including, but
2615 not limited to, an accounting firm, to conduct such study.

2616 (2) Each pharmaceutical manufacturer that is the subject of a study
2617 conducted pursuant to subdivision (1) of this subsection shall submit to
2618 the [office] Department of Public Health, or any contractor engaged by
2619 the [office] department or the Comptroller to perform such study, the
2620 following information for the pipeline drug that is the subject of such
2621 study:

2622 (A) The primary disease, condition or therapeutic area studied in
2623 connection with such drug, and whether such drug is therapeutically
2624 indicated for such disease, condition or therapeutic area;

2625 (B) Each route of administration studied for such drug;

2626 (C) Clinical trial comparators, if applicable, for such drug;

2627 (D) The estimated year of market entry for such drug;

2628 (E) Whether the federal Food and Drug Administration has
2629 designated such drug as an orphan drug, a fast track product or a
2630 breakthrough therapy; and

2631 (F) Whether the federal Food and Drug Administration has
2632 designated such drug for accelerated approval and, if such drug
2633 contains a new molecular entity, for priority review.

2634 (d) (1) [On or before] Not later than March [1, 2020, and] first
2635 annually, [thereafter,] the Commissioner of [Health Strategy] Public
2636 Health, in consultation with the Comptroller [,] and the Commissioner
2637 of Social Services, [and Commissioner of Public Health,] shall prepare a
2638 list of not more than ten outpatient prescription drugs that the
2639 Commissioner of [Health Strategy] Public Health, in the commissioner's
2640 discretion, determines are (A) provided at substantial cost to the state,
2641 considering the net cost of such drugs, or (B) critical to public health.
2642 The list shall include outpatient prescription drugs from different
2643 therapeutic classes of outpatient prescription drugs and not less than

2644 one generic outpatient prescription drug.

2645 (2) Prior to publishing the annual list pursuant to subdivision (1) of
2646 this subsection, the [commissioner] Commissioner of Public Health
2647 shall prepare a preliminary list that includes outpatient prescription
2648 drugs that the commissioner plans to include on such annual list. The
2649 commissioner shall make such preliminary list available for public
2650 comment for not less than thirty days. During the public comment
2651 period, any manufacturer of an outpatient prescription drug included
2652 on the preliminary list may produce documentation, as permitted by
2653 federal law, to the commissioner to establish that the wholesale
2654 acquisition cost of such drug, less all rebates paid to the state for such
2655 outpatient prescription drug during the immediately preceding
2656 calendar year, does not exceed the limits established in subdivision (3)
2657 of this subsection. If such documentation establishes, to the satisfaction
2658 of the commissioner, that the wholesale acquisition cost of the drug, less
2659 all rebates paid to the state for such drug during the immediately
2660 preceding calendar year, does not exceed the limits established in
2661 subdivision (3) of this subsection, the commissioner shall, not later than
2662 fifteen days after the closing of the public comment period, remove such
2663 drug from the preliminary list before publishing the annual list
2664 pursuant to subdivision (1) of this subsection.

2665 (3) The [commissioner] Commissioner of Public Health shall not list
2666 any outpatient prescription drugs under subdivision (1) or (2) of this
2667 subsection unless the wholesale acquisition cost of such outpatient
2668 prescription drug (A) increased by not less than sixteen per cent
2669 cumulatively during the immediately preceding two calendar years,
2670 and (B) was not less than forty dollars for a course of treatment.

2671 (4) (A) The pharmaceutical manufacturer of an outpatient
2672 prescription drug included on a list prepared by the [commissioner]
2673 Commissioner of Public Health pursuant to subdivision (1) of this
2674 subsection shall provide to the [office] Department of Public Health, in
2675 a form and manner specified by the commissioner, (i) a written,
2676 narrative description, suitable for public release, of all factors that

2677 caused the increase in the wholesale acquisition cost of the listed
2678 outpatient prescription drug, and (ii) aggregate, company-level research
2679 and development costs and such other capital expenditures that the
2680 commissioner, in the commissioner's discretion, deems relevant for the
2681 most recent year for which final audited data are available.

2682 (B) The quality and types of information and data that a
2683 pharmaceutical manufacturer submits to the [office] department under
2684 this subdivision shall be consistent with the quality and types of
2685 information and data that the pharmaceutical manufacturer includes in
2686 (i) such pharmaceutical manufacturer's annual consolidated report on
2687 Securities and Exchange Commission Form 10-K, or (ii) any other public
2688 disclosure.

2689 (5) The [office] Department of Public Health shall establish a
2690 standardized form for reporting information and data pursuant to this
2691 subsection after consulting with pharmaceutical manufacturers. The
2692 form shall be designed to minimize the administrative burden and cost
2693 of reporting on the [office] department and pharmaceutical
2694 manufacturers.

2695 (e) The [office] Department of Public Health may impose a penalty of
2696 not more than seven thousand five hundred dollars on a pharmaceutical
2697 manufacturer or sponsor for each violation of this section by the
2698 pharmaceutical manufacturer or sponsor.

2699 (f) The [office] Department of Public Health may adopt regulations,
2700 in accordance with the provisions of chapter 54, to carry out the
2701 purposes of this section.

2702 Sec. 69. Subsections (a) to (c), inclusive, of section 19a-754c of the
2703 general statutes are repealed and the following is substituted in lieu
2704 thereof (*Effective July 1, 2026*):

2705 (a) For the purposes of this section:

2706 (1) "Affordable Care Act" has the same meaning as provided in

2707 section 38a-1080;

2708 (2) "Covered Connecticut program" means the program established
2709 under subsection (b) of this section;

2710 (3) "Exchange" has the same meaning as provided in section 38a-1080;

2711 (4) "Health carrier" has the same meaning as provided in section 38a-
2712 1080;

2713 (5) "Individual market" has the same meaning as provided in 42 USC
2714 18024(a), as amended from time to time; and

2715 [(6) "Office of Health Strategy" means the Office of Health Strategy
2716 established under section 19a-754a; and]

2717 [(7) (6) "Silver level" has the same meaning as provided in 42 USC
2718 18022(d), as amended from time to time.

2719 (b) There is established within the Department of Social Services the
2720 Covered Connecticut program for the purpose of reducing the state's
2721 uninsured rate. The Commissioner of Social Services shall administer
2722 said program in consultation with the [Office of Health Strategy,]
2723 Insurance Commissioner and exchange, and, as part of said program,
2724 the Department of Social Services shall:

2725 (1) Provide premium and cost-sharing subsidies that are sufficient to
2726 ensure fully subsidized coverage:

2727 (A) On and after July 1, 2021, for parents and needy caretaker
2728 relatives, and their tax dependents not older than twenty-six years of
2729 age, who (i) are eligible for premium and cost-sharing subsidies for a
2730 qualified health plan, (ii) are ineligible for Medicaid because their
2731 income exceeds the Medicaid income limits under chapter 319v, (iii)
2732 have household income up to one hundred seventy-five per cent of the
2733 federal poverty level, (iv) are receiving coverage under a qualified
2734 health plan offered through the exchange in the individual market at a
2735 silver level of coverage, and (v) are utilizing the full amount of

2736 applicable premium subsidies for such plan;

2737 (B) On and after July 1, 2021, for the following additional family
2738 members of parents and caretaker relatives receiving coverage under
2739 such qualified health plan, provided the requirements of subparagraph
2740 (A) of subdivision (1) of this subsection are met: (i) A child over twenty-
2741 six years of age who is permanently and totally disabled, as defined by
2742 the Internal Revenue Service pursuant to 26 USC 152, or (ii) a child who
2743 is over the age of twenty-six and is incapable of self-sustaining
2744 employment by reason of mental or physical handicap and is chiefly
2745 dependent upon the parent or caretaker relative for support and
2746 maintenance, as described in sections 38a-489 and 38a-512a, or (iii) a
2747 child or stepchild receiving coverage under such qualified health plan
2748 as described in sections 38a-497 and 38a-512b;

2749 (C) On and after July 1, 2022, for all parents, needy caretaker relatives
2750 and low-income adults who (i) are at least nineteen but not more than
2751 sixty-four years of age, (ii) are eligible for premium and cost-sharing
2752 subsidies for a qualified health plan, (iii) are ineligible for Medicaid
2753 because their income exceeds the Medicaid income limits under chapter
2754 319v, (iv) have household income up to one hundred seventy-five per
2755 cent of the federal poverty level, (v) are receiving coverage under a
2756 qualified health plan offered through the exchange in the individual
2757 market at a silver level of coverage, and (vi) are utilizing the full amount
2758 of applicable premium subsidies for such plan; and

2759 (D) On and after July 1, 2022, for the following additional family
2760 members of parents, caretaker relatives, and adults receiving coverage
2761 under such qualified health plan, provided the requirements of
2762 subparagraph (C) of subdivision (1) of this subsection are met: (i) A
2763 child over twenty-six years of age who is permanently and totally
2764 disabled, as defined by the Internal Revenue Service pursuant to 26 USC
2765 152, or (ii) a child who is over the age of twenty-six and is incapable of
2766 self-sustaining employment by reason of mental or physical handicap
2767 and is chiefly dependent upon the parent or caretaker relative for
2768 support and maintenance, as described in sections 38a-489 and 38a-512a,

2769 or (iii) a child or stepchild, as described in sections 38a-497 and 38a-512b.

2770 (2) Not earlier than July 1, 2022, provide dental and nonemergency
2771 medical transportation services, as provided under chapter 319v, to all
2772 eligible individuals described in subdivision (1) of this subsection;

2773 (3) Establish procedures to, on a quarterly basis, pay in
2774 reimbursement to each health carrier offering the qualified health plan
2775 described in subparagraph (A) or (B) of subdivision (1) of this
2776 subsection, as applicable, the premium and cost-sharing subsidies
2777 required under subdivision (1) of this subsection to ensure fully
2778 subsidized coverage; and

2779 (4) Consult with the [Office of Health Strategy and] Insurance
2780 Commissioner for the purposes set forth in section 17b-312, as amended
2781 by this act.

2782 (c) (1) The [Office of Health Strategy] Department of Social Services
2783 may, subject to the approval required under subdivision (3) of this
2784 subsection, seek a waiver pursuant to Section 1332 of the Affordable
2785 Care Act, as amended from time to time, to advance the purpose of the
2786 Covered Connecticut program. The [Office of Health Strategy]
2787 department shall implement such waiver if the federal government
2788 issues such waiver.

2789 (2) The [Office of Health Strategy] Commissioner of Social Services
2790 shall submit a report, in accordance with section 11-4a, to the joint
2791 standing committees of the General Assembly having cognizance of
2792 matters relating to appropriations, human services and insurance
2793 containing any proposed waiver described in subdivision (1) of this
2794 subsection before seeking such waiver from the federal government.

2795 (3) Not later than thirty days after the [Office of Health Strategy]
2796 Commissioner of Social Services submits a report under subdivision (2)
2797 of this subsection, the joint standing committees of the General
2798 Assembly having cognizance of matters relating to appropriations,
2799 human services and insurance shall convene a joint public hearing on

2800 the proposed waiver contained in the report submitted pursuant to
2801 subdivision (2) of this subsection, separately vote to approve or reject
2802 such proposed waiver and advise the [Office of Health Strategy]
2803 commissioner of their approval or rejection of such proposed waiver. If
2804 any committee takes no action on such proposed waiver within the
2805 thirty-day period, the proposed waiver shall be deemed rejected.

2806 Sec. 70. Section 19a-754d of the general statutes is repealed and the
2807 following is substituted in lieu thereof (*Effective July 1, 2026*):

2808 (a) [On and after January 1, 2022, any] Any state agency, board or
2809 commission that directly, or by contract with another entity, collects
2810 demographic data concerning the ancestry or ethnic origin, ethnicity,
2811 race or primary language of residents of the state in the context of health
2812 care or for the provision or receipt of health care services or for any
2813 public health purpose shall:

2814 (1) Collect such data in a manner that allows for aggregation and
2815 disaggregation of data;

2816 (2) Expand race and ethnicity categories to include subgroup
2817 identities as specified by the [Community and Clinical Integration
2818 Program of the Office of Health Strategy] Office of Policy and
2819 Management and follow the hierarchical mapping to align with United
2820 States Office of Management and Budget standards;

2821 (3) Provide the option to individuals of selecting one or more ethnic
2822 or racial designations and include an "other" designation with the ability
2823 to write in identities not represented by other codes;

2824 (4) Provide the option to individuals to refuse to identify with any
2825 ethnic or racial designations;

2826 (5) Collect primary language data employing language codes set by
2827 the International Organization for Standardization; and

2828 (6) Ensure, in cases where data concerning an individual's ethnic
2829 origin, ethnicity or race is reported to any other state agency, board or

2830 commission, that such data is neither tabulated nor reported without all
2831 of the following information: (A) The number or percentage of
2832 individuals who identify with each ethnic or racial designation as their
2833 sole ethnic or racial designation and not in combination with any other
2834 ethnic or racial designation; (B) the number or percentage of individuals
2835 who identify with each ethnic or racial designation, whether as their sole
2836 ethnic or racial designation or in combination with other ethnic or racial
2837 designations; (C) the number or percentage of individuals who identify
2838 with multiple ethnic or racial designations; and (D) the number or
2839 percentage of individuals who do not identify or refuse to identify with
2840 any ethnic or racial designations.

