**OLR Bill Analysis**

**sHB 5042 (as amended by House "A")***

***AN ACT CONCERNING HEALTH CARE COST GROWTH.***

## SUMMARY

This bill expands the Office of Health Strategy's (OHS) duties to include, among other things, setting annual health care cost growth benchmarks, health care quality benchmarks, and primary care spending targets. (In doing so, it codifies several provisions of Executive Order 5.) When developing these benchmarks and spending targets, the executive director may hold informational public hearings and consider certain specified information.

Under the bill, the executive director must publish annual reports on the total health care expenditures in Connecticut and the health care quality benchmarks, including how payers (e.g., insurers) and provider entities (e.g., physician groups) meet or exceed these metrics. The bill correspondingly requires payers and provider entities to provide the executive director with specified health care cost and quality data. She must annually report on these issues to the Insurance and Public Health committees.

Additionally, the bill requires the executive director to identify (1) payers and provider entities who exceed the health care cost growth and quality benchmarks or fail to meet the primary care spending target and (2) any other entities (e.g., drug manufacturers) that significantly contribute to health care cost growth. The bill allows the executive director to require these payers, providers, and entities to participate in a public hearing and discuss, among other topics, ways to reduce their contribution to future health costs.

The bill also allows the executive director to adopt implementing regulations to carry out the bill's provisions and OHS's existing statutory obligations (§ 7). Finally, it makes minor and conforming

changes.

Separately, the bill requires health carriers (e.g., insurers and HMOs) that deliver, issue, renew, amend, or continue certain individual and group health insurance policies in the state to develop at least two health enhancement programs (HEPs) under the policies by January 1, 2024. Under the bill, an HEP is a health benefit program that ensures access and removes barriers to essential, high-value clinical services. The bill authorizes the insurance commissioner to adopt related implementing regulations.

Additionally, the bill addresses matters concerning the state's certificate of need (CON) program, which OHS administers. Under the CON law, health care institutions (e.g., hospitals, freestanding emergency departments, outpatient surgical facilities) must generally receive state approval when establishing new facilities or services, changing ownership, acquiring certain equipment, or terminating services. The bill increases the nonrefundable CON application fee from $500 to a range of $1,000 to $10,000 depending on the proposed project's cost. Also, for purposes of applying the CON requirements, the bill defines "termination of services" to mean ending services for more than 180 days (§ 10).

Lastly, the bill makes technical changes, including to ensure that the OHS executive director remains a department head as of July 1, 2022 (§ 11).

*House Amendment "A" (1) requires, rather than allows, the OHS executive director to hold certain hearings related to benchmarks and spending targets; (2) requires she meet with certain entities before identifying them as missing these benchmarks or exceeding the spending targets; (3) makes several minor changes to the benchmark and spending target provisions, including to the type of information certain annual reports to the legislature must contain; and (4) adds the HEP and CON provisions.

EFFECTIVE DATE: Upon passage, except the HEP provisions are effective January 1, 2023, and a technical change is effective July 1, 2022.

## § 2 — DEFINITIONS

Under the bill, "total medical expense" is the total cost of care for a payer or provider entity's patient population in a calendar year, calculated as the sum of (1) all claims-based spending paid to providers by public and private payers, net of pharmacy rebates; (2) all nonclaims payments, including incentive and care coordination payments; and (3) all per-capita patient cost-sharing amounts.

A "provider entity" is an organized group of clinicians that (1) come together for contracting purposes or (2) is an established billing unit with enough attributed lives (i.e., patients), collectively, to participate in total cost of care contracts during any given calendar year, even if it is not participating in these contracts. At a minimum, a provider entity must include primary care providers. (The specific number of attributed lives required to participate in a total cost of care contract is unclear under the bill.)

A "payer" is a government (e.g., Medicaid and Medicare) or non-government health plan, and any of their affiliates, subsidiaries, or businesses acting as a payer that, during any calendar year, pays (1) health care providers for health care services or (2) pharmacies or private entities for prescription drugs that the OHS executive director designates.

"Total healthcare expenditures" are the sum of all health care expenditures in Connecticut from public and private sources for a given calendar year, including all claims-based spending paid to providers, net of pharmacy rebates; all patient cost-sharing amounts; and the net cost of private health insurance.

