



July 2015

## Connecticut Enacts New Health Law Legislation

### **PUBLIC ACT 15-146: AN ACT CONCERNING HOSPITALS, INSURERS AND HEALTH CARE CONSUMERS**

On June 30, 2015, Connecticut Governor Dannel P. Malloy signed into law Public Act 15-146, "An Act Concerning Hospitals, Insurers and Health Care Consumers" (P.A. 15-146), which makes significant changes to the Certificate of Need (CON) approval process for hospital sales, places restrictions on facility fees, requires increased transparency regarding the price of medical care, establishes a statewide health information exchange, and makes several other important changes affecting health care providers. Below are highlights of P.A. 15-146.

#### **Certificate of Need Process for Transferring Hospital Ownership**

##### ***Effective July 1, 2015***

This legislation provides the Office of Health Care Access (OHCA) with increased authority when reviewing transactions that involve transferring ownership of a hospital. P.A. 15-146 defines "transfer of ownership of a hospital" as a transfer that affects or changes the governance or controlling body of a hospital and includes mergers, affiliations, or any sale or transfer of a hospital's net assets. The following new provisions enacted by P.A. 15-146 apply only to transfers of ownership of hospitals for which a CON application or CON determination letter is filed on or after December 1, 2015.

Under current law, the transfer of ownership of a health care facility, including a hospital, is subject to Connecticut's CON approval process. Existing law mandates that the Department of Public Health (DPH) deny a CON application involving the transfer of a nonprofit hospital to a for-profit entity unless, among other things, the affected community will continue to have access to high-quality, affordable health care following the transaction. This legislation requires OHCA to deny a CON application for the transfer of hospital ownership, whether to a for-profit or nonprofit entity, unless DPH finds that the affected community will have access to high-quality, affordable health care after the transaction. DPH must account for proposed changes that affect hospital staffing when making such determination.

When reviewing a CON application, this legislation requires OHCA to consider whether the hospital fairly contemplated alternative proposals and whether the parties have demonstrated how the new hospital will provide health care services for the first three years following the transaction. Furthermore, this legislation requires OHCA to hold a public hearing for all CON applications involving the transfer of hospital ownership.

Under existing law, DPH and the Connecticut attorney general (AG) may impose conditions on a transaction involving a for-profit entity's purchase of a nonprofit hospital. This legislation permits OHCA to

place additional conditions on the approval of a CON application involving a transfer of ownership of a hospital. OHCA must balance the purposes of the CON process against the cumulative burden of the conditions on the transaction. Each condition must be reasonable in time and scope. OHCA must provide an explanation for any condition it imposes on a CON approval. The transacting parties can petition OHCA to amend the conditions due to hardship, changed circumstances, or other good cause.

As part of the CON application process for transferring hospital ownership, the transaction parties must submit certain information to OHCA. This legislation requires the transaction parties to submit additional information to OHCA, including (1) a plan for how health care services will be provided at the new hospital for the first three years after the transaction; (2) the names of the parties' officers, directors, and senior managers; (3) whether such individuals will continue to work for the hospital after the transaction; and (4) whether such individuals will receive a financial gain as a result of the transaction.

### **Hospital Transfers Involving Large Hospitals, Health Systems, and For-Profit Entities**

#### ***Effective July 1, 2015***

P.A. 15-146 requires OHCA to retain an independent consultant to conduct a cost and market impact review related to CON applications that involve the transfer of hospital ownership where the purchaser is either (1) a for-profit entity or (2) a hospital or health system with a 2013 net patient revenue of greater than \$1.5 billion. The purchaser must pay for the independent consultant and may be charged up to \$200,000 per CON application. This legislation requires OHCA to review applicable information and documents regarding the transfer of ownership and to consider any factors that OHCA determines are in the public interest, which may include the parties' size, market share, pricing as compared to other hospitals in the parties' service areas, quality of services provided, and impact on existing providers in the area. OHCA is required to prepare a report of its findings. If the report shows that the transaction will result in an entity with a dominant market share that is likely to either charge higher prices than other health care providers in the market or have a materially higher health status adjusted total medical expense than other health care providers in the area, then OHCA must submit the report to the AG. The AG may then conduct an investigation and take appropriate actions to protect consumers, including an action under the Connecticut Antitrust Act or the Connecticut Unfair Trade Practices Act. The AG may use OHCA's report as evidence in such action.