2841 (b) Each health care provider with an electronic health record system
2842 capable of connecting to and participating in the State-wide Health
2843 Information Exchange as specified in section 17b-59e, as amended by
2844 this act, shall, collect and include in its electronic health record system
2845 self-reported patient demographic data including, but not limited to,
2846 race, ethnicity, primary language, insurance status and disability status
2847 based upon the implementation plan developed [under subsection (c) of
2848 this section] in consultation with consumer advocates, health equity
2849 experts, state agencies and health care providers for the changes
2850 required by this section. Race and ethnicity data shall adhere to
2851 standard categories as determined in subsection (a) of this section.

2852 [(c) Not later than August 1, 2021, the Office of Health Strategy shall
2853 consult with consumer advocates, health equity experts, state agencies
2854 and health care providers, to create an implementation plan for the
2855 changes required by this section.]

2856 [(d)] (c) The Office of [Health Strategy] Policy and Management shall
2857 (1) review (A) demographic changes in race and ethnicity, as
2858 determined by the U.S. Census Bureau, and (B) health data collected by
2859 the state, and (2) reevaluate the standard race and ethnicity categories
2860 from time to time, in consultation with health care providers, consumers
2861 and the joint standing committee of the General Assembly having
2862 cognizance of matters relating to public health.

2863 Sec. 71. Section 19a-754f of the general statutes is repealed and the
2864 following is substituted in lieu thereof (*Effective July 1, 2026*):

2865 For the purposes of this section and sections 19a-754g to 19a-754k,
2866 inclusive, as amended by this act:

2867 (1) "Drug manufacturer" means the manufacturer of a drug that is:
2868 (A) Included in the information and data submitted by a health carrier
2869 pursuant to section 38a-479qqq, (B) studied or listed pursuant to
2870 subsection (c) or (d) of section 19a-754b, as amended by this act, or (C)
2871 in a therapeutic class of drugs that the [Commissioner of Health
2872 Strategy] Secretary of the Office of Policy and Management determines,
2873 through public or private reports, has had a substantial impact on
2874 prescription drug expenditures, net of rebates, as a percentage of total
2875 health care expenditures;

2876 [(2) "Commissioner" means the Commissioner of Health Strategy;]

2877 [(3)] (2) "Health care cost growth benchmark" means the annual
2878 benchmark established pursuant to section 19a-754g, as amended by
2879 this act;

2880 [(4)] (3) "Health care quality benchmark" means an annual
2881 benchmark established pursuant to section 19a-754g, as amended by
2882 this act;

2883 [(5)] (4) "Health care provider" has the same meaning as provided in
2884 subdivision (1) of subsection (a) of section 19a-17b;

2885 [(6)] (5) "Net cost of private health insurance" means the difference
2886 between premiums earned and benefits incurred, and includes insurers'
2887 costs of paying bills, advertising, sales commissions, and other
2888 administrative costs, net additions or subtractions from reserves, rate
2889 credits and dividends, premium taxes and profits or losses;

2890 [(7)] (6) "Office" means the Office of [Health Strategy established
2891 under section 19a-754a] Policy and Management;

2892 [(8)] (7) "Other entity" means a drug manufacturer, pharmacy
2893 benefits manager or other health care provider that is not considered a
2894 provider entity;

2895 [(9)] (8) "Payer" means a payer, including Medicaid, Medicare and
2896 governmental and nongovernment health plans, and includes any
2897 organization acting as payer that is a subsidiary, affiliate or business
2898 owned or controlled by a payer that, during a given calendar year, pays
2899 health care providers for health care services or pharmacies or provider
2900 entities for prescription drugs designated by the [Commissioner of
2901 Health Strategy] Secretary of the Office of Policy and Management;

2902 [(10)] (9) "Performance year" means the most recent calendar year for
2903 which data were submitted for the applicable health care cost growth
2904 benchmark, primary care spending target or health care quality
2905 benchmark;

2906 [(11)] (10) "Pharmacy benefits manager" has the same meaning as
2907 provided in subdivision (10) of section 38a-479ooo;

2908 [(12)] (11) "Primary care spending target" means the annual target
2909 established pursuant to section 19a-754g, as amended by this act;

2910 [(13)] (12) "Provider entity" means an organized group of clinicians
2911 that come together for the purposes of contracting, or are an established
2912 billing unit that, at a minimum, includes primary care providers, and
2913 that collectively, during any given calendar year, has enough attributed
2914 lives to participate in total cost of care contracts, even if they are not
2915 engaged in a total cost of care contract;

2916 [(14)] (13) "Potential gross state product" means a forecasted measure
2917 of the economy that equals the sum of the (A) expected growth in
2918 national labor force productivity, (B) expected growth in the state's labor
2919 force, and (C) expected national inflation, minus the expected state
2920 population growth;

2921 (14) "Secretary" means the Secretary of the Office of Policy and

2922 Management;

2923 (15) "Total health care expenditures" means the sum of all health care
2924 expenditures in this state from public and private sources for a given
2925 calendar year, including: (A) All claims-based spending paid to
2926 providers, net of pharmacy rebates, (B) all patient cost-sharing amounts,
2927 and (C) the net cost of private health insurance; and

2928 (16) "Total medical expense" means the total cost of care for the
2929 patient population of a payer or provider entity for a given calendar
2930 year, where cost is calculated for such year as the sum of (A) all claims-
2931 based spending paid to providers by public and private payers, and net
2932 of pharmacy rebates, (B) all nonclaims payments for such year,
2933 including, but not limited to, incentive payments and care coordination
2934 payments, and (C) all patient cost-sharing amounts expressed on a per
2935 capita basis for the patient population of a payer or provider entity in
2936 this state.

2937 Sec. 72. Section 19a-754g of the 2026 supplement to the general
2938 statutes is repealed and the following is substituted in lieu thereof
2939 (*Effective July 1, 2026*):

2940 [(a) Not later than July 1, 2022, the commissioner shall publish (1) the
2941 health care cost growth benchmarks and annual primary care spending
2942 targets as a percentage of total medical expenses for the calendar years
2943 2021 to 2025, inclusive, and (2) the annual health care quality
2944 benchmarks for the calendar years 2022 to 2025, inclusive, on the office's
2945 Internet web site.]

2946 [(b)] (a) (1) (A) Not later than July 1, 2025, and every five years
2947 thereafter, the [commissioner] secretary shall develop and adopt annual
2948 health care cost growth benchmarks and annual primary care spending
2949 targets for the succeeding five calendar years for provider entities and
2950 payers.

2951 (B) In developing the health care cost growth benchmarks and
2952 primary care spending targets pursuant to this subdivision, the

2953 [commissioner] secretary shall consider (i) any historical and forecasted
2954 changes in median income for individuals in the state and the growth
2955 rate of potential gross state product, (ii) the rate of inflation, and (iii) the
2956 most recent report prepared by the [commissioner] secretary pursuant
2957 to subsection (b) of section 19a-754h, as amended by this act.

2958 (C) (i) The [commissioner] secretary shall hold at least one
2959 informational public hearing prior to adopting the health care cost
2960 growth benchmarks and primary care spending targets for each
2961 succeeding five-year period described in this subdivision. The
2962 [commissioner] secretary may hold informational public hearings
2963 concerning any annual health care cost growth benchmark and primary
2964 care spending target set pursuant to [subsection (a) of this section or]
2965 this subdivision. [(1) of subsection (b) of this section.] Such
2966 informational public hearings shall be held at a time and place
2967 designated by the [commissioner] secretary in a notice prominently
2968 posted by the [commissioner] secretary on the office's Internet web site
2969 and in a form and manner prescribed by the [commissioner] secretary.
2970 The [commissioner] secretary shall make available on the office's
2971 Internet web site a summary of any such informational public hearing
2972 and include the [commissioner's] secretary's recommendations, if any,
2973 to modify or not to modify any such annual benchmark or target.

2974 (ii) If the [commissioner] secretary determines, after any
2975 informational public hearing held pursuant to this subparagraph, that a
2976 modification to any health care cost growth benchmark or annual
2977 primary care spending target is, in the [commissioner's] secretary's
2978 discretion, reasonably warranted, the [commissioner] secretary may
2979 modify such benchmark or target.

2980 (iii) The [commissioner] secretary shall annually (I) review the
2981 current and projected rate of inflation, and (II) include on the office's
2982 Internet web site the [commissioner's] secretary's findings of such
2983 review, including the reasons for making or not making a modification
2984 to any applicable health care cost growth benchmark. If the
2985 [commissioner] secretary determines that the rate of inflation requires

2986 modification of any health care cost growth benchmark adopted under
2987 this section, the [commissioner] secretary may modify such benchmark.
2988 In such event, the [commissioner] secretary shall not be required to hold
2989 an informational public hearing concerning such modified health care
2990 cost growth benchmark.

2991 (D) The [commissioner] secretary shall post each adopted health care
2992 cost growth benchmark and annual primary care spending target on the
2993 office's Internet web site.

2994 (E) Notwithstanding the provisions of subparagraphs (A) to (D),
2995 inclusive, of this subdivision, if the average annual health care cost
2996 growth benchmark for a succeeding five-year period described in this
2997 subdivision differs from the average annual health care cost growth
2998 benchmark for the five-year period preceding such succeeding five-year
2999 period by more than one-half of one per cent, the [commissioner]
3000 secretary shall submit the annual health care cost growth benchmarks
3001 developed for such succeeding five-year period to the joint standing
3002 committee of the General Assembly having cognizance of matters
3003 relating to insurance for the committee's review and approval. The
3004 committee shall be deemed to have approved such annual health care
3005 cost growth benchmarks for such succeeding five-year period, except
3006 upon a vote to reject such benchmarks by the majority of committee
3007 members at a meeting of such committee called for the purpose of
3008 reviewing such benchmarks and held not later than thirty days after the
3009 [commissioner] secretary submitted such benchmarks to such
3010 committee. If the committee votes to reject such benchmarks, the
3011 [commissioner] secretary may submit to the committee modified annual
3012 health care cost growth benchmarks for such succeeding five-year
3013 period for the committee's review and approval in accordance with the
3014 provisions of this subparagraph. The [commissioner] secretary shall not
3015 be required to hold an informational public hearing concerning such
3016 modified benchmarks. Until the joint standing committee of the General
3017 Assembly having cognizance of matters relating to insurance approves
3018 annual health care cost growth benchmarks for the succeeding five-year
3019 period, such benchmarks shall be deemed to be equal to the average

3020 annual health care cost growth benchmark for the preceding five-year
3021 period.

3022 (2) (A) Not later than July 1, 2025, and every five years thereafter, the
3023 [commissioner] secretary shall develop and adopt annual health care
3024 quality benchmarks for the succeeding five calendar years for provider
3025 entities and payers.

3026 (B) In developing annual health care quality benchmarks pursuant to
3027 this subdivision, the [commissioner] secretary shall consider (i) quality
3028 measures endorsed by nationally recognized organizations, including,
3029 but not limited to, the National Quality Forum, the National Committee
3030 for Quality Assurance, the Centers for Medicare and Medicaid Services,
3031 the National Centers for Disease Control and Prevention, the Joint
3032 Commission and expert organizations that develop health equity
3033 measures, and (ii) measures that: (I) Concern health outcomes,
3034 overutilization, underutilization and patient safety, (II) meet standards
3035 of patient-centeredness and ensure consideration of differences in
3036 preferences and clinical characteristics within patient subpopulations,
3037 and (III) concern community health or population health.

3038 (C) (i) The [commissioner] secretary shall hold at least one
3039 informational public hearing prior to adopting the health care quality
3040 benchmarks for each succeeding five-year period described in this
3041 subdivision. The [commissioner] secretary may hold informational
3042 public hearings concerning the quality measures the [commissioner]
3043 secretary proposes to adopt as health care quality benchmarks. Such
3044 informational public hearings shall be held at a time and place
3045 designated by the [commissioner] secretary in a notice prominently
3046 posted by the [commissioner] secretary on the office's Internet web site
3047 and in a form and manner prescribed by the [commissioner] secretary.
3048 The [commissioner] secretary shall make available on the office's
3049 Internet web site a summary of any such informational public hearing
3050 and include the recommendations, if any, to modify or not modify any
3051 such health care quality benchmark.

3052 (ii) If the [commissioner] secretary determines, after any
3053 informational public hearing held pursuant to this subparagraph, that
3054 modifications to any health care quality benchmarks are, in the
3055 [commissioner's] secretary's discretion, reasonably warranted, the
3056 [commissioner] secretary may modify such quality benchmarks. The
3057 [commissioner] secretary shall not be required to hold an additional
3058 informational public hearing concerning such modified quality
3059 benchmarks.

3060 (D) The [commissioner] secretary shall post each adopted health care
3061 quality benchmark on the office's Internet web site.

3062 [(c)] (b) The [commissioner] secretary may enter into such contractual
3063 agreements as may be necessary to carry out the purposes of this section,
3064 including, but not limited to, contractual agreements with actuarial,
3065 economic and other experts and consultants.

3066 Sec. 73. Section 19a-754h of the general statutes is repealed and the
3067 following is substituted in lieu thereof (*Effective July 1, 2026*):

3068 (a) Not later than August [15, 2022, and] fifteenth annually,
3069 [thereafter,] each payer shall report to the [commissioner] secretary, in
3070 a form and manner prescribed by the [commissioner] secretary, for the
3071 preceding or prior years, if the [commissioner] secretary so requests
3072 based on material changes to data previously submitted, aggregated
3073 data, including aggregated self-funded data as applicable, necessary for
3074 the [commissioner] secretary to calculate total health care expenditures,
3075 primary care spending as a percentage of total medical expenses and net
3076 cost of private health insurance. Each payer shall also disclose, as
3077 requested by the [commissioner] secretary, payer data required for
3078 adjusting total medical expense calculations to reflect changes in the
3079 patient population.

