General Assembly

Amendment

January Session, 2021

LCO No. **10418**

Offered by:
SEN. KELLY, 21st Dist.
SEN. FORMICA, 20th Dist.
SEN. HWANG, 28th Dist.

To: Senate Bill No. **844** File No. 357 Cal. No. 229

"AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDATIONS REGARDING VALUE-ADDED PRODUCTS AND SERVICES AND PROHIBITED INSURANCE PRACTICES."

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1 After the last section, add the following and renumber sections and
2 internal references accordingly:

3 "Sec. 501. (NEW) (*Effective July 1, 2021*) For the purposes of this section
4 and sections 502 to 508, inclusive, of this act:

5 (1) "Device manufacturer" means a manufacturer that manufactures
6 a device for which annual sales in this state exceed ten million dollars;

7 (2) "Drug manufacturer" means the manufacturer of a drug that is:
8 (A) Included in information and data submitted by a health carrier
9 pursuant to section 38a-479qqq of the general statutes; (B) studied or
10 listed pursuant to subsection (c) or (d) of section 19a-754b of the general
11 statutes; or (C) in a therapeutic class of drugs that the executive director
12 determines, through public or private reports, has had a substantial
13 impact on prescription drug expenditures, net of rebates, as a
14 percentage of total health care expenditures;

15 (3) "Executive director" means the executive director of the office;

16 (4) "Health care cost growth benchmark" means the annual
17 benchmark established pursuant to section 502 of this act;

18 (5) "Health care entity" means an accountable care organization,
19 ambulatory surgical center, clinic, hospital or provider organization in
20 this state, other than a health care provider contracting unit that, for a
21 given calendar year: (A) Has a patient panel of not more than ten
22 thousand patients; or (B) represents health care providers who
23 collectively receive less than twenty million dollars in net patient service
24 revenue from health carriers;

25 (6) "Health care facility" has the same meaning as provided in section
26 19a-630 of the general statutes;

27 (7) "Health care quality benchmark" means an annual benchmark
28 established pursuant to section 507 of this act;

29 (8) "Health care provider" has the same meaning as provided in
30 section 19a-17b of the general statutes;

31 (9) "Health status adjusted total medical expenses" means: (A) The
32 total cost of care for the patient population of a provider organization
33 with at least thirty-six thousand member months for a given calendar
34 year, which cost (i) is calculated for such year on the basis of the allowed
35 claims for all categories of medical expenses and all nonclaims
36 payments for such year, including, but not limited to, cost-sharing
37 payments, adjusted by health status and expressed on a per member,
38 per month basis for all members in this state, (ii) is reported to the
39 executive director separately for Medicaid, Medicare and
40 nongovernment health plans for such year, and (iii) discloses the health
41 adjustment risk score and the version of the risk adjustment tool used to
42 calculate such score for such provider organization for such year; and
43 (B) the total aggregate medical expenses for all health care providers and
44 provider organizations with fewer than thirty-six thousand member
45 months for a given calendar year;

46 (10) "Hospital outpatient department" has the same meaning as such
47 term is used in 42 CFR 413.65, as amended from time to time;

48 (11) "Institutional provider" means any health care provider that
49 provides skilled nursing facility services, or acute, chronic or
50 rehabilitation hospital services, in this state;

51 (12) "Office" means the Office of Health Strategy established under
52 section 19a-754a of the general statutes, as amended by this act;

53 (13) "Other entity" means a device manufacturer, drug manufacturer
54 or pharmacy benefits manager;

55 (14) "Payer" means a payer that, during a given calendar year, pays
56 health care providers for health care services on behalf of, or pays
57 pharmacies for prescription drugs dispensed to, more than ten
58 thousand individuals in this state;

59 (15) "Pharmacy benefits manager" has the same meaning as provided
60 in section 38a-479ooo of the general statutes;

61 (16) "Primary care target" means the annual target established
62 pursuant to section 502 of this act;