Under this legislation, OHCA may deny a CON application involving the transfer of ownership of a hospital, subject to a cost and market impact review on finding that the community will not continue to receive high-quality, affordable health care and that any prospective increase in the cost of health care services or total health care spending in Connecticut is likely to have a negative impact on health care affordability.

This legislation also requires OHCA to hire an independent consultant to report to OHCA on post-transfer issues for three years following an approved transaction that was subject to a cost and market impact review. The purchaser must pay for the consultant in an amount determined by OHCA but no more than \$200,000 annually. As part of the consultant's reporting requirements, the consultant will meet with members of the affected community and have access to the purchaser's records and facilities.

### **Hospital Affiliations and Group Medical Practice Transactions**

#### ***Effective October 1, 2015***

Current law requires 30 days' prior notification to the AG if a "group practice" (consisting of two or more physicians) engages in a transaction that results in a material change to its business or corporate structure. The legislation expands this notification requirement to apply to any transaction that results in an "affiliation" between one hospital or health system and another hospital or health system. Under current law, affiliation is defined as the formation of a relationship between at least two entities that allows the entities to negotiate jointly with third parties for medical service rates. This legislation does not affect the definition of affiliation.

In addition to the notice requirement described above, this legislation requires each hospital and health

system to annually file with the AG and DPH a report describing each of its affiliations with another hospital or health system. The first annual report is due December 31, 2015. This legislation also imposes an additional requirement on group practice transactions, requiring the parties to a transaction resulting in a group practice material change to provide DPH notice within 30 days after the effective date of such transaction.

### **CON for Large Group Practice Sales**

#### ***Effective July 1, 2015***

Under current law, the transfer of ownership of a group practice of eight or more physicians requires a CON unless the transfer is to a physician or group of physicians. This legislation defines a group practice of eight or more physicians as a "large group practice." It also narrows the exemption from the CON requirement such that large group practices are exempt only if the transfer is to a physician or a group of two or more physicians legally organized in a partnership, professional corporation, or limited liability company, formed to render professional services, and not employed by or affiliated with a hospital, medical foundation, insurance company, or similar entity.

### **Limitations on and Notices of Facility Fees**

#### ***Effective October 1, 2015***

Under current law, hospitals and health systems that charge facility fees for outpatient services provided in a hospital-based facility must provide patients with certain notices regarding such fees. This legislation requires all billing statements that include a facility fee issued on or after January 1, 2016, to clearly identify the facility fee; provide the comparable Medicare facility fee reimbursement rate; state that the facility fee is intended to cover operational expenses; inform the patient that the financial liability may have been less if the facility was not owned by a hospital or health system; inform the patient of the right to request a reduction in any portion of the bill, including the facility fee; and provide the telephone number that the patient may call to request the reduction.

This legislation also imposes new requirements on hospital-based facilities formed through a hospital's acquisition of a group practice. Under this legislation, if any transaction between a hospital or health system and a group practice on or after January 1, 2016, results in the establishment of a hospital-based facility where facility fees will likely be billed, the hospital or health system is required to provide notice of the transaction to any patient served by the facility within the three years prior to the transaction. The notice must inform patients that the facility is now part of a hospital or health system; provide the name, address, and telephone number of the hospital or health system; state that the facility will, or is likely to, charge a facility fee; advise patients that they may be subject to higher fees for services received at the hospital-based facility than they would be subject to if the services were received at a facility that is not hospital-based; include an estimate of the amount or range of amounts of the applicable facility fee or provide an example of facility fees for common services; and advise patients to contact their insurer for additional information about such facility fees. Notice must be sent via first class mail within 30 days of the transaction. A copy of the notice must be filed with OHCA. This legislation requires OHCA to post a copy of the notice on its website. Under this legislation, it is an unfair trade practice for a hospital, health system, or hospital-based facility to collect a facility fee for services provided at a hospital-based facility until at least 30 days after the above-described patient notice is mailed or the date on which a copy of such notice is filed with OHCA, whichever is later.