3080 (b) Not later than March [31, 2023, and] thirty-first annually,
3081 [thereafter, the commissioner] the secretary shall prepare and post on
3082 the office's Internet web site, a report concerning the total health care
3083 expenditures utilizing the total aggregate medical expenses reported by

3084 payers pursuant to subsection (a) of this section, including, but not
3085 limited to, a breakdown of such population-adjusted total medical
3086 expenses by payer and provider entities. The report may include, but
3087 [shall] need not be limited to, information regarding the following:

3088 (1) Trends in major service category spending;

3089 (2) Primary care spending as a percentage of total medical expenses;

3090 (3) The net cost of private health insurance by payer by market
3091 segment, including individual, small group, large group, self-insured,
3092 student and Medicare Advantage markets; and

3093 (4) Any other factors the [commissioner] secretary deems relevant to
3094 providing context on such data, which shall include, but not be limited
3095 to, the following factors: (A) The impact of the rate of inflation and rate
3096 of medical inflation; (B) impacts, if any, on access to care; and (C)
3097 responses to public health crises or similar emergencies.

3098 (c) The [commissioner] secretary shall annually submit a request to
3099 the federal Centers for Medicare and Medicaid Services for the
3100 unadjusted total medical expenses of Connecticut residents.

3101 (d) Not later than August [15, 2023, and] fifteenth annually,
3102 [thereafter,] each payer or provider entity shall report to the
3103 [commissioner] secretary, in a form and manner prescribed by the
3104 [commissioner] secretary, for the preceding year, and for prior years if
3105 the [commissioner] secretary so requests based on material changes to
3106 data previously submitted, on the health care quality benchmarks
3107 adopted pursuant to section 19a-754g, as amended by this act.

3108 (e) Not later than March [31, 2024, and] thirty-first annually,
3109 [thereafter, the commissioner] the secretary shall prepare and post on
3110 the office's Internet web site, a report concerning health care quality
3111 benchmarks reported by payers and provider entities pursuant to
3112 subsection (d) of this section.

3113 (f) The commissioner may enter into such contractual agreements as

3114 may be necessary to carry out the purposes of this section, including,
3115 but not limited to, contractual agreements with actuarial, economic and
3116 other experts and consultants.

3117 Sec. 74. Section 19a-754i of the general statutes is repealed and the
3118 following is substituted in lieu thereof (*Effective July 1, 2026*):

3119 (a) (1) For each calendar year, beginning on January 1, 2023, the
3120 [commissioner] secretary shall, if the payer or provider entity subject to
3121 the cost growth benchmark or primary care spending target [so]
3122 requests [] a meeting, the secretary shall meet with such payer or
3123 provider entity to review and validate the total medical expenses data
3124 collected pursuant to section 19a-754h, as amended by this act, for such
3125 payer or provider entity. The [commissioner] secretary shall review
3126 information provided by the payer or provider entity and, if deemed
3127 necessary, amend findings for such payer or provider prior to the
3128 identification of payer or provider entities that exceeded the health care
3129 cost growth benchmark or failed to meet the primary care spending
3130 target for the performance year as set forth in section 19a-754h, as
3131 amended by this act. The [commissioner] secretary shall identify, not
3132 later than May first of such calendar year, each payer or provider entity
3133 that exceeded the health care cost growth benchmark or failed to meet
3134 the primary care spending target for the performance year.

3135 (2) For each calendar year beginning on or after January 1, 2024, the
3136 [commissioner] secretary shall, if the payer or provider entity subject to
3137 the health care quality benchmarks for the performance year [so]
3138 requests [] a meeting, the secretary shall meet with such payer or
3139 provider entity to review and validate the quality data collected
3140 pursuant to section 19a-754h, as amended by this act, for such payer or
3141 provider entity. The [commissioner] secretary shall review information
3142 provided by the payer or provider entity and, if deemed necessary,
3143 amend findings for such payer or provider prior to the identification of
3144 payer or provider entities that exceeded the health care quality
3145 benchmark as set forth in section 19a-754h, as amended by this act. The
3146 [commissioner] secretary shall identify, not later than May first of such

3147 calendar year, each payer or provider entity that exceeded the health
3148 care quality benchmark for the performance year.

3149 (3) Not later than thirty days after the [commissioner] secretary
3150 identifies each payer or provider entity pursuant to subdivisions (1) and
3151 (2) of this subsection, the [commissioner] secretary shall send a notice to
3152 each such payer or provider entity. Such notice shall be in a form and
3153 manner prescribed by the [commissioner] secretary, and shall disclose
3154 to each such payer or provider entity:

3155 (A) That the [commissioner] secretary has identified such payer or
3156 provider entity pursuant to subdivision (1) or (2) of this subsection; and

3157 (B) The factual basis for the [commissioner's] secretary's
3158 identification of such payer or provider entity pursuant to subdivision
3159 (1) or (2) of this subsection.

3160 (b) (1) For each calendar year beginning on and after January 1, 2023,
3161 if the [commissioner] secretary determines that the annual percentage
3162 change in total health care expenditures for the performance year
3163 exceeded the health care cost growth benchmark for such year, the
3164 [commissioner] secretary shall identify, not later than May first of such
3165 calendar year, any other entity that significantly contributed to
3166 exceeding such benchmark. Each identification shall be based on:

3167 (A) The report prepared by the [commissioner] secretary pursuant to
3168 subsection (b) of section 19a-754h, as amended by this act, for such
3169 calendar year;

3170 (B) The report filed pursuant to section 38a-479ppp for such calendar
3171 year;

3172 (C) The information and data reported to the office pursuant to
3173 subsection (d) of section 19a-754b, as amended by this act, for such
3174 calendar year;

3175 (D) Information obtained from the all-payer claims database
3176 established under section 19a-755a, as amended by this act; and

3177 (E) Any other information that the [commissioner] secretary, in the
3178 [commissioner's] secretary's discretion, deems relevant for the purposes
3179 of this section.

3180 (2) The [commissioner] secretary shall account for costs, net of rebates
3181 and discounts, when identifying other entities pursuant to this section.

3182 Sec. 75. Section 19a-754j of the general statutes is repealed and the
3183 following is substituted in lieu thereof (*Effective July 1, 2026*):

3184 (a) (1) Not later than June [30, 2023, and] thirtieth annually,
3185 [thereafter, the commissioner] the secretary shall hold an informational
3186 public hearing to compare the growth in total health care expenditures
3187 in the performance year to the health care cost growth benchmark
3188 established pursuant to section 19a-754g, as amended by this act, for
3189 such year. Such hearing shall involve an examination of:

3190 (A) The report most recently prepared by the [commissioner]
3191 secretary pursuant to subsection (b) of section 19a-754h, as amended by
3192 this act;

3193 (B) The expenditures of provider entities and payers, including, but
3194 not limited to, health care cost trends, primary care spending as a
3195 percentage of total medical expenses and the factors contributing to
3196 such costs and expenditures; and

3197 (C) Any other matters that the [commissioner] secretary, in the
3198 [commissioner's] secretary's discretion, deems relevant for the purposes
3199 of this section.

3200 (2) The [commissioner] secretary may require any payer or provider
3201 entity that, for the performance year, is found to be a significant
3202 contributor to health care cost growth in the state or has failed to meet
3203 the primary care spending target, to participate in such hearing. Each
3204 such payer or provider entity that is required to participate in such
3205 hearing shall provide testimony on issues identified by the
3206 [commissioner] secretary and provide additional information on actions

3207 taken to reduce such payer's or entity's contribution to future state-wide
3208 health care costs and expenditures or to increase such payer's or
3209 provider entity's primary care spending as a percentage of total medical
3210 expenses.

3211 (3) The [commissioner] secretary may require that any other entity
3212 that is found to be a significant contributor to health care cost growth in
3213 this state during the performance year participate in such hearing. Any
3214 other entity that is required to participate in such hearing shall provide
3215 testimony on issues identified by the [commissioner] secretary and
3216 provide additional information on actions taken to reduce such other
3217 entity's contribution to future state-wide health care costs. If such other
3218 entity is a drug manufacturer, and the [commissioner] secretary requires
3219 that such drug manufacturer participate in such hearing with respect to
3220 a specific drug or class of drugs, such hearing may, to the extent
3221 possible, include representatives from at least one brand-name
3222 manufacturer, one generic manufacturer and one innovator company
3223 that is less than ten years old.

3224 (4) Not later than October [15, 2023, and] fifteenth annually,
3225 [thereafter, the commissioner] the secretary shall prepare and submit a
3226 report, in accordance with section 11-4a, to the joint standing
3227 committees of the General Assembly having cognizance of matters
3228 relating to insurance and public health. Such report shall be based on
3229 the [commissioner's] secretary's analysis of the information submitted
3230 during the most recent informational public hearing conducted
3231 pursuant to this subsection and any other information that the
3232 [commissioner] secretary, in the [commissioner's] secretary's discretion,
3233 deems relevant for the purposes of this section, and shall:

3234 (A) Describe health care spending trends in this state, including, but
3235 not limited to, trends in primary care spending as a percentage of total
3236 medical expense, and the factors underlying such trends;

3237 (B) Include the findings from the report prepared pursuant to
3238 subsection (b) of section 19a-754h, as amended by this act;

3239 (C) Describe a plan for monitoring any unintended adverse
3240 consequences resulting from the adoption of cost growth benchmarks
3241 and primary care spending targets and the results of any findings from
3242 the implementation of such plan; and

3243 (D) Disclose the [commissioner's] secretary's recommendations, if
3244 any, concerning strategies to increase the efficiency of the state's health
3245 care system, including, but not limited to, any recommended legislation
3246 concerning the state's health care system.

3247 (b) (1) Not later than June [30, 2024, and] thirtieth annually,
3248 [thereafter, the commissioner] the secretary shall hold an informational
3249 public hearing to compare the performance of payers and provider
3250 entities in the performance year to the quality benchmarks established
3251 for such year pursuant to section 19a-754g, as amended by this act. Such
3252 hearing shall include an examination of:

3253 (A) The report most recently prepared by the [commissioner]
3254 secretary pursuant to subsection (e) of section 19a-754h, as amended by
3255 this act; and

3256 (B) Any other matters that the [commissioner] secretary, in the
3257 [commissioner's] secretary's discretion, deems relevant for the purposes
3258 of this section.

3259 (2) The [commissioner] secretary may require any payer or provider
3260 entity that failed to meet any health care quality benchmarks in this state
3261 during the performance year to participate in such hearing. Each such
3262 payer or provider entity that is required to participate in such hearing
3263 shall provide testimony on issues identified by the [commissioner]
3264 secretary and provide additional information on actions taken to
3265 improve such payer's or provider entity's quality benchmark
3266 performance.

3267 (3) Not later than October [15, 2024, and] fifteenth annually,
3268 [thereafter, the commissioner] the secretary shall prepare and submit a
3269 report, in accordance with section 11-4a, to the joint standing

3270 committees of the General Assembly having cognizance of matters
3271 relating to insurance and public health. Such report shall be based on
3272 the [commissioner's] secretary's analysis of the information submitted
3273 during the most recent informational public hearing conducted
3274 pursuant to this subsection and any other information that the
3275 [commissioner] secretary, in the [commissioner's] secretary's discretion,
3276 deems relevant for the purposes of this section, and shall:

3277 (A) Describe health care quality trends in this state and the factors
3278 underlying such trends;

3279 (B) Include the findings from the report prepared pursuant to
3280 subsection (e) of section 19a-754h, as amended by this act; and

3281 (C) Disclose the [commissioner's] secretary's recommendations, if
3282 any, concerning strategies to improve the quality of the state's health
3283 care system, including, but not limited to, any recommended legislation
3284 concerning the state's health care system.

3285 Sec. 76. Section 19a-754k of the general statutes is repealed and the
3286 following is substituted in lieu thereof (*Effective July 1, 2026*):

3287 The [Commissioner of Health Strategy] Secretary of the Office of
3288 Policy and Management may adopt regulations, in accordance with
3289 chapter 54, to implement the provisions of [section 19a-754a and]
3290 sections 19a-754f to 19a-754j, inclusive, as amended by this act.

3291 Sec. 77. Section 19a-755a of the general statutes is repealed and the
3292 following is substituted in lieu thereof (*Effective July 1, 2026*):

3293 (a) As used in this section:

3294 (1) "All-payer claims database" means a database that receives and
3295 stores data from a reporting entity relating to medical insurance claims,
3296 dental insurance claims, pharmacy claims and other insurance claims
3297 information from enrollment and eligibility files.

3298 (2) (A) "Reporting entity" means:

3299 (i) An insurer, as described in section 38a-1, licensed to do health
3300 insurance business in this state;

3301 (ii) A health care center, as defined in section 38a-175;

3302 (iii) An insurer or health care center that provides coverage under
3303 Part C or Part D of Title XVIII of the Social Security Act, as amended
3304 from time to time, to residents of this state;

3305 (iv) A third-party administrator, as defined in section 38a-720;

3306 (v) A pharmacy benefits manager, as defined in section 38a-479aaa;

3307 (vi) A hospital service corporation, as defined in section 38a-199;

3308 (vii) A nonprofit medical service corporation, as defined in section
3309 38a-214;

3310 (viii) A fraternal benefit society, as described in section 38a-595, that
3311 transacts health insurance business in this state;

3312 (ix) A dental plan organization, as defined in section 38a-577;

3313 (x) A preferred provider network, as defined in section 38a-479aa;
3314 and

3315 (xi) Any other person that administers health care claims and
3316 payments pursuant to a contract or agreement or is required by statute
3317 to administer such claims and payments.

