



**AN ACT ESTABLISHING A COMMISSION ON HEALTH CARE POLICY,  
COST CONTAINMENT AND PRICE VARIATION.**

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

1 Section 1. (NEW) (*Effective October 1, 2015*) (a) As used in this  
2 section:

3 (1) "Accountable care organization" or "ACO" means an  
4 organization of clinically integrated health care providers;

5 (2) "Health insurance carrier" means any insurer, health care center,  
6 hospital service corporation, medical service corporation or other  
7 entity delivering, issuing for delivery, renewing, amending or  
8 continuing any individual or group health insurance policy in this  
9 state providing coverage of the type specified in subdivisions (1), (2),  
10 (4), (11) and (12) of section 38a-469 of the general statutes;

11 (3) "Health care provider" means any person, corporation, facility or  
12 institution licensed by this state to provide health care services; and

13 (4) "Provider organization" means a corporation, partnership,  
14 business trust, association or organized group of persons that is in the  
15 business of health care delivery or management, whether or not  
16 incorporated, that represents one or more health care providers in  
17 contracting with health insurance carriers for the payments of health  
18 care services, including, but not limited to, a physician organization,

19 independent practice association, provider network or accountable  
20 care organization.

21 (b) There is established a Commission on Health Care Policy and  
22 Cost Containment, as an independent administrative commission that  
23 is not subject to the supervision or control of any other executive  
24 officer or agency. The commission shall be governed by a board of  
25 directors consisting of the following members:

26 (1) One appointed by the speaker of the House of Representatives  
27 who shall have demonstrated expertise in health care consumer  
28 advocacy;

29 (2) One appointed by the president pro tempore of the Senate who  
30 shall have demonstrated expertise in health care delivery or health  
31 care management at a senior level;

32 (3) One appointed by the majority leader of the House of  
33 Representatives who shall have expertise as an institutional purchaser  
34 of health insurance or health care services;

35 (4) One appointed by the majority leader of the Senate who shall  
36 have expertise in behavioral health and behavioral health  
37 reimbursement systems;

38 (5) One appointed by the minority leader of the House of  
39 Representatives who shall have demonstrated expertise in health plan  
40 administration and finance, including payment methodologies;

41 (6) One appointed by the minority leader of the Senate who shall  
42 have demonstrated expertise in the development and utilization of  
43 innovative medical technologies and treatments for patient care;

44 (7) One appointed by the House chairperson of the joint standing  
45 committee of the General Assembly having cognizance of matters  
46 relating to public health who shall be a primary care physician;

47 (8) One appointed by the Senate chairperson of the joint standing  
48 committee of the General Assembly having cognizance of matters  
49 relating to public health who shall have expertise in representing the  
50 health care workforce as a leader in a labor organization;

51 (9) One appointed by the House ranking member of the joint  
52 standing committee of the General Assembly having cognizance of  
53 matters relating to public health who shall be a health economist;

54 (10) One appointed by the Senate ranking member of the joint  
55 standing committee of the General Assembly having cognizance of  
56 matters relating to public health who shall have expertise as a  
57 purchaser of health insurance representing business management or  
58 health benefits administration;

59 (11) The commissioners of Public Health, Social Services and the  
60 Insurance Commissioner, or the commissioners' designees as ex-  
61 officio, nonvoting members; and

62 (12) The Healthcare Advocate, or the Healthcare Advocate's  
63 designee as an ex-officio, nonvoting member.

64 (c) (1) Initially, the members who have expertise in health care  
65 delivery or health care management at a senior level, behavioral health  
66 and behavioral health reimbursement systems and health plan  
67 administration and finance shall serve for five years and until their  
68 successors are appointed. The members who have demonstrated  
69 expertise in health care consumer advocacy, have demonstrated  
70 expertise in the development and utilization of innovative medical  
71 technologies and treatments for patient care, a primary care physician,  
72 have expertise in representing the health care workforce as a leader in  
73 a labor organization, a health economist, and have expertise as a  
74 purchaser of health insurance representing business management or  
75 health benefits administration shall serve for a term of three years and  
76 until their successors are appointed.

77 (2) All appointments to full terms subsequent to the initial

78 appointments shall be for three years. Vacancies shall be filled for the  
79 expiration of the term of the member being replaced in the same  
80 manner as original appointments. Members shall be eligible for  
81 reappointment under the same conditions as are applicable to initial  
82 appointments. The board shall elect annually one of its members as a  
83 chairperson and one as a vice chairperson. Members of the board shall  
84 receive no compensation but shall be reimbursed for their actual  
85 expenses incurred in service on the board. The board shall meet at least  
86 quarterly and more often as its duties require, upon the request of any  
87 two members and shall meet at least once each year with those persons  
88 and groups that are affected by board policies and procedures. A  
89 majority of the board members shall constitute a quorum. A majority  
90 vote of a quorum shall be required for any official action of the board.  
91 Any tie vote shall be decided by the chairperson of the board. The  
92 board shall adopt its own rules for the conduct of its meetings.