63 (17) "Provider organization" means a group of persons, including, but
64 not limited to, an accountable care organization, association, business
65 trust, corporation, independent practice association, partnership,
66 physician organization, physician-hospital organization or provider
67 network, that is in the business of health care delivery or management
68 in this state and represents a health care provider in contracting with a
69 payer for payment for health care services; and

70 (18) "Total health care expenditures" means the per capita sum of all
71 health care expenditures in this state from public and private sources
72 for a given calendar year, including: (A) All categories of medical
73 expenses and all nonclaims payments to health care providers and
74 health care facilities, as included in the health status adjusted total
75 medical expenses reported, if any, by the executive director pursuant to

76 subsection (c) of section 504 of this act; (B) all patient cost-sharing
77 amounts, including, but not limited to, deductibles and copayments; (C)
78 the net cost of nongovernment health insurance; (D) prescription drug
79 expenditures net of rebates and discounts; (E) device manufacturer
80 expenditures net of rebates and discounts; and (F) any other
81 expenditures specified by the executive director.

82 Sec. 502. (NEW) (*Effective July 1, 2021*) (a) Not later than December 1,
83 2021, and annually thereafter, the executive director shall establish a
84 health care cost growth benchmark for the calendar year next
85 succeeding. Such health care cost growth benchmark shall address the
86 average growth in total health care expenditures across all payers and
87 populations in this state for such year, and the executive director shall
88 include within such health care cost growth benchmark a primary care
89 target to ensure primary care spending as a percentage of total health
90 care expenditures reaches a goal of ten per cent for the calendar year
91 beginning January 1, 2026.

92 (b) In establishing each health care cost growth benchmark pursuant
93 to subsection (a) of this section, the executive director shall, at a
94 minimum:

95 (1) Consider any change in the consumer price index for all urban
96 consumers in the northeast region from the preceding calendar year,
97 and the most recent publicly available information concerning the
98 growth rate of the gross state product;

99 (2) Evaluate current primary care spending as a percentage of total
100 health care expenditures; and

101 (3) (A) Hold an informational public hearing concerning such health
102 care cost growth benchmark:

103 (i) At a time and place designated by the executive director in a notice
104 prominently posted by the executive director on the office's Internet
105 web site;

106 (ii) In a form and manner prescribed by the executive director; and

107 (iii) On the basis of the most recent report, if any, prepared by the
108 executive director pursuant to subsection (c) of section 504 of this act,
109 and any other information that the executive director, in the executive
110 director's discretion, deems relevant for the purposes of such hearing.

111 (B) Notwithstanding subparagraph (A) of this subdivision, the
112 executive director shall not be required to hold an informational public
113 hearing concerning a health care cost growth benchmark for any
114 calendar year beginning on or after January 1, 2023, if such health care
115 cost growth benchmark is the same as the health care cost growth
116 benchmark for the preceding calendar year.

117 (c) If the executive director determines, after any informational public
118 hearing held pursuant to subdivision (3) of subsection (b) of this section,
119 that a modification to the health care cost growth benchmark is, in the
120 executive director's discretion, reasonably warranted, the executive
121 director may modify such health care cost growth benchmark. The
122 executive director need not hold an additional informational public
123 hearing concerning such modified health care cost growth benchmark.

124 (d) The executive director shall post each health care cost growth
125 benchmark on the office's Internet web site.

126 (e) The executive director may enter into such contractual agreements
127 as may be necessary to carry out the purposes of this section, including,
128 but not limited to, contractual agreements with actuarial, economic and
129 other experts and consultants to assist the executive director in
130 establishing health care cost growth benchmarks.