3318 (B) "Reporting entity" does not include an employee welfare benefit
3319 plan, as defined in the federal Employee Retirement Income Security
3320 Act of 1974, as amended from time to time, that is also a trust established
3321 pursuant to collective bargaining subject to the federal Labor
3322 Management Relations Act.

3323 (3) "Medicaid data" means the Medicaid provider registry, health
3324 claims data and Medicaid recipient data maintained by the Department
3325 of Social Services.

3326 (4) "CHIP data" means the provider registry, health claims data and
3327 recipient data maintained by the Department of Social Services to
3328 administer the Children's Health Insurance Program.

3329 (b) (1) There is established an all-payer claims database program. The
3330 Office of [Health Strategy] Policy and Management shall: (A) Oversee
3331 the planning, implementation and administration of the all-payer claims
3332 database program for the purpose of collecting, assessing and reporting
3333 health care information relating to safety, quality, cost-effectiveness,
3334 access and efficiency for all levels of health care; (B) ensure that data
3335 received is securely collected, compiled and stored in accordance with
3336 state and federal law; (C) conduct audits of data submitted by reporting
3337 entities in order to verify its accuracy; and (D) in consultation with the
3338 Health Information Technology Advisory Council established under
3339 section 17b-59f, as amended by this act, maintain written procedures for
3340 the administration of such all-payer claims database. Any such written
3341 procedures shall include (i) reporting requirements for reporting
3342 entities, and (ii) requirements for providing notice to a reporting entity
3343 regarding any alleged failure on the part of such reporting entity to
3344 comply with such reporting requirements.

3345 (2) The [Commissioner of Health Strategy] Secretary of the Office of
3346 Policy and Management shall seek funding from the federal
3347 government, other public sources and other private sources to cover
3348 costs associated with the planning, implementation and administration
3349 of the all-payer claims database program.

3350 (3) (A) Upon the adoption of reporting requirements as set forth in
3351 subdivision (1) of this subsection, a reporting entity shall report health
3352 care information for inclusion in the all-payer claims database in a form
3353 and manner prescribed by the [Commissioner of Health Strategy]
3354 Secretary of the Office of Policy and Management. The [commissioner]
3355 secretary may, after notice and hearing, impose a civil penalty on any
3356 reporting entity that fails to report health care information as prescribed.
3357 Such civil penalty shall not exceed one thousand dollars per day for each
3358 day of violation and shall not be imposed as a cost for the purpose of

3359 rate determination or reimbursement by a third-party payer.

3360 (B) The [Commissioner of Health Strategy] Secretary of the Office of
3361 Policy and Management may provide the name of any reporting entity
3362 on which such penalty has been imposed to the Insurance
3363 Commissioner. After consultation with the [Commissioner of Health
3364 Strategy] secretary, the Insurance Commissioner may request the
3365 Attorney General to bring an action in the superior court for the judicial
3366 district of Hartford to recover any penalty imposed pursuant to
3367 subparagraph (A) of this subdivision.

3368 (4) The Commissioner of Social Services shall submit Medicaid and
3369 CHIP data to the [Commissioner of Health Strategy] Secretary of the
3370 Office of Policy and Management for inclusion in the all-payer claims
3371 database only for purposes related to administration of the State
3372 Medicaid and CHIP Plans, in accordance with 42 CFR 431.301 to 42 CFR
3373 431.306, inclusive.

3374 (5) The [Commissioner of Health Strategy] Secretary of the Office of
3375 Policy and Management shall: (A) Utilize data in the all-payer claims
3376 database to provide health care consumers in the state with information
3377 concerning the cost and quality of health care services for the purpose
3378 of allowing such consumers to make economically sound and medically
3379 appropriate health care decisions; and (B) make data in the all-payer
3380 claims database available to any state agency, insurer, employer, health
3381 care provider, consumer of health care services or researcher for the
3382 purpose of allowing such person or entity to review such data as it
3383 relates to health care utilization, costs or quality of health care services.
3384 If health information, as defined in 45 CFR 160.103, as amended from
3385 time to time, is permitted to be disclosed under the Health Insurance
3386 Portability and Accountability Act of 1996, P.L. 104-191, as amended
3387 from time to time, or regulations adopted thereunder, any disclosure
3388 thereof made pursuant to this subdivision shall have identifiers
3389 removed, as set forth in 45 CFR 164.514, as amended from time to time.
3390 Any disclosure made pursuant to this subdivision of information other
3391 than health information shall be made in a manner to protect the

3392 confidentiality of such other information as required by state and
3393 federal law. The [Commissioner of Health Strategy] secretary may set a
3394 fee to be charged to each person or entity requesting access to data
3395 stored in the all-payer claims database.

3396 (6) The [Commissioner of Health Strategy] Secretary of the Office of
3397 Policy and Management may (A) in consultation with the All-Payer
3398 Claims Database Advisory Group set forth in section 17b-59f, as
3399 amended by this act, enter into a contract with a person or entity to plan,
3400 implement or administer the all-payer claims database program, (B)
3401 enter into a contract or take any action that is necessary to obtain data
3402 that is the same data required to be submitted by reporting entities
3403 under Medicare Part A or Part B, (C) enter into a contract for the
3404 collection, management or analysis of data received from reporting
3405 entities, and (D) in accordance with subdivision (4) of this subsection,
3406 enter into a contract or take any action that is necessary to obtain
3407 Medicaid and CHIP data. Any such contract for the collection,
3408 management or analysis of such data shall expressly prohibit the
3409 disclosure of such data for purposes other than the purposes described
3410 in this subsection.

3411 (c) Unless otherwise specified, nothing in this section and no action
3412 taken by the [Commissioner of Health Strategy] Secretary of the Office
3413 of Policy and Management pursuant to this section or section 19a-755b,
3414 as amended by this act, shall be construed to preempt, supersede or
3415 affect the authority of the Insurance Commissioner to regulate the
3416 business of insurance in the state.

3417 Sec. 78. Section 19a-755b of the general statutes is repealed and the
3418 following is substituted in lieu thereof (*Effective July 1, 2026*):

3419 (a) For purposes of this section and sections 19a-904a, 19a-904b and
3420 38a-477d to 38a-477f, inclusive:

3421 (1) "Allowed amount" means the maximum reimbursement dollar
3422 amount that an insured's health insurance policy allows for a specific
3423 procedure or service;

3424 (2) "Consumer health information Internet web site" means an
3425 Internet web site developed and operated by the Office of [Health
3426 Strategy] Policy and Management to assist consumers in making
3427 informed decisions concerning their health care and informed choices
3428 among health care providers;

3429 (3) "Episode of care" means all health care services related to the
3430 treatment of a condition or a service category for such treatment and,
3431 for acute conditions, includes health care services and treatment
3432 provided from the onset of the condition to its resolution or a service
3433 category for such treatment and, for chronic conditions, includes health
3434 care services and treatment provided over a given period of time or a
3435 service category for such treatment;

3436 [(4) "Commissioner" means the Commissioner of Health Strategy;]

3437 [(5)] (4) "Health care provider" means any individual, corporation,
3438 facility or institution licensed by this state to provide health care
3439 services;

3440 [(6)] (5) "Health carrier" means any insurer, health care center,
3441 hospital service corporation, medical service corporation, fraternal
3442 benefit society or other entity delivering, issuing for delivery, renewing,
3443 amending or continuing any individual or group health insurance
3444 policy in this state providing coverage of the type specified in
3445 subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

3446 [(7)] (6) "Hospital" has the same meaning as provided in section 19a-
3447 490;

3448 [(8)] (7) "Out-of-pocket costs" means costs that are not reimbursed by
3449 a health insurance policy and includes deductibles, coinsurance and
3450 copayments for covered services and other costs to the consumer
3451 associated with a procedure or service;

3452 [(9)] (8) "Outpatient surgical facility" has the same meaning as
3453 provided in section 19a-493b, as amended by this act; [and]

3454 [(10)] (9) "Public or private third party" means the state, the federal
3455 government, employers, a health carrier, third-party administrator, as
3456 defined in section 38a-720, or managed care organization; and

3457 (10) "Secretary" means the Secretary of the Office of Policy and
3458 Management.

3459 (b) (1) Within available resources, the consumer health information
3460 Internet web site shall: (A) Contain information comparing the quality,
3461 price and cost of health care services, including, to the extent practicable,
3462 (i) comparative price and cost information for the health care services
3463 and procedures reported pursuant to subsection (c) of this section
3464 categorized by payer or listed by health care provider, (ii) links to
3465 Internet web sites and consumer tools where consumers may obtain
3466 comparative cost and quality information, including The Joint
3467 Commission and Medicare hospital compare tool, (iii) definitions of
3468 common health insurance and medical terms so consumers may
3469 compare health coverage and understand the terms of their coverage,
3470 and (iv) factors consumers should consider when choosing an insurance
3471 product or provider group, including provider network, premium, cost
3472 sharing, covered services and tier information; (B) be designed to assist
3473 consumers and institutional purchasers in making informed decisions
3474 regarding their health care and informed choices among health care
3475 providers and, to the extent practicable, provide reference pricing for
3476 services paid by various health carriers to health care providers; (C)
3477 present information in language and a format that is understandable to
3478 the average consumer; and (D) be publicized to the general public. All
3479 information outlined in this section shall be posted on an Internet web
3480 site established, or to be established, by the [Commissioner of Health
3481 Strategy] secretary in a manner and time frame as may be
3482 organizationally and financially reasonable in [his or her] the secretary's
3483 sole discretion.

3484 (2) Information collected, stored and published by the Office of
3485 [Health Strategy] Policy and Management pursuant to this section is
3486 subject to the federal Health Insurance Portability and Accountability

3487 Act of 1996, P.L. 104-191, as amended from time to time.

3488 (3) The [Commissioner of Health Strategy] secretary may consider
3489 adding quality measures to the consumer health information Internet
3490 web site.

3491 (c) Not later than January [1, 2018, and] first annually, [thereafter, the
3492 Commissioner of Health Strategy] the secretary shall, to the extent the
3493 information is available, make available to the public on the consumer
3494 health information Internet web site a list of: (1) The fifty most
3495 frequently occurring inpatient services or procedures in the state; (2) the
3496 fifty most frequently provided outpatient services or procedures in the
3497 state; (3) the twenty-five most frequent surgical services or procedures
3498 in the state; (4) the twenty-five most frequent imaging services or
3499 procedures in the state; and (5) the twenty-five most frequently used
3500 pharmaceutical products and medical devices in the state. Such lists
3501 may (A) be expanded to include additional admissions and procedures,
3502 (B) be based upon those services and procedures that are most
3503 commonly performed by volume or that represent the greatest
3504 percentage of related health care expenditures, or (C) be designed to
3505 include those services and procedures most likely to result in out-of-
3506 pocket costs to consumers or include bundled episodes of care.

3507 (d) Not later than January [1, 2018, and] first annually, [thereafter,] to
3508 the extent practicable, the [Commissioner of Health Strategy] secretary
3509 shall issue a report, in a form and manner prescribed by the
3510 [commissioner] secretary, that includes the (1) billed and allowed
3511 amounts paid to health care providers in each health carrier's network
3512 for each service and procedure included pursuant to subsection (c) of
3513 this section, and (2) out-of-pocket costs for each such service and
3514 procedure.

3515 (e) (1) [On and after January 1, 2018, each] Each hospital shall, at the
3516 time of scheduling a service or procedure for nonemergency care that is
3517 included in the report prepared by the [Commissioner of Health
3518 Strategy] secretary pursuant to subsection (d) of this section, regardless

3519 of the location or setting where such services are delivered, notify the
3520 patient of the patient's right to make a request for cost and quality
3521 information. Upon the request of a patient for a diagnosis or procedure
3522 included in such report, the hospital shall, not later than three business
3523 days after scheduling such service or procedure, provide written notice,
3524 electronically or by mail, to the patient who is the subject of the service
3525 or procedure concerning: (A) If the patient is uninsured, the amount to
3526 be charged for the service or procedure if all charges are paid in full
3527 without a public or private third party paying any portion of the
3528 charges, including the amount of any facility fee, or, if the hospital is not
3529 able to provide a specific amount due to an inability to predict the
3530 specific treatment or diagnostic code, the estimated maximum allowed
3531 amount or charge for the service or procedure, including the amount of
3532 any facility fee; (B) the corresponding Medicare reimbursement amount
3533 or, if there is no corresponding Medicare reimbursement amount for
3534 such diagnosis or procedure, (i) the approximate amount Medicare
3535 would have paid the hospital for the services on the billing statement,
3536 or (ii) the percentage of the hospital's charges that Medicare would have
3537 paid the hospital for the services; (C) if the patient is insured, the
3538 allowed amount, the toll-free telephone number and the Internet web
3539 site address of the patient's health carrier where the patient can obtain
3540 information concerning charges and out-of-pocket costs; (D) The Joint
3541 Commission's composite accountability rating and the Medicare
3542 hospital compare star rating for the hospital, as applicable; and (E) the
3543 Internet web site addresses for The Joint Commission and the Medicare
3544 hospital compare tool where the patient may obtain information
3545 concerning the hospital.