93 (d) The board shall appoint an executive director. The executive  
94 director shall not be required to obtain the approval of any other  
95 executive agency in connection with the appointment of employees  
96 and may establish personnel policies and regulations for the officers  
97 and employees of the commission. The executive director shall  
98 supervise the administrative affairs and general management and  
99 operations of the commission.

100 (e) The duties and responsibilities of the commission shall include:

101 (1) Setting health care cost growth goals for the state;

102 (2) Enhancing the transparency of provider organizations;

103 (3) Monitoring the development of ACOs and medical homes;

104 (4) Monitoring the adoption of alternative payment methodologies;

105 (5) Fostering innovative health care delivery and payment models  
106 that lower health care cost growth while improving the quality of  
107 patient care;

108 (6) Monitoring and reviewing the impact of changes within the  
109 health care marketplace;

110 (7) Protecting patient access to necessary health care services;

111 (8) Reviewing variation in prices and insurance reimbursement  
112 rates among health care providers, by payer and provider type, that  
113 shall include, but need not be limited to, (A) identifying factors  
114 contributing to such price and reimbursement variation, (B) assessing  
115 the impact of such variation on health care costs, insurance premiums,  
116 safety net providers and access to care, and (C) recommending policy  
117 changes to reduce provider price variations that are found to be  
118 unrelated to actual cost or quality differences or that unnecessarily  
119 contribute to health care cost inflation.

120 (9) Holding public hearings not less than annually to examine health  
121 care provider, provider organization and health insurance carrier  
122 costs, prices and cost trends with particular attention to factors that  
123 contribute to cost growth within the state's health care system;

124 (10) Establishing annual health care cost growth benchmarks for the  
125 average growth in total health care expenditures for the next calendar  
126 year and publishing such benchmarks on an Internet web site  
127 maintained by the commission;

128 (11) Establishing procedures to assist health care providers that  
129 exceed such health care cost growth benchmarks to improve efficiency  
130 and reduce cost growth, including procedures for such health care  
131 providers to implement performance improvement plans;

132 (12) Providing written notice to any health care provider that  
133 exceeds such health care cost growth benchmark and assisting each  
134 such health care entity with the implementation of a performance  
135 improvement plan;

136 (13) Developing and administering a registration program for health  
137 care providers and provider organizations that shall require each

138 health care provider and provider organization in the state to register  
139 under the program or be prohibited from negotiating a network  
140 contract with a health insurance carrier or third-party administrator;

141 (14) Requiring registered provider organizations to report such data  
142 as it considers necessary in order to better protect the public's interest  
143 in monitoring the financial conditions, organizational structure,  
144 business practices and market share of each registered provider  
145 organization;

146 (15) Reviewing and commenting on all capital expenditure projects  
147 requiring a certificate of need pursuant to chapter 368z of the general  
148 statutes;

149 (16) Collecting and analyzing such data as it considers necessary to  
150 monitor the financial conditions of acute care hospitals, including, but  
151 not limited to, (A) gross and net patient service revenues, (B) sources  
152 of hospital revenue, (C) trends in the availability and utilization of  
153 health care services provided by hospitals, nursing homes and  
154 outpatient clinics, (D) total payroll as a percentage of operating  
155 expenses and other salary and benefit information, and (E) other  
156 relevant measures of financial health or distress of health care facilities;

157 (17) Ensuring the uniform reporting of revenues, charges, costs,  
158 prices and utilization of health care services and other data as the  
159 commission may require to analyze changes in (A) health insurance  
160 premium levels, (B) benefits and cost-sharing in health insurance  
161 plans, (C) measures of health insurance plan cost and utilization, and  
162 (D) payment methods;

163 (18) Entering into such contractual agreements, in accordance with  
164 established procedures, as may be necessary to carry out the  
165 provisions of this section; and

166 (19) Taking any other action necessary to carry out the provisions of  
167 this section.

168 (f) (1) The board may request any (A) office, department, board,  
169 commission or other agency of the state, or (B) health care provider,  
170 health insurance carrier or provider organization to supply such  
171 reports, information and assistance as may be necessary or appropriate  
172 in order to carry out the commission's duties and responsibilities.