"Net cost of private health insurance" is the difference between premiums earned and benefits incurred, including the insurers' cost of paying bills; advertising; sales commissions and other administrative costs; net additions or subtractions from reserves; rate credits and dividends; premium taxes; and profits or losses.

## § 1 — OHS DUTIES

The bill adds the following to OHS's duties:

1. setting an annual health care cost growth benchmark and primary care spending target, as described below;

2. developing and adopting health care quality benchmarks, as described below;

3. developing strategies, in consultation with stakeholders, to meet these benchmarks and targets;

4. enhancing the transparency of provider entities; and

5. monitoring the (a) development of accountable care organizations and patient-centered medical homes and (b) adoption of alternative payment methodologies in Connecticut.

## § 3 — ANNUAL HEALTH CARE BENCHMARKS AND SPENDING TARGETS

By July 1, 2022, the OHS executive director must publish on the office's website the following:

1. health care cost growth benchmarks and annual primary care spending targets as a percentage of total medical expenses for calendar years 2021 through 2025, and

2. annual health care quality benchmarks for calendar years 2022 through 2025.

She must also publish on the website each adopted health care cost growth benchmark and annual primary care spending target.

The director must develop, adopt, and post on the office's website by July 1, 2025, and every five years after, the following:

1. annual health care cost growth benchmarks and annual primary care spending targets for the next five calendar years for provider entities and payers and

2. annual health care quality benchmarks for the next five calendar years.

### *Developing Health Care Benchmarks and Spending Targets*

In developing the health care cost growth benchmarks and primary care spending targets, the bill requires the executive director to consider (1) any historical and forecasted changes in median income for residents and the potential gross state product growth rate; (2) the inflation rate; and (3) the most recent annual health care expenditure report required under the bill (see § 4).

For health care quality benchmarks, the executive director must consider the following:

1. quality measures endorsed by nationally recognized organizations, including the National Quality Forum, the National Committee for Quality Assurance, the federal Centers for Medicare and Medicaid Services and Centers for Disease Control and Prevention, the Joint Commission, and other expert organizations that develop health quality measures;

2. measures about health outcomes, overutilization, underutilization, patient safety, and community or population health; and

3. measures that meet standards of patient-centeredness and ensure consideration of differences in preferences and clinical characteristics within patient subpopulations.

### *Public Hearings and Modifying Benchmarks or Targets*

The bill requires the executive director to hold at least one informational public hearing before adopting the health care benchmarks and spending targets. It also authorizes her to hold additional informational hearings on (1) health care cost growth benchmarks and primary care spending targets after they have been set and (2) the quality measures she proposes as health care quality benchmarks. The hearings must be held at a time and place she designates, and a notice must be prominently posted on the OHS

website and in a form and manner she prescribes.

Under the bill, the executive director may modify any benchmark or spending target if she determines, after a hearing, that doing so is reasonably warranted.

The bill requires the executive director to annually review the current and projected inflation rates and post her findings on OHS's website, including her reasons for changing or maintaining a benchmark. For modifications to health care cost growth benchmarks, an additional hearing is not required if the modifications are due to inflation rates.

The executive director must post a summary of any informational public hearing she holds on these benchmarks and targets on OHS's website, including her decision to modify them if applicable.

### *Authority to Contract*

The bill allows the executive director to enter into necessary contractual agreements with actuarial, economic, and other experts and consultants to develop, adopt, and publish these health care benchmarks and spending targets.

## § 4 — ANNUAL REPORTING REQUIREMENTS

### *Payer Reports*

Beginning by August 15, 2022, the bill requires each payer to report aggregated data annually to the OHS executive director, including aggregated, self-funded data necessary for her to calculate (1) total health care expenditures; (2) primary care spending as a percentage of total medical expenses; and (3) net cost of private health insurance. Payers must also disclose, upon request, payer data required for OHS to adjust total medical expense calculations to reflect patient population changes.

Additionally, the bill requires payers and provider entities, starting by August 15, 2023, to report annually to the executive director on the health care quality benchmarks she adopts.