3546 (2) If the patient is insured and the hospital is out-of-network under
3547 the patient's health insurance policy, such written notice shall include a
3548 statement that the service or procedure will likely be deemed out-of-
3549 network and that any out-of-network applicable rates under such policy
3550 may apply.

3551 Sec. 79. Subsection (b) of section 19a-911 of the general statutes is
3552 repealed and the following is substituted in lieu thereof (*Effective July 1,*

3553 2026):

3554 (b) The Council on Protecting Women's Health shall be comprised of
3555 (1) the following ex-officio voting members: (A) The Commissioner of
3556 Public Health, or the commissioner's designee; (B) the Commissioner of
3557 Mental Health and Addiction Services, or the commissioner's designee;
3558 (C) the Insurance Commissioner, or the commissioner's designee; (D)
3559 [the Commissioner of Health Strategy, or the commissioner's designee;
3560 (E)] the Healthcare Advocate, or the Healthcare Advocate's designee;
3561 and [(F)] (E) the Secretary of the Office of Policy and Management, or
3562 the secretary's designee; and (2) fourteen public members, three of
3563 whom shall be appointed by the president pro tempore of the Senate,
3564 three of whom shall be appointed by the speaker of the House of
3565 Representatives, two of whom shall be appointed by the majority leader
3566 of the Senate, two of whom shall be appointed by the majority leader of
3567 the House of Representatives, two of whom shall be appointed by the
3568 minority leader of the Senate and two of whom shall be appointed by
3569 the minority leader of the House of Representatives, and all of whom
3570 shall be knowledgeable on issues relative to women's health care in the
3571 state. The membership of the council shall fairly and adequately
3572 represent women who have had issues accessing quality health care in
3573 the state.

3574 Sec. 80. Subsections (b) and (c) of section 20-195ttt of the 2026
3575 supplement to the general statutes are repealed and the following is
3576 substituted in lieu thereof (*Effective July 1, 2026*):

3577 (b) There is established within the [Office of Health Strategy]
3578 Department of Public Health a Community Health Worker Advisory
3579 Body. Said body shall (1) advise [said office and the Department of
3580 Public Health] the department on matters relating to the educational
3581 and certification requirements for training programs for community
3582 health workers, including the minimum number of hours and
3583 internship requirements for certification of community health workers,
3584 (2) conduct a continuous review of such educational and certification
3585 programs, and (3) provide the department with a list of approved

3586 educational and certification programs for community health workers.

3587 (c) The Commissioner of [Health Strategy] Public Health, or the
3588 commissioner's designee, shall act as the chair of the Community Health
3589 Worker Advisory Body and shall appoint the following members to said
3590 body:

3591 (1) Six members who are actively practicing as community health
3592 workers in the state;

3593 (2) A member of the Community Health Workers Association of
3594 Connecticut or any successor or comparable professional organization
3595 that represents community health workers in the state;

3596 (3) A representative of a community-based community health worker
3597 training organization;

3598 (4) A representative of the Connecticut State Community College;

3599 (5) An employer of community health workers;

3600 (6) A representative of a health care organization that employs
3601 community health workers; and

3602 (7) A health care provider who works directly with community health
3603 workers.]; and]

3604 [(8) The Commissioner of Public Health, or the commissioner's
3605 designee.]

3606 Sec. 81. Subsection (b) of section 28-33 of the 2026 supplement to the
3607 general statutes is repealed and the following is substituted in lieu
3608 thereof (*Effective July 1, 2026*):

3609 (b) The task force shall consist of the following members:

3610 (1) Two appointed by the speaker of the House of Representatives,
3611 one of whom has expertise in prescription drug supply chains and one
3612 of whom has expertise in federal law concerning prescription drug

3613 shortages;

3614 (2) Two appointed by the president pro tempore of the Senate, one of
3615 whom represents hospitals and one of whom represents health care
3616 providers who treat patients with rare diseases;

3617 (3) One appointed by the majority leader of the House of
3618 Representatives, who represents one of the two federally recognized
3619 Indian tribes in the state;

3620 (4) One appointed by the majority leader of the Senate, who
3621 represents one of the two federally recognized Indian tribes in the state;

3622 (5) One appointed by the minority leader of the House of
3623 Representatives, who represents health insurance companies;

3624 (6) One appointed by the minority leader of the Senate, who is a
3625 representative of the Connecticut Health Insurance Exchange;

3626 [(7) The Commissioner of Health Strategy, or the commissioner's
3627 designee;]

3628 [(8)] (7) The Commissioner of Consumer Protection, or the
3629 commissioner's designee;

3630 [(9)] (8) The Commissioner of Social Services, or the commissioner's
3631 designee;

3632 [(10)] (9) The Commissioner of Public Health, or the commissioner's
3633 designee;

3634 [(11)] (10) The chief executive officer of The University of Connecticut
3635 Health Center, or the chief executive officer's designee;

3636 [(12)] (11) The Insurance Commissioner, or the commissioner's
3637 designee;

3638 [(13)] (12) The Commissioner of Economic and Community
3639 Development, or the commissioner's designee; and

3640 [(14)] (13) Any other members as deemed necessary by the
3641 chairpersons of the task force.

3642 Sec. 82. Subsections (e) to (g), inclusive, of section 33-182bb of the
3643 general statutes are repealed and the following is substituted in lieu
3644 thereof (*Effective July 1, 2026*):

3645 (e) Any medical foundation organized on or after July 1, 2009, shall
3646 file a copy of its certificate of incorporation and any amendments to its
3647 certificate of incorporation with the Health Systems Planning Unit of the
3648 [Office of Health Strategy] Department of Public Health not later than
3649 ten business days after the medical foundation files such certificate of
3650 incorporation or amendment with the Secretary of the State pursuant to
3651 chapter 602.

3652 (f) Any medical group clinic corporation formed under chapter 594
3653 of the general statutes, revision of 1958, revised to 1995, which amends
3654 its certificate of incorporation pursuant to subsection (a) of section 33-
3655 182cc, shall file with the Health Systems Planning Unit of the [Office of
3656 Health Strategy] Department of Public Health a copy of its certificate of
3657 incorporation and any amendments to its certificate of incorporation,
3658 including any amendment to its certificate of incorporation that
3659 complies with the requirements of subsection (a) of section 33-182cc, not
3660 later than ten business days after the medical foundation files its
3661 certificate of incorporation or any amendments to its certificate of
3662 incorporation with the Secretary of the State.

3663 (g) Any medical foundation, regardless of when organized, shall file
3664 notice with the Health Systems Planning Unit of the [Office of Health
3665 Strategy] Department of Public Health and the Secretary of the State of
3666 its liquidation, termination, dissolution or cessation of operations not
3667 later than ten business days after a vote by its board of directors or
3668 members to take such action. A medical foundation shall, annually,
3669 provide the office with (1) a statement of its mission, (2) the name and
3670 address of the organizing members, (3) the name and specialty of each
3671 physician employed by or acting as an agent of the medical foundation,

3672 (4) the location or locations where each such physician practices, (5) a
3673 description of the services provided at each such location, (6) a
3674 description of any significant change in its services during the preceding
3675 year, (7) a copy of the medical foundation's governing documents and
3676 bylaws, (8) the name and employer of each member of the board of
3677 directors, and (9) other financial information as reported on the medical
3678 foundation's most recently filed Internal Revenue Service return of
3679 organization exempt from income tax form, or any replacement form
3680 adopted by the Internal Revenue Service, or, if such medical foundation
3681 is not required to file such form, information substantially similar to that
3682 required by such form. The Health Systems Planning Unit shall make
3683 such forms and information available to members of the public and
3684 accessible on said unit's Internet web site.

3685 Sec. 83. Subdivisions (2) and (3) of subsection (a) of section 38a-47 of
3686 the general statutes are repealed and the following is substituted in lieu
3687 thereof (*Effective July 1, 2026*):

3688 (2) The amount appropriated to the Office of [Health Strategy] Policy
3689 and Management from the Insurance Fund for the fiscal year, [including
3690 the cost of fringe benefits for office personnel as estimated by the
3691 Comptroller,] which shall be reduced by the amount of federal
3692 reimbursement received for allowable Medicaid administrative
3693 expenses;

3694 (3) The expenditures made on behalf of the department and said
3695 offices from the Capital Equipment Purchase Fund pursuant to section
3696 4a-9 for such year, but excluding such estimated expenditures made on
3697 behalf of the Health Systems Planning Unit of the [Office of Health
3698 Strategy] Department of Public Health; and

3699 Sec. 84. Subsections (b) to (f), inclusive, of section 38a-48 of the
3700 general statutes are repealed and the following is substituted in lieu
3701 thereof (*Effective July 1, 2026*):

3702 (b) On or before July thirty-first, annually, the Insurance
3703 Commissioner shall render to each domestic insurance company or

3704 other domestic entity liable for payment under section 38a-47, as
3705 amended by this act:

3706 (1) A statement that includes (A) the amount appropriated to the
3707 Insurance Department, the Office of the Healthcare Advocate and the
3708 Office of [Health Strategy] Policy and Management from the Insurance
3709 Fund established under section 38a-52a for the fiscal year beginning July
3710 first of the same year, (B) the cost of fringe benefits for department and
3711 office personnel for such year, as estimated by the Comptroller, (C) the
3712 estimated expenditures on behalf of the department and the offices from
3713 the Capital Equipment Purchase Fund pursuant to section 4a-9 for such
3714 year, not including such estimated expenditures made on behalf of the
3715 Health Systems Planning Unit of the [Office of Health Strategy]
3716 Department of Public Health, and (D) the amount appropriated to the
3717 Department of Aging and Disability Services for the fall prevention
3718 program established in section 17a-859 from the Insurance Fund for the
3719 fiscal year;

3720 (2) A statement of the total amount of taxes reported in the annual
3721 statement rendered to the Insurance Commissioner pursuant to
3722 subsection (a) of this section; and

3723 (3) The proposed assessment against that company or entity,
3724 calculated in accordance with the provisions of subsection (c) of this
3725 section, provided for the purposes of this calculation the amount
3726 appropriated to the Insurance Department, the Office of the Healthcare
3727 Advocate and the Office of [Health Strategy] Policy and Management
3728 from the Insurance Fund plus the cost of fringe benefits for department
3729 and office personnel and the estimated expenditures on behalf of the
3730 department and said offices from the Capital Equipment Purchase Fund
3731 pursuant to section 4a-9, not including such expenditures made on
3732 behalf of the Health Systems Planning Unit of the [Office of Health
3733 Strategy] Department of Public Health shall be deemed to be the actual
3734 expenditures of the department and said offices, and the amount
3735 appropriated to the Department of Aging and Disability Services from
3736 the Insurance Fund for the fiscal year for the fall prevention program

3737 established in section 17a-859 shall be deemed to be the actual
3738 expenditures for the program.

3739 (c) (1) The proposed assessments for each domestic insurance
3740 company or other domestic entity shall be calculated by (A) allocating
3741 twenty per cent of the amount to be paid under section 38a-47, as
3742 amended by this act, among the domestic entities organized under
3743 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,
3744 in proportion to their respective shares of the total amount of taxes
3745 reported in the annual statement rendered to the Insurance
3746 Commissioner pursuant to subsection (a) of this section, and (B)
3747 allocating eighty per cent of the amount to be paid under section 38a-47,
3748 as amended by this act, among all domestic insurance companies and
3749 domestic entities other than those organized under sections 38a-199 to
3750 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to
3751 their respective shares of the total amount of taxes reported in the
3752 annual statement rendered to the Insurance Commissioner pursuant to
3753 subsection (a) of this section, provided if there are no domestic entities
3754 organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to
3755 38a-225, inclusive, at the time of assessment, one hundred per cent of
3756 the amount to be paid under section 38a-47, as amended by this act, shall
3757 be allocated among such domestic insurance companies and domestic
3758 entities.

3759 (2) When the amount any such company or entity is assessed
3760 pursuant to this section exceeds twenty-five per cent of the actual
3761 expenditures of the Insurance Department, the Office of the Healthcare
3762 Advocate and the Office of [Health Strategy] Policy and Management
3763 from the Insurance Fund, such excess amount shall not be paid by such
3764 company or entity but rather shall be assessed against and paid by all
3765 other such companies and entities in proportion to their respective
3766 shares of the total amount of taxes reported in the annual statement
3767 rendered to the Insurance Commissioner pursuant to subsection (a) of
3768 this section, except that for purposes of any assessment made to fund
3769 payments to the Department of Public Health to purchase vaccines, such
3770 company or entity shall be responsible for its share of the costs,

3771 notwithstanding whether its assessment exceeds twenty-five per cent of
3772 the actual expenditures of the Insurance Department, the Office of the
3773 Healthcare Advocate and the Office of [Health Strategy] Policy and
3774 Management from the Insurance Fund. The provisions of this
3775 subdivision shall not be applicable to any corporation that has
3776 converted to a domestic mutual insurance company pursuant to section
3777 38a-155 upon the effective date of any public act that amends said
3778 section to modify or remove any restriction on the business such a
3779 company may engage in, for purposes of any assessment due from such
3780 company on and after such effective date.

3781 (d) Each annual payment determined under section 38a-47, as
3782 amended by this act, and each annual assessment determined under this
3783 section shall be calculated based on the total amount of taxes reported
3784 in the annual statement rendered to the Insurance Commissioner
3785 pursuant to subsection (a) of this section.