173 (2) The board shall consult with the Insurance Commissioner,  
174 Commissioner of Public Health and the Connecticut Insurance  
175 Exchange to avoid duplicative reporting requirements and to  
176 consolidate and simplify such requirements as appropriate.

177 (g) (1) Each health care provider and provider organization shall,  
178 before making any material change to its operations or governance  
179 structure submit written notice to the commission. Upon the  
180 commission's request, each health care provider and provider  
181 organization submitting such notice shall submit information  
182 concerning such change as is necessary, as determined in the  
183 commission's discretion, for the commission to determine whether  
184 such change is likely to result in a significant impact on the state's  
185 ability to meet the health care cost growth benchmarks established by  
186 the commission in accordance with subsection (e) of this section or on  
187 the competitive market.

188 (2) The commission shall conduct a cost and market impact review  
189 relating to such material change in operations or governance structure  
190 that shall include, but need not be limited to, consideration of the  
191 following: (A) Whether the health care provider or provider  
192 organization has a dominant market share for the services it provides;  
193 (B) whether the health care provider or provider organization charges  
194 prices for services that are materially higher than the median prices  
195 charged by other health care providers for the same services in the  
196 same market; (C) the quality of services offered by the health care  
197 provider or provider organization; (D) the availability and accessibility  
198 of services similar to those provided or proposed to be provided in the  
199 primary service areas; (E) the impact on competing options for the  
200 delivery of health care services in the primary service area; (F) the role

201 of the health care provider or provider organization in serving at-risk  
202 and underserved populations, including those receiving state medical  
203 assistance; and (G) any consumer concerns or complaints against the  
204 health care provider or provider organization.

205 (3) After completing a cost and market impact review, the  
206 commission shall issue a preliminary report. The health care provider  
207 or provider organization that is the subject of the report may, not later  
208 than thirty days after receiving such report, submit a written response  
209 to the commission on the findings contained in the report. After  
210 consideration of any response received from the health care provider  
211 or provider organization, the commission shall issue a final report and  
212 submit such report to the Attorney General for the Attorney General's  
213 consideration.

214 (h) The Attorney General may review and analyze information  
215 reported to the commission and may require that any health care  
216 provider, health insurance carrier or provider organization submit  
217 additional information or provide testimony under oath relating to  
218 health care costs, factors that contribute to cost growth within the  
219 state's health care system or the relationship between provider costs  
220 and health insurance premium rates.

221 (i) The commission may assess health care providers and health  
222 insurance carriers reasonable administrative fees to defray the costs of  
223 implementing the provisions of this section.

224 (j) On or before January 1, 2017, and annually thereafter, the board  
225 shall report, in accordance with section 11-4a of the general statutes, on  
226 the commission's activities to the joint standing committee of the  
227 General Assembly having cognizance of matters relating to public  
228 health. The report shall include, but need not be limited to: (1)  
229 Information on spending trends and underlying factors; (2)  
230 recommendations for strategies to increase the efficiency of the health  
231 care system; (3) recommendations to reduce provider price variation;  
232 (4) information concerning cost, price, quality, utilization and market

233 power in the state's health care system; (5) cost growth trends for care  
234 provided within and outside of accountable care organizations and  
235 patient-centered medical homes; (6) cost growth trends by health care  
236 provider sector, including, but not limited to, hospitals, hospital  
237 systems, non-acute health care providers, pharmaceuticals, medical  
238 devices and durable medical equipment; (7) factors that contribute to  
239 cost growth within the state's health care system and to the  
240 relationship between health care provider costs and health insurance  
241 premium rates; (8) the proportion of health care expenditures  
242 reimbursed under fee-for-service and alternative payment  
243 methodologies; (9) the impact of health care payment and delivery  
244 reform efforts on health care costs including, but not limited to, the  
245 development of limited and tiered networks, increased price  
246 transparency, increased utilization of electronic medical records and  
247 other health technology; (10) trends in utilization of unnecessary or  
248 duplicative services, with particular emphasis on imaging and other  
249 high-cost services; (11) the prevalence and trends in adoption of  
250 alternative payment methodologies and impact of alternative payment  
251 methodologies on overall health care spending, health insurance  
252 premiums and health care provider rates; (12) the development and  
253 status of health care provider organizations in the state including, but  
254 not limited to, acquisitions, mergers, consolidations and any evidence  
255 of excess consolidation or anti-competitive behavior by provider  
256 organizations; and (13) the impact of health care payment and delivery  
257 reform on the quality of health care services delivered in the state.

258 (k) The board may adopt regulations, in accordance with chapter 54  
259 of the general statutes, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2015	New section

**PH**      *Joint Favorable Subst. -LCO*

**GAE**      *Joint Favorable*