131 Sec. 503. (NEW) (*Effective July 1, 2021*) (a) (1) Not later than May 1,
132 2023, and annually thereafter, the executive director shall hold an
133 informational public hearing to compare the growth in total health care
134 expenditures during the preceding calendar year to the health care cost
135 growth benchmark established pursuant to section 502 of this act for
136 such year. Such hearing shall include an examination of:

137 (A) The report, if any, most recently prepared by the executive
138 director pursuant to subsection (c) of section 504 of this act;

139 (B) The expenditures of health care entities and payers, including, but
140 not limited to, health care cost trends, primary care spending as a
141 percentage of total health care expenditures, and the factors
142 contributing to such costs and expenditures;

143 (C) Whether one category of expenditures may be offset by savings
144 in another category of expenditures; and

145 (D) Any other matters that the executive director, in the executive
146 director's discretion, deems relevant for the purposes of this section.

147 (2) The executive director may require that any health care entity or
148 payer that is found to be a significant contributor to health care cost
149 growth in this state during the preceding calendar year participate in
150 such hearing. Each such health care entity or payer that is required to
151 participate in such hearing shall provide testimony on issues identified
152 by the executive director, and provide additional information on actions
153 taken to reduce such health care entity's contribution to future state-
154 wide health care costs and expenditures.

155 (b) Not later than October 1, 2023, and annually thereafter, the
156 executive director shall prepare and submit a report, in accordance with
157 section 11-4a of the general statutes, to the joint standing committees of
158 the General Assembly having cognizance of matters relating to
159 insurance and public health. Such report shall be based on the executive
160 director's analysis of the information submitted during the most recent
161 informational public hearing conducted pursuant to subsection (a) of
162 this section and any other information that the executive director, in the
163 executive director's discretion, deems relevant for the purposes of this
164 section, and shall:

165 (1) Describe health care spending trends in this state, including, but
166 not limited to, trends in primary care spending as a percentage of total
167 health care expenditures, and the factors underlying such trends; and

168 (2) Disclose the executive director's recommendations, if any,
169 concerning strategies to increase the efficiency of this state's health care
170 system, including, but not limited to, any recommended legislation
171 concerning this state's health care system.

172 Sec. 504. (NEW) (*Effective July 1, 2021*) (a) Not later than March 1, 2023,
173 and annually thereafter, each institutional provider, on behalf of such
174 institutional provider and its parent organization and affiliated entities,
175 health care provider that is not an institutional provider and provider
176 organization in this state, shall submit to the executive director, for the
177 preceding calendar year:

178 (1) Data concerning:

179 (A) The utilization of health care services provided by such provider
180 or organization;

181 (B) The charges, prices imposed and payments received by such
182 provider or organization for such services;

183 (C) The costs incurred, and revenues earned, by such provider or
184 organization in providing such services; and

185 (D) Any other matter that the executive director deems relevant for
186 the purposes of this section; and

187 (2) If such provider is a hospital, the data described in subdivision (1)
188 of this subsection, and such additional data, information and documents
189 designated by the executive director, including, but not limited to,
190 charge masters, cost data, audited financial statements and merged
191 billing and discharge data, provided such provider shall not be required
192 to submit any data contained in a report that is filed pursuant to
193 chapters 368aa to 368*ll*, inclusive, of the general statutes and available to
194 the executive director.

195 (b) The executive director shall establish standards to ensure that the
196 data, information and documents submitted to the executive director
197 pursuant to subsection (a) of this section are submitted to the executive

198 director in a uniform manner. Such standards shall enable the executive
199 director to identify, on a patient-centered and health care provider-
200 specific basis, state-wide and regional trends in the availability, cost,
201 price and utilization of medical, surgical, diagnostic and ancillary
202 services and prescription drugs provided by hospital outpatient
203 departments, acute care hospitals, chronic disease hospitals,
204 rehabilitation hospitals and other specialty hospitals, clinics, including,
205 but not limited to, psychiatric clinics, urgent care facilities and facilities
206 providing ambulatory care. Such standards may require hospitals to
207 submit such data, information and documents to the executive director
208 in an electronic form, provided such standards shall provide for a
209 waiver of such requirement if such waiver is reasonable in the judgment
210 of the executive director.