This legislation requires each hospital and health system, beginning on July 1, 2016, and annually thereafter, to provide DPH with a report describing the facility fees that the hospital or health system charged over the prior year. The report must include the number of patient visits; the amount, range, and number of facility fees paid by Medicare, Medicaid, and private insurers; the revenue received from facility fees for each facility and in the aggregate; the ten procedures or services that generated the greatest amount of facility fee revenue; and the top ten procedures by patient volume for which facility fees are charged. DPH will publish the foregoing information on OHCA's website. For purposes of the above provision of this legislation, "facility" means a hospital-based facility that is not located on a hospital campus.

Furthermore, as of January 1, 2017, this legislation prohibits hospitals, health systems, or hospital-based facilities from collecting a facility fee (1) for outpatient services provided at an off-campus hospital-based facility, other than a hospital emergency department, that uses a current procedural terminology evaluation and management code or (2) from uninsured patients in excess of the Medicare rate for outpatient services, unless such services were provided in an emergency department not located on a hospital campus. Notwithstanding these new limitations, if a contract providing for payment of facility fees was in effect on July 1, 2016, between a health insurer and a hospital, health system, or hospital-based facility, then such provider may continue to collect reimbursement from health insurers until the expiration of such contract. It is an unfair trade practice for a hospital, health system, or hospital-based facility to collect a facility fee in violation of the above provisions.

Effective October 1, 2015, when an insured patient has not satisfied the deductible, this legislation prohibits hospitals, health systems, and hospital-based facilities from collecting more than the facility fee reimbursement rate agreed to by the particular insurer. Additionally, this legislation prohibits health insurers and similar entities that reimburse hospitals, health systems, and hospital-based facilities from charging a separate copayment for reimbursement of a facility fee related to outpatient services provided at a hospital-based facility that is not on a hospital's campus.

### **Surprise Billing**

#### ***Effective July 1, 2016***

Under P.A. 15-146, an insured patient who receives a "surprise bill" from a health insurer for an out-of-network service is only required to pay the coinsurance, deductible, or other out-of-pocket expense that would be required if the services were performed by an in-network provider. This legislation defines "surprise bill" as a bill for health care services that were provided by an out-of-network provider to an insured patient either at an in-network facility during a service or procedure performed by an in-network provider or that were previously approved by a health insurer, and the insured patient did not knowingly choose to receive such services from an out-of-network provider. The term "surprise bill" does not include emergency services or services that the patient knowingly elected to receive from an out-of-network provider and for which an in-network provider was available. In the event of a surprise bill, the health insurer must pay the health care provider at the in-network rate under the insured's plan unless the insurer and health care provider otherwise agree.

This legislation also addresses emergency services. It prohibits a health insurer from requiring prior authorization for emergency services. This legislation prohibits a health insurer from charging an insured patient a higher coinsurance, deductible, or other out-of-pocket amount for emergency services provided by an out-of-network provider than would be charged if the services were provided by an in-network provider. In the event that an out-of-network provider renders emergency services to an insured, this legislation requires the health insurer to reimburse such health care provider at the greater of (1) the in-network rate; (2) the usual, customary, and reasonable rate; or (3) the Medicare reimbursement rate. This legislation defines "usual, customary and reasonable rate" as the 80th percentile of all charges for the service provided in the same geographic region by a same or similar specialty, as determined by reference to a database designated by the insurance commissioner. This legislation does not prohibit the health care provider and health insurer from agreeing to a higher reimbursement amount.