3786 (e) On or before September first, annually, for each fiscal year, the
3787 Insurance Commissioner, after receiving any objections to the proposed
3788 assessments and making such adjustments as in the commissioner's
3789 opinion may be indicated, shall assess each such domestic insurance
3790 company or other domestic entity an amount equal to its proposed
3791 assessment as so adjusted. Each domestic insurance company or other
3792 domestic entity shall pay to the Insurance Commissioner (1) on or before
3793 June thirtieth, annually, an estimated payment against its assessment for
3794 the following year equal to twenty-five per cent of its assessment for the
3795 fiscal year ending such June thirtieth, (2) on or before September
3796 thirtieth, annually, twenty-five per cent of its assessment adjusted to
3797 reflect any credit or amount due from the preceding fiscal year as
3798 determined by the commissioner under subsection (f) of this section,
3799 and (3) on or before the following December thirty-first and March
3800 thirty-first, annually, each domestic insurance company or other
3801 domestic entity shall pay to the Insurance Commissioner the remaining
3802 fifty per cent of its proposed assessment to the department in two equal
3803 installments.

3804 (f) If the actual expenditures for the fall prevention program
3805 established in section 17a-859 are less than the amount allocated, the
3806 Commissioner of Aging and Disability Services shall notify the
3807 Insurance Commissioner. Immediately following the close of the fiscal
3808 year, the Insurance Commissioner shall recalculate the proposed
3809 assessment for each domestic insurance company or other domestic
3810 entity in accordance with subsection (c) of this section using the actual
3811 expenditures made during the fiscal year by the Insurance Department
3812 , the Office of the Healthcare Advocate and the Office of [Health
3813 Strategy] Policy and Management from the Insurance Fund, the actual
3814 expenditures made on behalf of the department and said offices from
3815 the Capital Equipment Purchase Fund pursuant to section 4a-9, not
3816 including such expenditures made on behalf of the Health Systems
3817 Planning Unit of the [Office of Health Strategy] Department of Public
3818 Health, and the actual expenditures for the fall prevention program. On
3819 or before July thirty-first, annually, the Insurance Commissioner shall
3820 render to each such domestic insurance company and other domestic
3821 entity a statement showing the difference between their respective
3822 recalculated assessments and the amount they have previously paid. On
3823 or before August thirty-first, the Insurance Commissioner, after
3824 receiving any objections to such statements, shall make such
3825 adjustments that in the commissioner's opinion may be indicated, and
3826 shall render an adjusted assessment, if any, to the affected companies.
3827 Any such domestic insurance company or other domestic entity may
3828 pay to the Insurance Commissioner the entire assessment required
3829 under this subsection in one payment when the first installment of such
3830 assessment is due.

3831 Sec. 85. Subsection (a) of section 38a-477e of the general statutes is
3832 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3833 *2026*):

3834 (a) [On and after January 1, 2017, each] Each health carrier, as defined
3835 in section 19a-755b, as amended by this act, shall maintain an Internet
3836 web site and toll-free telephone number that enables consumers to
3837 request and obtain: (1) Information on in-network costs for inpatient

3838 admissions, health care procedures and services, including (A) the
3839 allowed amount for, at a minimum, admissions and procedures
3840 reported to the [Commissioner of Health Strategy] Secretary of the
3841 Office of Policy and Management pursuant to section 19a-755b, as
3842 amended by this act, for each health care provider in the state; (B) the
3843 estimated out-of-pocket costs that a consumer would be responsible for
3844 paying for any such admission or procedure that is medically necessary,
3845 including any facility fee, coinsurance, copayment, deductible or other
3846 out-of-pocket expense; and (C) data or other information concerning (i)
3847 quality measures for the health care provider, (ii) patient satisfaction, to
3848 the extent such information is available, (iii) a directory of participating
3849 providers, as defined in section 38a-472f, in accordance with the
3850 provisions of section 38a-477h; and (2) information on out-of-network
3851 costs for inpatient admissions, health care procedures and services.

3852 Sec. 86. Subdivision (2) of subsection (c) of section 38a-477ee of the
3853 2026 supplement to the general statutes is repealed and the following is
3854 substituted in lieu thereof (*Effective July 1, 2026*):

3855 (2) The Attorney General [.] and Healthcare Advocate. [and
3856 Commissioner of Health Strategy.]

3857 Sec. 87. Subdivisions (13) to (17), inclusive, of subsection (c) of section
3858 38a-1083 of the general statutes are repealed and the following is
3859 substituted in lieu thereof (*Effective July 1, 2026*):

3860 (13) Make and enter into any contract or agreement necessary or
3861 incidental to the performance of its duties and execution of its powers,
3862 including, but not limited to, an agreement with the Office of [Health
3863 Strategy] Policy and Management to use funds collected under this
3864 section for the operation of the all-payer claims database established
3865 under section 19a-755a, as amended by this act, and to receive data from
3866 such database. The contracts entered into by the exchange shall not be
3867 subject to the approval of any other state department, office or agency,
3868 provided copies of all contracts of the exchange shall be maintained by
3869 the exchange as public records, subject to the proprietary rights of any

3870 party to the contract, except any agreement with the Office of [Health
3871 Strategy] Policy and Management shall be subject to approval by said
3872 office [and the Office of Policy and Management] and no portion of such
3873 agreement shall be considered proprietary;

3874 (14) To the extent permitted under its contract with other persons,
3875 consent to any termination, modification, forgiveness or other change of
3876 any term of any contractual right, payment, royalty, contract or
3877 agreement of any kind to which the exchange is a party;

3878 (15) Award grants to trained and certified individuals and
3879 institutions that will assist individuals, families and small employers
3880 and their employees in enrolling in appropriate coverage through the
3881 exchange. Applications for grants from the exchange shall be made on
3882 a form prescribed by the board;

3883 (16) Limit the number of plans offered, and use selective criteria in
3884 determining which plans to offer, through the exchange, provided
3885 individuals and employers have an adequate number and selection of
3886 choices;

3887 (17) Evaluate [jointly with the Health Care Cabinet established
3888 pursuant to section 19a-725] the feasibility of implementing a basic
3889 health program option as set forth in Section 1331 of the Affordable Care
3890 Act;

3891 Sec. 88. Subdivision (26) of section 38a-1084 of the general statutes is
3892 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3893 *2026*):

3894 (26) Consult with the Commissioner of Social Services, Insurance
3895 Commissioner and Office of [Health Strategy, established under section
3896 19a-754a] Policy and Management for the purposes set forth in section
3897 19a-754c, as amended by this act;

3898 Sec. 89. Subsection (d) of section 3-123ddd of the general statutes is
3899 repealed and the following is substituted in lieu thereof (*Effective July 1,*

3900 2026):

3901 (d) Nothing in sections 3-123aaa to 3-123hhh, inclusive, 19a-654, as
3902 amended by this act, [19a-725,] 19a-755a, as amended by this act, 38a-
3903 513f or 38a-513g shall diminish any right to retiree health insurance
3904 pursuant to a collective bargaining agreement or any other provision of
3905 the general statutes.

3906 Sec. 90. Subsection (b) of section 3-123hhh of the general statutes is
3907 repealed and the following is substituted in lieu thereof (*Effective July 1,*
3908 *2026*):

3909 (b) Nothing in this section or sections 3-123aaa to 3-123ggg, inclusive,
3910 19a-654, as amended by this act, [19a-725,] 19a-755a, as amended by this
3911 act, 38a-513f or 38a-513g shall modify the state employee plan in any
3912 way without the written consent of the State Employees Bargaining
3913 Agent Coalition and the Secretary of the Office of Policy and
3914 Management.

3915 Sec. 91. (NEW) (*Effective July 1, 2026*) (a) The Department of Public
3916 Health shall constitute a successor agency, in accordance with the
3917 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
3918 Office of Health Strategy with respect to all functions, powers and
3919 duties of the Office of Health Strategy concerning (1) the Health Systems
3920 Planning Unit established pursuant to section 19a-612 of the general
3921 statutes, as amended by this act, and (2) the certificate of need process
3922 set forth in sections 19a-638 to 19a-641, inclusive, of the general statutes,
3923 as amended by this act. Any order, decision, agreed settlement or
3924 regulation of the former Office of Health Strategy concerning any of the
3925 functions described in subdivisions (1) and (2) of this subsection that is
3926 in force on July 1, 2026, shall continue in force and effect as an order,
3927 decision, agreed settlement or regulation of the Department of Public
3928 Health until amended, repealed or superseded pursuant to law. Where
3929 any order, decision, agreed settlement or regulation of said department
3930 and said former office conflict, the Commissioner of Public Health may
3931 implement policies and procedures consistent with the provisions of

3932 chapters 368v and 368z of the general statutes while in the process of
3933 adopting the policies or procedures in regulation form, provided the
3934 commissioner shall publish notice of intention to adopt regulations on
3935 the Department of Public Health's Internet web site and the
3936 eRegulations System not later than twenty days after implementation of
3937 such policies and procedures. Any such policies or procedures shall be
3938 valid until such regulations are adopted.

3939 (b) If the words "Office of Health Strategy" or "Commissioner of
3940 Health Strategy" are used or referred to in any public or special act of
3941 2026, or in any section of the general statutes that is amended in 2026
3942 that concerns said office's or commissioner's functions with regard to (1)
3943 the Health Systems Planning Unit established pursuant to section 19a-
3944 612 of the general statutes, as amended by this act, or (2) the certificate
3945 of need process set forth in sections 19a-638 to 19a-641, inclusive, of the
3946 general statutes, as amended by this act, such words shall be deemed to
3947 mean or refer to the Department of Public Health or the Commissioner
3948 of Public Health, respectively.

3949 Sec. 92. (NEW) (*Effective July 1, 2026*) (a) The Office of Policy and
3950 Management shall constitute a successor agency, in accordance with the
3951 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
3952 Office of Health Strategy with respect to all functions, powers and
3953 duties of the Office of Health Strategy concerning (1) the State-wide
3954 Health Information Exchange, established pursuant to section 17b-59d
3955 of the general statutes, as amended by this act, (2) the all-payer claims
3956 database program, established pursuant to section 19a-755a of the
3957 general statutes, as amended by this act, and (3) the development,
3958 publication and modification of health care cost growth benchmarks
3959 and health care quality benchmarks required pursuant to sections 19a-
3960 754f to 19a-754k, inclusive, of the general statutes, as amended by this
3961 act. Any order, decision, agreed settlement or regulation of the former
3962 Office of Health Strategy concerning any of the functions described in
3963 subdivisions (1) to (3), inclusive, of this subsection that is in force on July
3964 1, 2026, shall continue in force and effect as an order, decision, agreed
3965 settlement or regulation of the Office of Policy and Management until

3966 amended, repealed or superseded pursuant to law. Where any order,
3967 decision, agreed settlement or regulation of said offices conflict, the
3968 Secretary of the Office of Policy and Management may implement
3969 policies and procedures consistent with the provisions of part III of
3970 chapter 319o and chapter 368ee of the general statutes while in the
3971 process of adopting the policies or procedures in regulation form,
3972 provided the secretary shall publish notice of intention to adopt
3973 regulations on the Office of Policy and Management's Internet web site
3974 and the eRegulations System not later than twenty days after
3975 implementation of such policies and procedures. Any such policy or
3976 procedure shall be valid until such regulations are adopted.

3977 (b) If the words "Office of Health Strategy" or "Commissioner of
3978 Health Strategy" are used or referred to in any public or special act of
3979 2026, or in any section of the general statutes that is amended in 2026
3980 that concerns said office's or commissioner's functions with regard to (1)
3981 the State-wide Health Information Exchange, established pursuant to
3982 section 17b-59d of the general statutes, as amended by this act, (2) the
3983 all-payer claims database program, established pursuant to section 19a-
3984 755a of the general statutes, as amended by this act, or (3) the
3985 development, publication and modification of health care cost growth
3986 benchmarks and health care quality benchmarks required pursuant to
3987 sections 19a-754f to 19a-754k, inclusive, of the general statutes, as
3988 amended by this act, such words shall be deemed to mean or refer to the
3989 Office of Policy and Management or the Secretary of the Office of Policy
3990 and Management, respectively.

3991 Sec. 93. (NEW) (*Effective July 1, 2026*) (a) The Department of Social
3992 Services shall constitute a successor agency, in accordance with the
3993 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
3994 Office of Health Strategy with respect to all functions, powers and
3995 duties of the Office of Health Strategy concerning hospital financial
3996 health reporting by hospitals pursuant to section 19a-486 of the general
3997 statutes, as amended by this act. Any order, decision, agreed settlement
3998 or regulation of the former Office of Health Strategy concerning such
3999 functions that is in force on July 1, 2026, shall continue in force and effect

4000 as an order, decision, agreed settlement or regulation of the Department
4001 of Social Services until amended, repealed or superseded pursuant to
4002 law. Where any order, decision, agreed settlement or regulation of said
4003 offices conflict, the Commissioner of Social Services may implement
4004 policies and procedures consistent with the provisions of part III of
4005 chapter 319o and chapter 368ee of the general statutes while in the
4006 process of adopting the policies or procedures in regulation form,
4007 provided the secretary shall publish notice of intention to adopt
4008 regulations on the Department of Social Services' Internet web site and
4009 the eRegulations System not later than twenty days after
4010 implementation of such policies and procedures. Any such policy or
4011 procedure shall be valid until such regulations are adopted.