211 (c) (1) Not later than December 1, 2022, and annually thereafter, the
212 executive director shall prepare, to the extent practicable, and post on
213 the office's Internet web site, a report concerning health status adjusted
214 total medical expenses for the preceding calendar year, including, but
215 not limited to, a breakdown of such health status adjusted total medical
216 expenses by:

217 (A) Major service category;

218 (B) Payment methodology;

219 (C) Relative price;

220 (D) Direct hospital inpatient cost;

221 (E) Indirect hospital inpatient cost;

222 (F) Direct hospital outpatient cost;

223 (G) Indirect hospital outpatient cost; and

224 (H) Primary care spending as a percentage of total health care
225 expenditures.

226 (2) Notwithstanding subdivision (1) of this subsection, the executive
227 director shall not disclose any health care provider-specific data or
228 information unless the executive director provides at least ten days'
229 advance written notice of such disclosure to each health care provider
230 that would be affected by such disclosure.

231 (d) The executive director shall, at least annually, submit a request to
232 the federal Centers for Medicare and Medicaid Services for the health
233 status adjusted total medical expenses of provider organizations that
234 served Medicare patients during the calendar year next preceding.

235 (e) The executive director may enter into such contractual agreements
236 as may be necessary to carry out the purposes of this section, including,
237 but not limited to, contractual agreements with actuarial, economic and
238 other experts and consultants.

239 Sec. 505. (NEW) (*Effective July 1, 2021*) (a) (1) For each calendar year
240 beginning on or after January 1, 2023, if the executive director
241 determines that the average annual percentage change in total health
242 care expenditures for the preceding calendar year exceeded the health
243 care cost growth benchmark for such year, the executive director shall
244 identify, not later than May first of such calendar year, each health care
245 entity or payer that exceeded such health care cost growth benchmark
246 for such year.

247 (2) The executive director may require any health care entity or payer
248 that is found to be a significant contributor to health care cost growth in
249 this state during the preceding calendar year to participate in the
250 informational public hearing held pursuant to subsection (a) of section
251 503 of this act. Each such entity or payer that is required to participate
252 in such hearing shall provide testimony on issues identified by the
253 executive director, and provide additional information on actions taken
254 to reduce such entity's or payer's contribution to future state-wide
255 health care costs.

256 (b) Not later than thirty days after the executive director identifies
257 each health care entity or payer pursuant to subdivision (1) of subsection

258 (a) of this section, the executive director shall send a notice to each such
259 entity or payer. Such notice shall be in a form and manner prescribed by
260 the executive director, and disclose to each such entity or payer:

261 (1) That the executive director has identified such entity or payer
262 pursuant to subdivision (1) of subsection (a) of this section;

263 (2) The factual basis for the executive director's identification of such
264 entity or payer pursuant to subdivision (1) of subsection (a) of this
265 section; and

266 (3) That such entity or payer shall file a proposed performance
267 improvement plan pursuant to subdivision (1) of subsection (e) of this
268 section, provided such entity or payer may:

269 (A) File a request for an extension of time, or a waiver, pursuant to
270 subdivision (1) of subsection (c) of this section; and

271 (B) Request a hearing pursuant to subsection (d) of this section.

272 (c) (1) (A) Each health care entity or payer identified by the executive
273 director pursuant to subdivision (1) of subsection (a) of this section may,
274 not later than thirty days after the executive director sends a notice to
275 such entity or payer pursuant to subsection (b) of this section, file with
276 the executive director, in a form and manner prescribed by the executive
277 director, a request seeking:

278 (i) An extension of time to file a proposed performance improvement
279 plan pursuant to subdivision (1) of subsection (e) of this section; or

280 (ii) A waiver from the requirement that such entity or payer file a
281 proposed performance improvement plan pursuant to subdivision (1)
282 of subsection (e) of this section.