### **Unfair Trade Practices**

#### ***Effective July 1, 2016***

Under current law, it is an unfair trade practice for a health care provider to request payment, other than a copayment or deductible, from a managed care enrollee for medical services covered under a managed care plan. This legislation revises the current law to permit health care providers to request coinsurance or other out-of-pocket expenses in addition to copayments and deductibles. It also makes it an unfair trade practice for a health care provider to request payment from a health plan enrollee (other than coinsurance, deductible, copayment, or out-of-pocket expense) for (1) a covered health care service or facility fee, (2) covered emergency services provided by an out-of-network provider, or (3) a surprise bill.

## **Consumer Health Information Website**

***Effective October 1, 2015***

This legislation requires the Connecticut Health Insurance Exchange (HIX) to establish, by July 1, 2016, a consumer health information website that contains information comparing the quality, price, and cost of health care services among health care providers in Connecticut. The HIX website must include price and cost information for the most common inpatient diagnoses and procedures, outpatient procedures, and surgical and imaging procedures based on a list published by the Department of Public Health (DPH) and the Insurance Department (DPH List). This information will be listed by health care provider and categorized by third-party payer. The HIX website must also include information to assist consumers in making informed health care decisions, such as what to consider when choosing a health care provider, as well as links to the Joint Commission and Medicare websites, where consumers can obtain information to compare the quality of health care providers. The information must be publicized in a language and format understandable to the average consumer. Notwithstanding the above, the legislation allows the HIX sole discretion on the manner and timeframe for posting information to the consumer health website.

Under this new legislation, as of January 1, 2017, hospitals will be required to inform a patient of the right to request cost and quality information at the time of scheduling a diagnosis or procedure for nonemergency care that is on the DPH List. If the patient requests such information regarding the diagnosis or procedure, a hospital must, within three business days, provide the patient information on (1) the amount the patient will be charged if uninsured, including the amount of a facility fee; (2) the Medicare reimbursement amount; (3) if the patient is insured, the allowed amount and the insurer's contact information so that the patient may obtain additional information regarding charges and out-of-pocket costs; (4) the hospital's Joint Commission composite accountability rating and Medicare star rating; and (5) the website addresses for the Joint Commission and Medicare hospital compare tool. If the patient is insured and the hospital is out-of-network under the insurance policy, the hospital's notice must also state that out-of-network rates may apply.

## **Notices to Patients**

***Effective October 1, 2015***

This new legislation requires health care providers to determine whether a patient is covered by a health insurance policy prior to any scheduled admission, procedure, or service for nonemergency care. If the patient is not insured or the health care provider is out-of-network, the provider must notify the patient in writing (1) of the charges for the admission, procedure, or service; (2) that the patient may be charged for additional, unforeseen services and will be responsible for payment for such services; and (3) if the health care provider is out-of-network, that out-of-network rates may apply. The notice must be written in a manner that is "understandable to an average reader." While the effective date of this legislation is October 1, 2015, the requirement to provide notice to patients does not take effect until January 1, 2016.

This legislation also requires health care providers to notify a patient whenever the health care provider refers a patient to an affiliated health care provider who is not a member of the same partnership, professional corporation, or limited liability company as the referring provider. Under the legislation, "affiliated" means a relationship between providers that allows them to negotiate rates with third parties jointly or as a member of the same group. The notice must disclose the affiliation and inform the patient of the right to receive care from a provider of his or her choosing and disclose that the patient is not required to see the affiliated provider. To obtain information about other in-network providers and a cost estimate for the particular service, the notice must also include the telephone number and website address of the patient's health insurer. The legislation exempts health care providers from this notice requirement if the provider gives patients a substantially similar notice under federal law, such as when complying with the in-office ancillary services exception to the federal Physician Self-Referral Law for certain advanced imaging services.