4012 (b) If the words "Office of Health Strategy" or "Commissioner of
4013 Health Strategy" are used or referred to in any public or special act of
4014 2026, or in any section of the general statutes that is amended in 2026
4015 that concerns said office's or commissioner's functions with regard to
4016 hospital financial health reporting by hospitals pursuant to section 19a-
4017 486j of the general statutes, as amended by this act, such terms shall be
4018 deemed to mean or refer to the Department of Social Services or the
4019 Commissioner of Social Services, respectively.

4020 Sec. 94. (NEW) (*Effective July 1, 2026*) (a) The Office of the Healthcare
4021 Advocate shall constitute a successor agency, in accordance with the
4022 provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the
4023 Office of Health Strategy with respect to all functions, powers and
4024 duties of the Office of Health Strategy concerning community benefit
4025 program reporting by hospitals pursuant to section 19a-127k of the
4026 general statutes, as amended by this act. Any order, decision, agreed
4027 settlement or regulation of the former Office of Health Strategy
4028 concerning such functions that is in force on July 1, 2026, shall continue
4029 in force and effect as an order, decision, agreed settlement or regulation
4030 of the Office of the Healthcare Advocate until amended, repealed or
4031 superseded pursuant to law. Where any order, decision, agreed
4032 settlement or regulation of said offices conflict, the Office of the
4033 Healthcare Advocate may implement policies and procedures

4034 consistent with the provisions of part III of chapter 319o and chapter
4035 368ee of the general statutes while in the process of adopting the policies
4036 or procedures in regulation form, provided the secretary shall publish
4037 notice of intention to adopt regulations on the Office of the Healthcare
4038 Advocate's Internet web site and the eRegulations System not later than
4039 twenty days after implementation of such policies and procedures. Any
4040 such policy or procedure shall be valid until such regulations are
4041 adopted.

4042 (b) If the words "Office of Health Strategy" or "Commissioner of
4043 Health Strategy" are used or referred to in any public or special act of
4044 2026, or in any section of the general statutes that is amended in 2026
4045 that concerns said office's or commissioner's functions with regard to
4046 community benefit program reporting by hospitals pursuant to section
4047 19a-127k of the general statutes, as amended by this act, such terms shall
4048 be deemed to mean or refer to the Office of the Healthcare Advocate or
4049 the Healthcare Advocate, respectively.

4050 Sec. 95. Section 19a-2a of the 2026 supplement to the general statutes
4051 is repealed and the following is substituted in lieu thereof (*Effective July*
4052 *1, 2026*):

4053 The Commissioner of Public Health shall employ the most efficient
4054 and practical means for the prevention and suppression of disease and
4055 shall administer all laws under the jurisdiction of the Department of
4056 Public Health and the Public Health Code. The commissioner shall have
4057 responsibility for the overall operation and administration of the
4058 Department of Public Health. The commissioner shall have the power
4059 and duty to: (1) Administer, coordinate and direct the operation of the
4060 department; (2) adopt and enforce regulations, in accordance with
4061 chapter 54, as are necessary to carry out the purposes of the department
4062 as established by statute; (3) establish rules for the internal operation
4063 and administration of the department; (4) establish and develop
4064 programs and administer services to achieve the purposes of the
4065 department as established by statute; (5) enter into a contract, including,
4066 but not limited to, a contract with another state, for facilities, services

4067 and programs to implement the purposes of the department as
4068 established by statute; (6) designate a deputy commissioner or other
4069 employee of the department to sign any license, certificate or permit
4070 issued by said department; (7) conduct a hearing, issue subpoenas,
4071 administer oaths, compel testimony and render a final decision in any
4072 case when a hearing is required or authorized under the provisions of
4073 any statute dealing with the Department of Public Health; (8) with the
4074 health authorities of this and other states, secure information and data
4075 concerning the prevention and control of epidemics and conditions
4076 affecting or endangering the public health, and compile such
4077 information and statistics and shall disseminate among health
4078 authorities and the people of the state such information as may be of
4079 value to them; (9) annually issue a list of reportable diseases, emergency
4080 illnesses and health conditions and a list of reportable laboratory
4081 findings and amend such lists as the commissioner deems necessary and
4082 distribute such lists as well as any necessary forms to each licensed
4083 physician, licensed physician assistant, licensed advanced practice
4084 registered nurse and clinical laboratory in this state. The commissioner
4085 shall prepare printed forms for reports and returns, with such
4086 instructions as may be necessary, for the use of directors of health,
4087 boards of health and registrars of vital statistics; [and] (10) specify
4088 uniform methods of keeping statistical information by public and
4089 private agencies, organizations and individuals, including a client
4090 identifier system, and collect and make available relevant statistical
4091 information, including the number of persons treated, frequency of
4092 admission and readmission, and frequency and duration of treatment.
4093 The client identifier system shall be subject to the confidentiality
4094 requirements set forth in section 17a-688 and regulations adopted
4095 thereunder; and (11) direct and oversee the Health Systems Planning
4096 Unit, established under section 19a-612, as amended by this act, and all
4097 of its duties and responsibilities concerning the certificate of need
4098 process as set forth in chapter 368z. The commissioner may designate
4099 any person to perform any of the duties listed in subdivision (7) of this
4100 section. The commissioner shall have authority over directors of health
4101 and may, for cause, remove any such director; but any person claiming

4102 to be aggrieved by such removal may appeal to the Superior Court
4103 which may affirm or reverse the action of the commissioner as the public
4104 interest requires. The commissioner shall assist and advise local
4105 directors of health and district directors of health in the performance of
4106 their duties, and may require the enforcement of any law, regulation or
4107 ordinance relating to public health. In the event the commissioner
4108 reasonably suspects impropriety on the part of a local director of health
4109 or district director of health, or employee of such director, in the
4110 performance of his or her duties, the commissioner shall provide
4111 notification and any evidence of such impropriety to the appropriate
4112 governing authority of the municipal health authority, established
4113 pursuant to section 19a-200, or the district department of health,
4114 established pursuant to section 19a-244, for purposes of reviewing and
4115 assessing a director's or an employee's compliance with such duties.
4116 Such governing authority shall provide a written report of its findings
4117 from the review and assessment to the commissioner not later than
4118 ninety days after such review and assessment. When requested by local
4119 directors of health or district directors of health, the commissioner shall
4120 consult with them and investigate and advise concerning any condition
4121 affecting public health within their jurisdiction. The commissioner shall
4122 investigate nuisances and conditions affecting, or that he or she has
4123 reason to suspect may affect, the security of life and health in any
4124 locality and, for that purpose, the commissioner, or any person
4125 authorized by the commissioner, may enter and examine any ground,
4126 vehicle, apartment, building or place, and any person designated by the
4127 commissioner shall have the authority conferred by law upon
4128 constables. Whenever the commissioner determines that any provision
4129 of the general statutes or regulation of the Public Health Code is not
4130 being enforced effectively by a local health department or health district,
4131 he or she shall forthwith take such measures, including the performance
4132 of any act required of the local health department or health district, to
4133 ensure enforcement of such statute or regulation and shall inform the
4134 local health department or health district of such measures. In
4135 September of each year the commissioner shall certify to the Secretary
4136 of the Office of Policy and Management the population of each

4137 municipality. The commissioner may solicit and accept for use any gift
4138 of money or property made by will or otherwise, and any grant of or
4139 contract for money, services or property from the federal government,
4140 the state, any political subdivision thereof, any other state or any private
4141 source, and do all things necessary to cooperate with the federal
4142 government or any of its agencies in making an application for any grant
4143 or contract. The commissioner may enter into any contracts or
4144 agreements, in accordance with any established procedures, as may be
4145 necessary for the distribution or use of such money, services or property
4146 in accordance with any requirements to fulfill any conditions of a gift,
4147 grant or contract. The commissioner may establish state-wide and
4148 regional advisory councils. For purposes of this section, "employee of
4149 such director" means an employee of, a consultant employed or retained
4150 by or an independent contractor retained by a local director of health, a
4151 district director of health, a local health department or a health district.

4152 Sec. 96. Section 4-66 of the general statutes is repealed and the
4153 following is substituted in lieu thereof (*Effective July 1, 2026*):

4154 The Secretary of the Office of Policy and Management shall have the
4155 following functions and powers:

4156 (1) To keep on file information concerning the state's general
4157 accounts;

4158 (2) To furnish all accounting statements relating to the financial
4159 condition of the state as a whole, to the condition and operation of state
4160 funds, to appropriations, to reserves and to costs of operations;

4161 (3) To furnish such statements as and when they are required for
4162 administrative purposes and, at the end of each fiscal period, to prepare
4163 and publish such financial statements and data as will convey to the
4164 General Assembly the essential facts as to the financial condition, the
4165 revenues and expenditures and the costs of operations of the state
4166 government;

4167 (4) To furnish to the State Comptroller on or before the twentieth day

4168 of each month cumulative monthly statements of revenues and
4169 expenditures to the end of the last-completed month together with (A)
4170 a statement of estimated revenue by source to the end of the fiscal year,
4171 at least in the same detail as appears in the budget act, and (B) a
4172 statement of appropriation requirements of the state's General Fund to
4173 the end of the fiscal year itemized as far as practicable for each budgeted
4174 agency, including estimates of lapsing appropriations, unallocated
4175 lapsing balances and unallocated appropriation requirements;

4176 (5) To transmit to the Office of Fiscal Analysis a copy of monthly
4177 position data and monthly bond project run;

4178 (6) To inquire into the operation of, and make or recommend
4179 improvement in, the methods employed in the preparation of the
4180 budget and the procedure followed in determining whether the funds
4181 expended by the departments, boards, commissions and institutions
4182 supported in whole or in part by the state are wisely, judiciously and
4183 economically expended and to submit such findings and
4184 recommendations to the General Assembly at each regular session,
4185 together with drafts of proposed legislation, if any;

4186 (7) To examine each department, state college, state hospital, state-
4187 aided hospital, reformatory and prison and each other institution or
4188 other agency supported in whole or in part by the state, except public
4189 schools, for the purpose of determining the effectiveness of its policies,
4190 management, internal organization and operating procedures and the
4191 character, amount, quality and cost of the service rendered by each such
4192 department, institution or agency;

4193 (8) To recommend, and to assist any such department, institution or
4194 agency to effect, improvements in organization, management methods
4195 and procedures and to report its findings and recommendations and
4196 submit drafts of proposed legislation, if any, to the General Assembly at
4197 each regular session;

4198 (9) To consider and devise ways and means whereby comprehensive
4199 plans and designs to meet the needs of the several departments and

4200 institutions with respect to physical plant and equipment and whereby
4201 financial plans and programs for the capital expenditures involved may
4202 be made in advance and to make or assist in making such plans;

4203 (10) To devise and prescribe the form of operating reports that shall
4204 be periodically required from the several departments, boards,
4205 commissions, institutions and agencies supported in whole or in part by
4206 the state;

4207 (11) To require the several departments, boards, commissions,
4208 institutions and agencies to make such reports for such periods as said
4209 secretary may determine; [and]

4210 (12) To verify the correctness of, and to analyze, all such reports and
4211 to take such action as may be deemed necessary to remedy
4212 unsatisfactory conditions disclosed by such reports;

4213 (13) To (A) coordinate the state's health information technology
4214 initiatives, (B) seek funding for and oversee the planning,
4215 implementation and development of policies and procedures for the
4216 administration of the all-payer claims database program established
4217 under section 19a-775a, (C) establish and maintain a consumer health
4218 information Internet web site under section 19a-755b, as amended by
4219 this act, and (D) designate an unclassified individual from the office to
4220 perform the duties of a health information technology officer as set forth
4221 in sections 17b-59f and 17b-59g, as amended by this act; and

4222 (14) To (A) set an annual health care cost growth benchmark and
4223 primary care spending target pursuant to section 19a-754g, as amended
4224 by this act, (B) develop and adopt health care quality benchmarks
4225 pursuant to section 19a-754g, as amended by this act, (C) develop
4226 strategies, in consultation with stakeholders, to meet such benchmarks
4227 and targets developed pursuant to section 19a-754g, as amended by this
4228 act, (D) enhance the transparency of provider entities, as defined in
4229 subdivision (13) of section 19a-754f, as amended by this act, (E) monitor
4230 the development of accountable care organizations and patient-centered
4231 medical homes in the state, and (F) monitor the adoption of alternative

4232 payment methodologies in the state.