283 (B) Each health care entity or payer that files a request pursuant to
284 subparagraph (A) of this subdivision shall set forth in such request the
285 reasons for such request.

286 (2) Not later than thirty days after a health care entity or payer files a
287 request pursuant to subdivision (1) of this subsection, the executive
288 director shall:

289 (A) Examine the reasons set forth in the request and decide, on the
290 basis of such reasons, whether to approve or deny such request; and

291 (B) Send a notice, in a form and manner prescribed by the executive
292 director, to the entity or payer that filed such request disclosing, at a
293 minimum:

294 (i) The executive director's decision concerning such request and the
295 reasons therefor;

296 (ii) If the executive director denies such entity's or payer's request,
297 that such entity or payer may file a request for a hearing pursuant to
298 subsection (d) of this section; and

299 (iii) If such entity's or payer's request is a request for an extension of
300 time to file a proposed performance improvement plan pursuant to
301 subdivision (1) of subsection (e) of this section and the executive director
302 approves such request, the date by which such entity or payer shall file
303 such proposed performance improvement plan.

304 (d) Each health care entity or payer identified by the executive
305 director pursuant to subsection (a) of this section may, not later than
306 thirty days after the executive director sends a notice to such entity or
307 payer pursuant to subsection (b) of this section or subparagraph (B) of
308 subdivision (2) of subsection (c) of this section, as applicable, file with
309 the executive director a request for a hearing. Each hearing conducted
310 pursuant to this subsection shall be conducted in accordance with the
311 procedures for hearings on contested cases established in chapter 54 of
312 the general statutes.

313 (e) (1) Each health care entity or payer identified by the executive
314 director pursuant to subdivision (1) of subsection (a) of this section, or
315 required by the executive director pursuant to subparagraph (C)(ii)(III)

316 of subdivision (4) of subsection (f) of this section, shall, subject to the
317 provisions of subsections (b) to (d), inclusive, of this section, file with
318 the executive director a proposed performance improvement plan. Such
319 entity or payer shall file such proposed performance improvement plan,
320 which shall include an implementation timetable, with the executive
321 director, in a form and manner prescribed by the executive director, not
322 later than whichever of the following dates first occurs:

323 (A) The date that is thirty days after the date on which the executive
324 director sent a notice to such entity or payer pursuant to subsection (b)
325 of this section;

326 (B) The date that the executive director disclosed to such entity or
327 payer pursuant to subparagraph (B)(iii) of subdivision (2) of subsection
328 (c) of this section; or

329 (C) The date that is thirty days after the date on which the notice of a
330 final decision is issued following a hearing conducted pursuant to
331 subsection (d) of this section.

332 (2) (A) The executive director shall review each health care entity's
333 and payer's proposed performance improvement plan filed pursuant to
334 subdivision (1) of this subsection to determine whether, in the executive
335 director's judgment, it is reasonably likely that:

336 (i) Such proposed performance improvement plan will address the
337 cause of such entity's or payer's excessive cost growth; and

338 (ii) Such entity or payer will successfully implement such proposed
339 performance improvement plan.

340 (B) After the executive director reviews a proposed performance
341 improvement plan pursuant to subparagraph (A) of this subdivision,
342 the executive director shall:

343 (i) Approve such proposed performance improvement plan if the
344 executive director determines, in the executive director's judgment, that
345 such proposed plan satisfies the criteria established in subparagraph (A)

346 of this subdivision; or

347 (ii) Deny such proposed performance improvement plan if the
348 executive director determines, in the executive director's judgment, that
349 such proposed performance improvement plan does not satisfy the
350 criteria established in subparagraph (A) of this subdivision.