## **Statewide Health Information Exchange**

***Effective October 1, 2015***

This legislation contains several provisions to encourage the free exchange of patient health information among providers and consumers. Hospitals, health systems, and electronic health record (EHR) providers are prohibited from "health information blocking," and this legislation establishes that such action is an unfair trade practice. Health information blocking is defined as either knowingly (1) interfering or engaging in conduct reasonably likely to interfere with a patient's, health care provider's, or other authorized person's ability to access or use an EHR or (2) using an EHR to both steer patients to affiliated providers and prevent or unreasonably interfere with patient referrals to unaffiliated health care providers. This legislation excludes from the definition of health information blocking referrals between providers participating in an accountable care organization or other value-based care model.

P.A. 15-146 also establishes a statewide health information exchange operated by the Department of Social Services. The establishment of the exchange is subject to the authorization of bond funds by the Connecticut General Assembly and approval by Connecticut's Bond Commission. The goals of the exchange include securely allowing real-time access to patient health information across all provider settings, enabling patients to access their health information at no cost, providing real-time alerts and other tools in support of care coordination efforts, reducing costs associated with preventable readmissions, and promoting EHR interoperability. Within one year of the exchange's launch, hospitals and clinical laboratories must have an EHR capable of connecting to the exchange and must begin the process of participating in the exchange. Other health care providers with EHR systems able to connect to the exchange must begin the process of participation within two years of the exchange's launch.

This legislation also requires each hospital that has an EHR system capable of exchanging electronically patient health information to take all reasonable steps to enable the bidirectional and secure exchange of a patient's electronic health information to all other health care providers furnishing services to the patient that maintain EHR systems capable of exchanging such records. Such information exchange must include laboratory and diagnostic tests, radiological and other imaging results, continuity of care documents, and discharge documents. While this legislation requires each hospital to implement technology already purchased to accomplish this exchange of information, it does not require hospitals to purchase additional software or equipment. Under this legislation, a hospital's failure to take reasonable steps to comply with these requirements will be deemed evidence of health information blocking.

**Provider / Insurer Relationship**

***Effective October 1, 2015***

This legislation prohibits any contract entered into on or after January 1, 2016, between a health care provider and health insurer from containing a provision that prevents disclosure of billed or allowed amounts, reimbursement rates, out-of-pocket costs, or any other data provided to Connecticut's all-payer claims database program.

Beginning on October 1, 2015, health care providers must notify a health insurer within 30 days of the date the health care provider no longer accepts patients enrolled in the health insurer's insurance plans. This legislation also requires health insurers to update their health care provider directories at least monthly.

**Annual Reporting and Audited Financial Statements**

***Effective July 1, 2015***

Currently, short-term acute care general and children's hospitals must annually provide OHCA with the salaries and benefits paid to the 10 highest-paid hospital positions; the name of each partnership, joint venture, subsidiary, and other corporation related to the hospital; and the salaries paid to hospital employees by those entities. This legislation requires hospitals to report the above information for both hospitals and health systems. Existing law defines "health system" as a business entity comprising a

parent corporation of one or more licensed hospitals affiliated through governance, membership, or other means. This legislation also requires each hospital that was a party to a hospital transfer of ownership that received CON approval during the preceding year to include in its annual report a description of any salary, severance payment, or other financial gain realized by any officer, director, board member, or senior manager as a result of the transaction.

Under current law, each hospital other than a short-term acute care general or children's hospital must file an audited financial statement annually with OHCA. This legislation permits a health system to submit a single audited financial statement for all of its hospitals. As used in connection with this auditing requirement, health system refers to a business entity consisting of a parent corporation of one or more licensed hospitals and affiliated through governance, membership, or some other means or a hospital and any entity affiliated with such hospital through ownership, governance, membership, or other means.

### **CON Exemptions for Certain Scanners**

#### ***Effective July 1, 2015***

Currently, a CON is required for the purchase of any computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners, or positron emission tomography-computed tomography scanners unless such device will be used exclusively for research not involving humans. This legislation eliminates the CON requirement for the replacement of any of the above-listed scanners previously acquired pursuant to a CON approval or CON determination.

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