Payers and provider entities must report the data described above in

a form and manner the executive director prescribes for the preceding or prior years, upon her request, based on material changes to data previously submitted.

### *Annual OHS Health Care Expenditure Report*

Beginning by March 31, 2023, the OHS executive director must annually prepare and post on the office website a report on total health care expenditures. The report must use the total aggregate medical expenses that payers report, including a breakdown of population-adjusted total medical expenses by payer and provider entities. It may also include information on the following:

1. trends in major service category spending;
2. primary care spending as a percentage of total medical expenses;
3. the net cost of health insurance by payer by market segment, including individual, small group, large group, self-insured, student, and Medicare Advantage markets; and
4. any other factors the executive director deems relevant to providing context, which must include the impact of inflation and medical inflation, the impacts on access to care, and responses to public health crises or similar emergencies.

The bill also requires the executive director to annually request the unadjusted total medical expenses for Connecticut residents from the federal Centers for Medicare and Medicaid Services.

### *Annual OHS Health Care Quality Benchmark Report*

The bill requires the executive director, by March 31, 2024, to annually prepare and post on the office's website a report about health care quality benchmarks reported by payers and provider entities.

### *Authority to Contract*

The bill allows the executive director to enter into contractual agreements necessary to prepare the annual health care expenditure and quality benchmark reports, including contracts with actuarial,

economic, and other experts and consultants.

## §§ 5 & 6 — FAILURE TO MEET HEALTH CARE BENCHMARKS AND SPENDING TARGETS

### *Payers and Provider Entities*

Beginning in 2023, the bill requires the OHS executive director to identify each payer or provider entity that exceeded the health care cost growth benchmark or failed to meet the primary care spending target for the performance year (i.e., the most recent year for which certain data are available). She must do so annually by May 1. However, before identifying any payer or provider entity, she must meet with it upon its request to review and validate the total medical expense data collected. She must review any information the payer or provider entity provides and, if necessary, amend her findings before identifying it as exceeding the health care cost growth benchmark or failing to meet the spending targets.

Beginning in 2024, she must also identify, annually by May 1, each payer or provider entity that exceeded the health care quality benchmark for the performance year. She must similarly meet with any payer or provider entity upon its request to review and validate the quality data she collected and, if necessary, amend her findings before making a determination.

Within 30 days of making these identifications, the bill requires the executive director to notify the payer or provider entity, in a form and manner she prescribes, that (1) she identified its failure to meet a health care benchmark or spending target and (2) the factual basis for her identification.

### *Other Contributing Entities*

Beginning in 2023, if the executive director determines that the annual percentage change in total health care expenditures for the performance year exceeded the health care cost growth benchmark, then the bill requires her to identify any entity that significantly contributed to exceeding the benchmark. Under the bill, an "other entity" is a pharmacy benefit manager (PBM), provider that is not a provider entity,

or a drug manufacturer. She must do this for each calendar year by May 1, based on:

1. the OHS total health care expenditure annual report required under the bill (see § 4);

2. annual reports that existing law requires PBMs to submit to the insurance commissioner on prescription drug rebates;

3. OHS's annual list of up to 10 outpatient prescription drugs that are either provided at substantial cost to the state or critical to public health, required under existing law;

4. information from the state's all-payer claims database; and

5. any other information the executive director, in her discretion, deems relevant.

The bill requires the executive director to also account for costs, net of rebates and discounts, when identifying these entities.

### *Annual Informational Public Hearings*

The bill requires the executive director to annually hold informational public hearings as follows:

1. starting by June 30, 2023, a hearing to compare the growth in total health care expenditures in the performance year to the associated health care cost growth benchmark and

2. starting by June 30, 2024, a hearing to compare the performance of payers and provider entities in the performance year to the associated health care quality benchmark.

### *Hearings on Total Health Care Expenditures*

The bill requires annual informational public hearings on health care expenditures to examine the following:

1. OHS's most recent annual total health care expenditure report required under the bill;

2. payer and provider entity expenditures, including health care cost trends, primary care spending as a percentage of total medical expenses, and the factors contributing to them; and

3. any other matters the executive director deems relevant.