351 (C) (i) Not later than thirty days after the executive director approves
352 or denies a proposed performance improvement plan pursuant to
353 subparagraph (B) of this subdivision, the executive director shall send a
354 notice to the health care entity or payer that filed such proposed
355 performance improvement plan disclosing, at a minimum, that:

356 (I) The executive director approved such proposed performance
357 improvement plan; or

358 (II) The executive director denied such proposed performance
359 improvement plan, the reasons for such denial and that such entity or
360 payer shall file with the executive director such amendments as are
361 necessary for such proposed performance improvement plan to satisfy
362 the criteria established in subparagraph (A) of this subdivision.

363 (ii) The executive director shall post a notice on the office's Internet
364 web site disclosing:

365 (I) The name of each health care entity or payer that files, and receives
366 approval for, a proposed performance improvement plan; and

367 (II) That such health care entity or payer is implementing such
368 performance improvement plan.

369 (D) Each health care entity or payer that receives a notice from the
370 executive director pursuant to subparagraph (C)(i) of this subdivision
371 notifying such entity or payer that the executive director has denied
372 such entity's or payer's proposed performance improvement plan shall
373 file with the executive director, in a form and manner prescribed by the
374 executive director and not later than thirty days after the date that the
375 executive director sends such notice to such entity or payer, such

376 amendments as are necessary for such proposed performance
377 improvement plan to satisfy the criteria established in subparagraph (A)
378 of this subdivision.

379 (f) (1) Each health care entity or payer that receives a notice from the
380 executive director pursuant to subparagraph (C)(i) of subdivision (2) of
381 subsection (e) of this section notifying such entity or payer that the
382 executive director has approved such entity's or payer's proposed
383 performance improvement plan:

384 (A) Shall immediately make good faith efforts to implement such
385 performance improvement plan; and

386 (B) May amend such plan at any time during the implementation
387 timetable included in such performance improvement plan, provided
388 the executive director approves such amendment.

389 (2) The office may provide such assistance to each health care entity
390 or payer that the executive director, in the executive director's
391 discretion, deems necessary and appropriate to ensure that such entity
392 or payer successfully implements such entity's or payer's performance
393 improvement plan.

394 (3) Each health care entity or payer shall be subject to such additional
395 reporting requirements that the executive director, in the executive
396 director's discretion, deems necessary to ensure that such entity or payer
397 successfully implements such entity's or payer's performance
398 improvement plan.

399 (4) (A) Each health care entity or payer that files, and receives
400 approval for, a performance improvement plan pursuant to this section
401 shall, not later than thirty days after the last date specified in the
402 implementation timetable included in such performance improvement
403 plan, submit to the executive director, in a form and manner prescribed
404 by the executive director, a report regarding the outcome of such entity's
405 or payer's implementation of such performance improvement plan.

406 (B) If the executive director determines, on the basis of the report
407 submitted by a health care entity or payer pursuant to subparagraph (A)
408 of this subdivision, that such entity or payer successfully implemented
409 such entity's or payer's performance improvement plan, the executive
410 director shall:

411 (i) Send a notice to such entity or payer, in a form and manner
412 prescribed by the executive director, disclosing such determination; and

413 (ii) Remove from the office's Internet web site the notice concerning
414 such entity or payer that the executive director posted on such Internet
415 web site pursuant to subparagraph (C)(ii) of subdivision (2) of
416 subsection (e) of this section.

417 (C) If the executive director determines, on the basis of the report
418 submitted by a health care entity or payer pursuant to subparagraph (A)
419 of this subdivision, that such entity or payer failed to successfully
420 implement such entity's or payer's performance improvement plan, the
421 executive director shall:

422 (i) Send a notice to such entity or payer, in a form and manner
423 prescribed by the executive director, disclosing such determination and
424 any action taken by the executive director pursuant to subparagraph
425 (C)(ii) of this subdivision; and

426 (ii) In the executive director's discretion:

427 (I) Extend the implementation timetable included in such
428 performance improvement plan;

429 (II) Require such entity or payer to file with the executive director, in
430 a form and manner prescribed by the executive director, such
431 amendments to such performance improvement plan as are, in the
432 executive director's judgment, necessary to ensure that such entity or
433 payer successfully implements such performance improvement plan;

434 (III) Require such entity or payer to file a new proposed performance
435 improvement plan pursuant to subdivision (1) of subsection (e) of this

436 section; or

437 (IV) Waive or delay the requirement that such entity or payer file any
438 future proposed performance improvement plan until the executive
439 director determines, in the executive director's discretion, that such
440 entity or payer has successfully implemented its current performance
441 improvement plan.

