# Senate

General Assembly

**File No. 362**

***February Session, 2022***

Substitute Senate Bill No. 416

*Senate, April 6, 2022*

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT PROMOTING COMPETITION IN CONTRACTS BETWEEN HEALTH CARRIERS AND HEALTH CARE PROVIDERS.***

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

Section 1. Section 38a-477g of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

(a) As used in this section:

(1) "All-or-nothing clause" means a provision in a health care contract that:

(A) Requires the health insurance carrier or health plan administrator to include all members of a health care provider in a network plan; or

(B) Requires the health insurance carrier or health plan administrator to enter into any additional contract with an affiliate of the health care provider as a condition to entering into a contract with such health care provider.

(2) "Anti-steering clause" means a provision of a health care contract that restricts the ability of the health insurance carrier or health plan administrator from encouraging an enrollee to obtain a health care service from a competitor of the hospital or health system, including offering incentives to encourage enrollees to utilize specific health care providers.

(3) "Anti-tiering clause" means a provision in a health care contract that:

(A) Restricts the ability of the health insurance carrier or health plan administrator to introduce and modify a tiered network plan or assign health care providers into tiers; or

(B) Requires the health insurance carrier or health plan administrator to place all members of a health care provider in the same tier of a tiered network plan.

**[**(1)**]** (4) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a. **[**, (2) "health care provider"**]**

(5) "Health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa. **[**, and (3) "intermediary"**]**

(6) "Health plan administrator" means a third-party administrator who acts on behalf of a plan sponsor to administer a health benefit plan.

(7) "Intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f.

(8) "Tiered network" has the same meaning as provided in section 38a-472f.

(b) (1) Each contract entered into, renewed or amended on or after January 1, 2017, between a health carrier and a participating provider shall include:

(A) A hold harmless provision that specifies protections for covered persons. Such provision shall include the following statement or a substantially similar statement: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.";

(B) A provision that in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in subdivision (2) of subsection (g) of section 38a-472f, or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including

any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled;

(C) (i) A provision that requires the participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons, and (ii) a statement that such participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records; and

(D) (i) If such contract is entered into, renewed or amended before July 1, 2022, definitions of what is considered timely notice and a material change for the purposes of subparagraph (A) of subdivision (2) of subsection (c) of this section, or (ii) if such contract is entered into, renewed or amended on or after July 1, 2022, (I) a statement disclosing the ninety-day advance written notice requirement established under subparagraph (B) of subdivision (2) of subsection (c) of this section and what is considered a material change for the purposes of subdivision (2) of subsection (c) of this section, and (II) provisions affording the participating provider a right to appeal any proposed change to the provisions, other documents, provider manuals or policies disclosed pursuant to subdivision (1) of subsection (c) of this section.

(2) The contract terms set forth in subparagraphs (A) and (B) of subdivision (1) of this subsection shall (A) be construed in favor of the covered person, (B) survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health carrier, and (C) supersede any oral or written agreement between a health care provider and a covered person or a covered person's authorized representative that is contrary to or inconsistent with the requirements set forth in subdivision (1) of this subsection.

(3) No contract subject to this subsection shall include any provision that conflicts with the provisions contained in the network plan or

required under this section, section 38a-472f or section 38a-477h.

(4) No health carrier or participating provider that is a party to a contract under this subsection shall assign or delegate any right or responsibility required under such contract without the prior written consent of the other party.

(c) (1) At the time a contract subject to subsection (b) of this section is signed, the health carrier or such health carrier's intermediary shall disclose to a participating provider:

(A) All provisions and other documents incorporated by reference in such contract; and

(B) If such contract is entered into, renewed or amended on or after July 1, 2022, all provider manuals and policies incorporated by reference in such contract, if any.

(2) While such contract is in force, the health carrier shall:

(A) If such contract is entered into, renewed or amended before July 1, 2022, timely notify a participating provider of any change to the provisions or other documents specified under subparagraph (A) of subdivision (1) of this subsection that will result in a material change to such contract; or

(B) If such contract is entered into, renewed or amended on or after July 1, 2022, provide to a participating provider at least ninety days' advance written notice of any change to the provisions or other documents specified under subparagraph (A) of subdivision (1) of this subsection, and any change to the provider manuals and policies specified under subparagraph (B) of subdivision (1) of this subsection, that will result in a material change to such contract or the procedures that a participating provider must follow pursuant to such contract.