4233 Sec. 97. Subsection (a) of section 17b-3 of the general statutes is
4234 repealed and the following is substituted in lieu thereof (*Effective July 1,*
4235 *2026*):

4236 (a) The Commissioner of Social Services shall administer all law
4237 under the jurisdiction of the Department of Social Services. The
4238 commissioner shall have the power and duty to do the following: (1)
4239 Administer, coordinate and direct the operation of the department; (2)
4240 adopt and enforce such regulations, in accordance with chapter 54, as
4241 are necessary to implement the purposes of the department as
4242 established by statute; (3) establish rules for the internal operation and
4243 administration of the department; (4) establish and develop programs
4244 and administer services to achieve the purposes of the department as
4245 established by statute; (5) enter into a contract, including, but not limited
4246 to, up to five contracts with other states, for facilities, services and
4247 programs to implement the purposes of the department as established
4248 by statute; (6) process applications and requests for services promptly;
4249 (7) with the approval of the Comptroller and in accordance with such
4250 procedures as may be specified by the Comptroller, make payments to
4251 providers of services for individuals who are eligible for benefits from
4252 the department as appropriate; (8) make no duplicate awards for items
4253 of assistance once granted, except for replacement of lost or stolen
4254 checks on which payment has been stopped; (9) promote economic self-
4255 sufficiency where appropriate in the department's programs, policies,
4256 practices and staff interactions with recipients; (10) act as advocate for
4257 the need of more comprehensive and coordinated programs for persons
4258 served by the department; (11) plan services and programs for persons
4259 served by the department; (12) coordinate outreach activities by public
4260 and private agencies assisting persons served by the department; (13)
4261 consult and cooperate with area and private planning agencies; (14)
4262 advise and inform municipal officials and officials of social service
4263 agencies about social service programs and collect and disseminate
4264 information pertaining thereto, including information about federal,
4265 state, municipal and private assistance programs and services; (15)

4266 encourage and facilitate effective communication and coordination
4267 among federal, state, municipal and private agencies; (16) inquire into
4268 the utilization of state and federal government resources which offer
4269 solutions to problems of the delivery of social services; (17) conduct,
4270 encourage and maintain research and studies relating to social services
4271 development; (18) prepare, review and encourage model
4272 comprehensive social service programs; (19) maintain an inventory of
4273 data and information and act as a clearing house and referral agency for
4274 information on state and federal programs and services; [and] (20)
4275 conduct, encourage and maintain research and studies and advise
4276 municipal officials and officials of social service agencies about forms of
4277 intergovernmental cooperation and coordination between public and
4278 private agencies designed to advance social service programs; (21)
4279 develop an annual summary and analysis of community benefit
4280 reporting by hospitals pursuant to section 19a-127k, as amended by this
4281 act; and (22) receive reports from each hospital regarding its financial
4282 health pursuant to section 19a-486j, as amended by this act. The
4283 commissioner may require notice of the submission of all applications
4284 by municipalities, any agency thereof, and social service agencies, for
4285 federal and state financial assistance to carry out social services. The
4286 commissioner shall establish state-wide and regional advisory councils.

4287 Sec. 98. Subsection (a) of section 19a-7p of the general statutes is
4288 repealed and the following is substituted in lieu thereof (*Effective July 1,*
4289 *2026*):

4290 (a) Not later than September first, annually, the Secretary of the Office
4291 of Policy and Management, in consultation with the Commissioner of
4292 Public Health, shall (1) determine the amounts appropriated from the
4293 Insurance Fund for the Health Systems Planning Unit, established
4294 pursuant to section 19a-612, as amended by this act, syringe services
4295 program, AIDS services, breast and cervical cancer detection and
4296 treatment, x-ray screening and tuberculosis care, sexually transmitted
4297 disease control and children's health initiatives; and (2) inform the
4298 Insurance Commissioner of such amounts.

4299 Sec. 99. Section 38a-477jj of the general statutes is repealed and the
4300 following is substituted in lieu thereof (*Effective July 1, 2026*):

4301 (a) For the purposes of this section:

4302 (1) "Affordable Care Act" has the same meaning as provided in
4303 section 38a-1080;

4304 (2) "Exchange" has the same meaning as provided in section 38a-1080;

4305 (3) "Health benefit plan" has the same meaning as provided in section
4306 38a-1080, except that such term shall not include a grandfathered health
4307 plan as such term is used in the Affordable Care Act;

4308 (4) "Health carrier" has the same meaning as provided in section 38a-
4309 1080;

4310 (5) "Office of Health Strategy" means the Office of Health Strategy
4311 established under section 19a-754a; and

4312 (6) "Qualified health plan" has the same meaning as provided in
4313 section 38a-1080.

4314 (b) Notwithstanding any provision of the general statutes and except
4315 as provided in subsection (c) of this section, no health carrier offering a
4316 health benefit plan in this state on or after January 1, 2022, that includes
4317 a pharmacy benefit and uses a drug formulary or list of covered drugs
4318 may:

4319 (1) Remove a prescription drug from the drug formulary or list of
4320 covered drugs during a plan year; or

4321 (2) Move a prescription drug from a cost-sharing tier that imposes a
4322 lesser coinsurance, copayment or deductible for the prescription drug to
4323 a cost-sharing tier that imposes a greater coinsurance, copayment or
4324 deductible for the prescription drug during a plan year, unless the
4325 prescription drug is subject to an in-network coinsurance, copayment or
4326 deductible that is not greater than forty dollars per prescription per

4327 month in any tier.

4328 (c) A health carrier offering a health benefit plan in this state on or
4329 after January 1, 2022, that includes a pharmacy benefit and uses a drug
4330 formulary or list of covered drugs may:

4331 (1) Remove a prescription drug from the drug formulary or list of
4332 covered drugs, upon at least ninety days' advance notice to a covered
4333 person and the covered person's treating physician, if:

4334 (A) The federal Food and Drug Administration issues an
4335 announcement, guidance, notice, warning or statement concerning the
4336 prescription drug that calls into question the clinical safety of the
4337 prescription drug, unless the covered person's treating physician states,
4338 in writing, that the prescription drug remains medically necessary
4339 despite such announcement, guidance, notice, warning or statement; or

4340 (B) The prescription drug is approved by the federal Food and Drug
4341 Administration for use without a prescription; and

4342 (2) Move a brand-name prescription drug from a cost-sharing tier
4343 that imposes a lesser coinsurance, copayment or deductible for the
4344 brand-name prescription drug to a cost-sharing tier that imposes a
4345 greater coinsurance, copayment or deductible for the brand-name
4346 prescription drug if the health carrier adds to the drug formulary or list
4347 of covered drugs a generic prescription drug that is:

4348 (A) Approved by the federal Food and Drug Administration for use
4349 as an alternative to such brand-name prescription drug; and

4350 (B) In a cost-sharing tier that imposes a coinsurance, copayment or
4351 deductible for the generic prescription drug that is lesser than the
4352 coinsurance, copayment or deductible that is imposed for such brand-
4353 name prescription drug.

4354 (d) Nothing in this section shall prevent or prohibit a health carrier
4355 from adding a prescription drug to a formulary or list of covered drugs
4356 at any time.

4357 [(e) (1) The Office of Health Strategy shall, at least annually, conduct
4358 a study to determine the impact that the requirements established in
4359 subsections (a) to (d), inclusive, of this section have on the cost of health
4360 benefit plans offered, delivered, issued for delivery, renewed, amended
4361 or continued in this state and qualified health plans offered and sold
4362 through the exchange.

4363 (2) Not later than January 31, 2023, and annually thereafter, the Office
4364 of Health Strategy shall submit a report, in accordance with the
4365 provisions of section 11-4a, to the commissioner and the joint standing
4366 committee of the General Assembly having cognizance of matters
4367 relating to insurance. Such report shall disclose the results of the study
4368 conducted pursuant to subdivision (1) of this subsection for the
4369 preceding year.]

4370 Sec. 100. Sections 19a-754a and 19a-754e of the 2026 supplement to
4371 the general statutes are repealed. (Effective July 1, 2026)

4372 Sec. 101. Sections 19a-725 and 20-195sss of the general statutes are
4373 repealed. (Effective July 1, 2026)

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2026	New section
Sec. 2	from passage	29-1r(a)
Sec. 3	July 1, 2026	14-21cc(d)
Sec. 4	from passage	4-65a(a)
Sec. 5	July 1, 2026	7-74(b)
Sec. 6	July 1, 2026	46a-52
Sec. 7	July 1, 2026	1-84(d)
Sec. 8	July 1, 2026	1-84b(c)
Sec. 9	July 1, 2026	2-137(b)
Sec. 10	July 1, 2026	4-5
Sec. 11	July 1, 2026	4-101a(b)
Sec. 12	July 1, 2026	8-37vvv(b)
Sec. 13	July 1, 2026	10-222tt(c)(8)
Sec. 14	July 1, 2026	10-532(b) to (d)
Sec. 15	July 1, 2026	12-34h(b)

Sec. 16	July 1, 2026	12-263q(c)(1)(B)
Sec. 17	July 1, 2026	17b-59a
Sec. 18	July 1, 2026	17b-59d(d) to (g)
Sec. 19	July 1, 2026	17b-59e(f)
Sec. 20	July 1, 2026	17b-59f
Sec. 21	July 1, 2026	17b-59g(a) and (b)
Sec. 22	July 1, 2026	17b-312
Sec. 23	July 1, 2026	17b-337(c)
Sec. 24	July 1, 2026	17b-340(f)(3)
Sec. 25	July 1, 2026	17b-356
Sec. 26	July 1, 2026	19a-6q
Sec. 27	July 1, 2026	19a-7(b)
Sec. 28	July 1, 2026	19a-7h(l)
Sec. 29	July 1, 2026	19a-75a(a)
Sec. 30	July 1, 2026	19a-127k
Sec. 31	July 1, 2026	19a-486
Sec. 32	July 1, 2026	19a-486g
Sec. 33	July 1, 2026	19a-486h
Sec. 34	July 1, 2026	19a-486i(d) to (i)
Sec. 35	July 1, 2026	19a-486j
Sec. 36	July 1, 2026	19a-490ii(b)
Sec. 37	July 1, 2026	19a-493b(b) and (c)
Sec. 38	July 1, 2026	19a-507(a)
Sec. 39	July 1, 2026	19a-508c(d) to (m)
Sec. 40	July 1, 2026	19a-509b(c)
Sec. 41	July 1, 2026	19a-612
Sec. 42	July 1, 2026	19a-612d
Sec. 43	July 1, 2026	19a-613(c)
Sec. 44	July 1, 2026	19a-614
Sec. 45	July 1, 2026	19a-630
Sec. 46	July 1, 2026	19a-631(b)
Sec. 47	July 1, 2026	19a-632a
Sec. 48	July 1, 2026	19a-634(a)
Sec. 49	July 1, 2026	19a-638(d) and (e)
Sec. 50	July 1, 2026	19a-639(a)(1)
Sec. 51	July 1, 2026	19a-639a(a)
Sec. 52	July 1, 2026	19a-639a(h)
Sec. 53	July 1, 2026	19a-639b(e)
Sec. 54	July 1, 2026	19a-639c(b)
Sec. 55	July 1, 2026	19a-639e(d)

Sec. 56	July 1, 2026	19a-639f(a)
Sec. 57	July 1, 2026	19a-639f(l)
Sec. 58	July 1, 2026	19a-639g(a) and (b)
Sec. 59	July 1, 2026	19a-643
Sec. 60	July 1, 2026	19a-644(a) and (b)
Sec. 61	July 1, 2026	19a-645
Sec. 62	July 1, 2026	19a-646(a)(1)
Sec. 63	July 1, 2026	19a-653(a) to (d)
Sec. 64	July 1, 2026	19a-654(b) to (g)
Sec. 65	July 1, 2026	19a-659(1)
Sec. 66	July 1, 2026	19a-673a
Sec. 67	July 1, 2026	19a-681(c)
Sec. 68	July 1, 2026	19a-754b(b) to (f)
Sec. 69	July 1, 2026	19a-754c(a) to (c)
Sec. 70	July 1, 2026	19a-754d
Sec. 71	July 1, 2026	19a-754f
Sec. 72	July 1, 2026	19a-754g
Sec. 73	July 1, 2026	19a-754h
Sec. 74	July 1, 2026	19a-754i
Sec. 75	July 1, 2026	19a-754j
Sec. 76	July 1, 2026	19a-754k
Sec. 77	July 1, 2026	19a-755a
Sec. 78	July 1, 2026	19a-755b
Sec. 79	July 1, 2026	19a-911(b)
Sec. 80	July 1, 2026	20-195ttt(b) and (c)
Sec. 81	July 1, 2026	28-33(b)
Sec. 82	July 1, 2026	33-182bb(e) to (g)
Sec. 83	July 1, 2026	38a-47(a)(2) and (3)
Sec. 84	July 1, 2026	38a-48(b) to (f)
Sec. 85	July 1, 2026	38a-477e(a)
Sec. 86	July 1, 2026	38a-477ee(c)(2)
Sec. 87	July 1, 2026	38a-1083(c)(13) to (17)
Sec. 88	July 1, 2026	38a-1084(26)
Sec. 89	July 1, 2026	3-123ddd(d)
Sec. 90	July 1, 2026	3-123hhh(b)
Sec. 91	July 1, 2026	New section
Sec. 92	July 1, 2026	New section
Sec. 93	July 1, 2026	New section
Sec. 94	July 1, 2026	New section
Sec. 95	July 1, 2026	19a-2a

Sec. 96	July 1, 2026	4-66
Sec. 97	July 1, 2026	17b-3(a)
Sec. 98	July 1, 2026	19a-7p(a)
Sec. 99	July 1, 2026	38a-477jj
Sec. 100	July 1, 2026	Repealer section
Sec. 101	July 1, 2026	Repealer section

Statement of Legislative Commissioners:

In Sections 52(h), 53(e), 54(b), 55(d) and 57(l), "department's" was changed to "Department of Public Health's" for clarity, in Section 64(c), "regarding" was inserted before "such outpatient data" for clarity, in Section 64(c) and (d), "unit" was bracketed in several places and "department" was inserted after the closing bracket in each place for consistency, in Section 68(b), "Beginning on" was bracketed and "On and after" was inserted after the closing bracket for consistency with standard drafting conventions, and in Section 68(d)(4)(A), "department" was changed to "Department of Public Health" for clarity.

APP *Joint Favorable Subst.*