442 (g) The executive director shall keep confidential all nonpublic
443 clinical, financial, operational or strategic documents and information
444 filed with, or submitted to, the executive director pursuant to this
445 section. The executive director shall not disclose any such document or
446 information to any person without the consent of the health care entity
447 or payer that filed such document or information with, or submitted
448 such document or information to, the executive director pursuant to this
449 section, except in summary form as part of an evaluative report if the
450 executive director determines that such disclosure should be made in
451 the public interest after taking into account any privacy, trade secret or
452 anti-competitive considerations. Notwithstanding any provision of the
453 general statutes, no document or information filed with, or submitted
454 to, the executive director pursuant to this section shall be deemed to be
455 a public record or subject to disclosure under the Freedom of
456 Information Act, as defined in section 1-200 of the general statutes.

457 Sec. 506. (NEW) (*Effective July 1, 2021*) (a) (1) For each calendar year
458 beginning on or after January 1, 2023, if the executive director
459 determines that the average annual percentage change in total health
460 care expenditures for the preceding calendar year exceeded the health
461 care cost growth benchmark for such year, the executive director shall
462 identify each other entity that significantly contributed to exceeding
463 such benchmark. Each identification shall be based on:

464 (A) The report, if any, prepared by the executive director pursuant to
465 subsection (c) of section 504 of this act for such calendar year;

466 (B) The report filed pursuant to section 38a-479ppp of the general
467 statutes for such calendar year;

468 (C) The information and data reported to the office pursuant to
469 section 19a-754b of the general statutes for such calendar year;

470 (D) Information obtained from the all-payer claims database
471 established under section 19a-755a of the general statutes; and

472 (E) Any other information that the executive director, in the executive
473 director's discretion, deems relevant for the purposes of this section.

474 (2) The executive director shall account for costs, net of rebates and
475 discounts, when identifying other entities pursuant to this section.

476 (b) The executive director may require that any other entity that is
477 found to be a significant contributor to health care cost growth in this
478 state during the preceding calendar year participate in the informational
479 public hearing held pursuant to subsection (a) of section 503 of this act.
480 Each such other entity that is required to participate in such hearing
481 shall provide testimony on issues identified by the executive director,
482 and provide additional information on actions taken to reduce such
483 other entity's contribution to future state-wide health care costs. If such
484 other entity is a drug manufacturer, and the executive director requires
485 that such drug manufacturer participate in such hearing with respect to
486 a specific drug or class of drugs, such hearing may, to the extent
487 possible, include representatives from at least one brand-name
488 manufacturer, one generic manufacturer and one innovator company
489 that is less than ten years old.

490 Sec. 507. (NEW) (*Effective July 1, 2021*) (a) (1) For each calendar year
491 beginning on or after January 1, 2023, the executive director shall
492 develop and adopt annual health care quality benchmarks for health
493 care entities and payers that:

494 (A) Enable health care entities and payers to report to the executive
495 director a standard set of information concerning health care quality for
496 such year; and

497 (B) Include measures concerning clinical health outcomes,

498 overutilization, underutilization and safety measures.