(d) (1) (A) Each contract between a health carrier and an intermediary entered into, renewed or amended on or after January 1, 2017, shall satisfy the requirements of this subsection.

(B) Each intermediary and participating providers with whom such intermediary contracts shall comply with the applicable requirements of this subsection.

(2) No health carrier shall assign or delegate to an intermediary such health carrier's responsibilities to monitor the offering of covered benefits to covered persons. To the extent a health carrier assigns or delegates to an intermediary other responsibilities, such health carrier shall retain full responsibility for such intermediary's compliance with the requirements of this section.

(3) A health carrier shall have the right to approve or disapprove the participation status of a health care provider or facility in such health carrier's own or a contracted network that is subcontracted for the purpose of providing covered benefits to the health carrier's covered persons.

(4) A health carrier shall maintain at its principal place of business in this state copies of all intermediary subcontracts or ensure that such health carrier has access to all such subcontracts. Such health carrier shall have the right, upon twenty days' prior written notice, to make copies of any intermediary subcontracts to facilitate regulatory review.

(5) (A) Each intermediary shall, if applicable, (i) transmit to the health carrier documentation of health care services utilization and claims paid, and (ii) maintain at its principal place of business in this state, for a period of time prescribed by the commissioner, the books, records, financial information and documentation of health care services received by covered persons, in a manner that facilitates regulatory review, and shall allow the commissioner access to such books, records, financial information and documentation as necessary for the commissioner to determine compliance with this section and section 38a-472f.

(B) Each health carrier shall monitor the timeliness and appropriateness of payments made by its intermediary to participating providers and of health care services received by covered persons.

(6) In the event of the intermediary's insolvency, a health carrier shall have the right to require the assignment to the health carrier of the provisions of a participating provider's contract that address such participating provider's obligation to provide covered benefits. If a health carrier requires such assignment, such health carrier shall remain obligated to pay the participating provider for providing covered benefits under the same terms and conditions as the intermediary prior to the insolvency.

(e) The commissioner shall not act to arbitrate, mediate or settle (1) disputes regarding a health carrier's decision not to include a health care provider or facility in such health carrier's network or network plan, or (2) any other dispute between a health carrier, such health carrier's intermediary or one or more participating providers, that arises under or by reason of a participating provider contract or the termination of such contract.

(f) No health insurance carrier, health care provider, health plan administrator, or any agents or other entities that contract on behalf of a health care provider, health insurance carrier or health plan administrator may offer, solicit, request, amend, renew or enter into a health care contract that would directly or indirectly include any of the following provisions:

(1) An all-or-nothing clause;

(2) An anti-steering clause;

(3) An anti-tiering clause; or

(4) Any other clause that results or intends to result in anticompetitive effects as may be adopted by the commissioner, in accordance with chapter 54.

(g) Any contract, written policy, written procedure or agreement that contains a clause contrary to the provisions set forth in subsection (f) of this section shall be null and void. All remaining clauses of the contract shall remain in effect for the duration of the contract term.

(h) The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of subsection (f) of this section.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *January 1, 2023* | 38a-477g |

***Statement of Legislative Commissioners:***
Subsecs. (a)(1), (a)(2), (a)(3) and Subsecs. (f)(1), (f)(2) and (f)(3) were reorganized alphabetically to comply with standard drafting conventions; and in Subsec. (a)(3)(A), "from introducing or modifying" was changed to "to introduce and modify" for clarity.

***INS*** *Joint Favorable Subst. -LCO*

*The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.*

## *OFA Fiscal Note*

### *State Impact:*

| Agency Affected | Fund-Effect | FY 23 $ | FY 24 $ |
|---|---|---|---|
| Insurance Dept. | IF - Potential Cost | At least 81,704 | At least 163,407 |
| Insurance Dept. | GF - Potential Revenue Gain | Minimal | Minimal |

Note: IF=Insurance Fund; GF=General Fund

### *Municipal Impact:*

| Municipalities | Effect | FY 23 $ | FY 24 $ |
|---|---|---|---|
| Various Municipalities | Uncertain | Potential | Potential |

### *Explanation*

The bill prohibits health insurance carriers, health care providers, health plan administrators, and the agents of those entities from including certain provisions in their health care contracts and results in the fiscal impacts described below.