The bill allows the executive director to require hearing participation from any payer or provider entity that she determines is a significant contributor to the state's health care cost growth or has failed to meet the primary care spending target for that year. These entities must testify on the issues the executive director identifies and provide additional information on actions they have taken to (1) reduce their contribution to future state health care costs and expenditures and (2) increase their primary care spending as a percentage of total medical expenses.

Similarly, the executive director may also require participation in the hearing by any other entity she determines is a significant contributor to the state's health care cost growth during the performance year. These entities must also provide testimony and additional information in the same manner as payers and provider entities described above. If the other entity is a drug manufacturer whose participation is required with respect to a specific drug or drug class, then the bill permits the hearing, to the extent possible, to include representatives from at least one brand-name manufacturer; one generic manufacturer; and one innovator company that is less than 10 years old.

### *Hearings on Quality Performance Benchmarks*

The bill requires the annual informational public hearing on provider entity quality performance to examine the most recent OHS annual report on health care quality benchmarks (see § 4) and any other matters that the executive director deems relevant.

Under the bill, the executive director may require hearing participation from any payer or provider entity that she determines failed to meet the health care quality benchmarks during the performance year. Payers or provider entities required to participate

must provide testimony on issues the executive director identifies and additional information on actions they have taken to improve their quality benchmark performance.

### *Annual Legislative Reports on Public Hearing Information*

The bill requires OHS, starting by October 15, 2023, to report annually to the Insurance and Public Health committees on her analysis of the information submitted during the most recent informational public hearing on total health care expenditures. The report must:

1. describe health care spending trends in the state, including trends in primary care spending as a percentage of total medical expenses, and the factors underlying these trends;

2. include any findings from the total health care expenditure report;

3. describe how to monitor any unintended adverse consequences from the cost growth benchmarks and primary care spending targets, as well as any findings from doing so; and

4. disclose the office's recommendations, if any, on strategies to increase the efficiency of the state's health care system, including any recommended legislative changes.

Additionally, the bill requires the executive director, starting by October 15, 2024, to report annually to the Insurance and Public Health committees on her analysis of the information submitted during the most recent informational public hearing on health care quality benchmarks. In the report, the executive director must do the following:

1. describe health care quality trends in the state and their underlying factors,

2. include the findings from the health care quality benchmark report

3. disclose the office's recommendations, if any, on strategies to improve the quality of the state's health care system, including

any recommended legislative changes.

## § 8 — HEALTH ENHANCEMENT PROGRAMS

The bill requires health carriers to develop at least two HEPs by January 1, 2024. Each HEP must (1) be available to each insured under the health insurance policy and (2) provide incentives to each insured directly related to providing health insurance coverage for insureds choosing to complete certain preventive examinations and screenings the U.S. Preventive Services Task Force recommends with an "A" or "B" rating.

The bill prohibits an HEP from imposing any penalty or negative incentive on an insured. It also specifies that an insured cannot be required to participate in an HEP.

The bill also requires certain individual and group health insurance policies to cover the HEPs. (However, it is unclear if this means they must cover HEP administration costs or the examinations and screenings insureds receive through the HEP.)

The bill's HEP provisions apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

## § 9 — CON APPLICATION FEE

The bill increases the nonrefundable CON application fee from $500 to a range of $1,000 to $10,000 depending on the proposed project's cost, as shown in Table 1 below.

**Table 1: CON Application Fees Under the Bill**

| *Application Fee* | *Project Cost* |
|---|---|
| $1,000 | Up to $50,000 |
| $2,000 | >$50,000 and up to $100,000 |
| $3,000 | >$100,000 and up to $500,000 |
| $4,000 | >$500,000 and up to $1 million |
| $5,000 | >$1 million and up to $5 million |

| *Application Fee* | *Project Cost* |
|---|---|
| $8,000 | >$5 million and up to $10 million |
| $10,000 | >$10 million |

## BACKGROUND

### *Related Bills*

sSB 15 (File 39), reported favorably by the Insurance and Real Estate Committee, contains similar HEP provisions as this bill.

sHB 5449 (File 343), reported favorably by the Insurance and Real Estate Committee, increases CON application fees in different amounts than this bill.

## COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 17 Nay 0 (03/10/2022)