499 (2) In developing annual health care quality benchmarks pursuant to
500 subdivision (1) of this subsection, the executive director shall:

501 (A) Consider:

502 (i) Nationally recognized quality measures that are recommended by
503 medical groups or provider organizations concerning appropriate
504 quality measures for such groups' or organizations' specialties; and

505 (ii) Measures, including, but not limited to, newly developed
506 measures, that:

507 (I) Concern health outcomes, overutilization, underutilization and
508 patient safety; and

509 (II) Meet standards of patient-centeredness and ensure consideration
510 of important differences in preferences and clinical characteristics
511 within patient subpopulations;

512 (B) Provide stakeholders with an opportunity to engage with the
513 executive director in developing such benchmarks; and

514 (C) Ensure that the processes the executive director uses to develop,
515 and any research that the executive director relies upon in developing,
516 such benchmarks is transparent.

517 (b) Not later than October 1, 2022, and annually thereafter, the
518 executive director shall, prior to adopting health care quality
519 benchmarks pursuant to subdivision (1) of subsection (a) of this section
520 for the calendar year next succeeding, hold an informational public
521 hearing concerning the quality measures the executive director
522 proposes to adopt as health care quality benchmarks for the calendar
523 year next succeeding.

524 (c) Not later than November 1, 2022, and annually thereafter, the
525 executive director shall send a notice to each health care entity, payer

526 and other entity disclosing the health care quality benchmarks that the
527 executive director has adopted for the calendar year next succeeding.

528 Sec. 508. (NEW) (*Effective July 1, 2021*) The executive director may
529 adopt regulations, in accordance with chapter 54 of the general statutes,
530 to implement the provisions of sections 501 to 507, inclusive, of this act.

531 Sec. 509. (NEW) (*Effective from passage*) (a) For the purposes of this
532 section:

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

535 (2) "Exchange" means the Connecticut Health Insurance Exchange
536 established under section 38a-1081 of the general statutes, as amended
537 by this act; and

538 (3) "Office" means the Office of Health Strategy established under
539 section 19a-754a of the general statutes, as amended by this act.

540 (b) The office shall, in conjunction with the Office of Policy and
541 Management, the Insurance Department and the Health Reinsurance
542 Association created under section 38a-556 of the general statutes, seek a
543 state innovation waiver under Section 1332 of the Affordable Care Act
544 to establish a reinsurance program pursuant to subsection (d) of this
545 section.

546 (c) Subject to the approval of a waiver described in subsection (b) of
547 this section, the office, not later than September 1, 2022, for plan year
548 2023 and annually thereafter for the subsequent plan year, shall:

549 (1) Determine the amount needed, not to exceed twenty-one million
550 two hundred ten thousand dollars, annually, to fund the reinsurance
551 program established pursuant to subsection (d) of this section; and

552 (2) Inform the Office of Policy and Management of the amount
553 determined pursuant to subdivision (1) of this subsection.

554 (d) The amount described in subsection (c) of this section shall be
555 utilized to establish a reinsurance program for the individual health
556 insurance market designed to lower premiums on health benefit plans
557 sold in such market, on and off the exchange, provided the federal
558 government approves the waiver described in subsection (b) of this
559 section. Any such reinsurance program shall be administered by the
560 Health Reinsurance Association. The Treasurer shall annually pay the
561 amount as described in subsection (c) of this section for the purpose of
562 administering such reinsurance program.

563 (e) If the waiver described in subsection (b) of this section terminates
564 and the office does not obtain another waiver pursuant to subsection (a)
565 of this section, the Treasurer shall cease paying the amount described in
566 subsection (c) of this section for the purpose of administering the
567 reinsurance program established pursuant to subsection (d) of this
568 section."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	*July 1, 2021*	New section
Sec. 502	*July 1, 2021*	New section
Sec. 503	*July 1, 2021*	New section
Sec. 504	*July 1, 2021*	New section
Sec. 505	*July 1, 2021*	New section
Sec. 506	*July 1, 2021*	New section
Sec. 507	*July 1, 2021*	New section
Sec. 508	*July 1, 2021*	New section
Sec. 509	*from passage*	New section