The bill authorizes the Insurance Commissioner to adopt regulations, including regulations that specify additional prohibited clauses with anti-competitive effects. In the event the Insurance Department (DOI) develops such regulations, the agency is anticipated to incur consultant costs of up to $25,000 because the agency lacks expertise in provider contracting arrangements.

DOI does not currently review contracts between health carriers and providers (or health plan administrators and providers), and the bill does not specify any enforcement requirements. To the extent DOI

begins reviewing such contracts for compliance in the agency's normal course of business, the agency is anticipated to require one or more additional staff with expertise in provider contracting. The annualized cost of one insurance associate examiner would be $163,407 ($81,814 salary and $81,593 fringe benefits). FY 23 would reflect half-year costs. Depending on the number of related complaints and violations, enforcement of the bill's provisions may result in 1) costs for outside legal services associated with more formal hearings and 2) a minimal revenue gain to the General Fund from fines of up to $15,000 each.

The bill may result in changes in health care costs or premiums to fully insured municipal health plans to the extent that plans contain contract limitations contained in the bill. Any changes in premium costs will occur when municipalities enter new health insurance contracts after January 1, 2023.

The bill does not result in a fiscal impact to the University of Connecticut Health Center because none of the health center's contracts include the provisions that are prohibited by the bill.

### *The Out Years*

The annualized ongoing fiscal impact identified above would continue into the future subject to the bill's impact on health care costs for municipalities, changes in costs for wages and fringe benefits for any additional staff, the number of DOI hearings related to the prohibited contract clauses, and the fines assessed.

*Sources: Connecticut Insurance Department*

**OLR Bill Analysis**

**sSB 416**

***AN ACT PROMOTING COMPETITION IN CONTRACTS BETWEEN HEALTH CARRIERS AND HEALTH CARE PROVIDERS.***

## SUMMARY

This bill prohibits certain anticompetitive provisions in health care contracts. It also authorizes the insurance commissioner to adopt implementing regulations.

Specifically, the bill prohibits health insurance carriers, health care providers, and health plan administrators (i.e., third-party administrators or TPAs), or their agents or other entities acting on their behalf, from offering, soliciting, requesting, amending, renewing, or entering into a health care contract that includes, directly or indirectly, (1) all-or-nothing, anti-steering, or anti-tiering clauses or (2) any other anticompetitive clause the commissioner adopts in accordance with the Uniform Administrative Procedure Act (i.e., in regulations).

Under the bill, any contract, procedure, or agreement with one of these clauses is null and void, except other clauses of a contract remain in effect for the duration of the contract term.

By law, anyone violating a provision of Title 38a of the general statutes for which no other penalty is provided is subject to a fine of up to $15,000 (CGS § 38a-2).

EFFECTIVE DATE: January 1, 2023

## DEFINITIONS

### *All-Or-Nothing Clause*

Under the bill, an "all-or-nothing clause" is a health care contract provision that requires health insurance carriers or TPAs to (1) include

all members of a health care provider in a network plan or (2) contract with the provider's affiliate as a condition of entering into the contract.

### *Anti-Steering Clause*

An "anti-steering clause" is a health care contract provision that limits the health insurance carrier's or TPA's ability to encourage enrollees to obtain health care from a hospital's or health system's competitor, including offering incentives that encourage enrollees to use specific providers.

### *Anti-Tiering Clause*

The bill defines an "anti-tiering clause" as a health care contract provision that (1) restricts the health insurance carrier's or TPA's ability to introduce or modify a tiered network plan or assign providers into tiers or (2) requires the carrier or TPA to place all members of a provider in the same tier of a tiered network plan.

By law, a "tiered network" is a network that places some or all types of health care providers and facilities into specific groups to which different participating provider reimbursement, access requirements, or cost sharing apply for the same health care services (CGS § 38a-472f).

## COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 17 Nay 0 (03/22/2022)