House of Representatives

File No. 677

General Assembly

February Session, 2022 ***(Reprint of File No. 56)***

Substitute House Bill No. 5042
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 29, 2022

AN ACT CONCERNING HEALTH CARE COST GROWTH.

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

Section 1. Section 19a-754a of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, as amended by this act, with the powers and duties therein prescribed.

(b) The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive

health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

(3) Directing and overseeing the State Innovation Model Initiative and related successor initiatives;

(4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establishing and maintaining a consumer health information Internet web site under section 19a-755b, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g;

(5) Directing and overseeing the Health Systems Planning Unit established under section 19a-612 and all of its duties and responsibilities as set forth in chapter 368z;

(6) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies; **[**and**]**

(7) (A) Administering the Covered Connecticut program established under section 19a-754c in consultation with the Commissioner of Social Services, Insurance Commissioner and Connecticut Health Insurance Exchange, and (B) consulting with the Commissioner of Social Services and Insurance Commissioner for the purposes set forth in section 17b-312; **[**.**]** and

(8) (A) Setting an annual health care cost growth benchmark and primary care spending target pursuant to section 3 of this act, (B) developing and adopting health care quality benchmarks pursuant to section 3 of this act, (C) developing strategies, in consultation with stakeholders, to meet such benchmarks and targets developed pursuant to section 3 of this act, (D) enhancing the transparency of provider entities, as defined in subdivision (13) of section 2 of this act, (E) monitoring the development of accountable care organizations and patient-centered medical homes in the state, and (F) monitoring the adoption of alternative payment methodologies in the state.

(c) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the functions, powers and duties of the following:

(1) The Connecticut Health Insurance Exchange, established pursuant to section 38a-1081, relating to the administration of the all-payer claims database pursuant to section 19a-755a; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725, and (C) (i) appointment of the health information technology officer, and (ii) oversight of the duties of such health information technology officer as set forth in sections 17b-59f and 17b-59g.

(d) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection (c) of this section that is in force on July 1, 2018, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 2. (NEW) (*Effective from passage*) For the purposes of this section and sections 3 to 7, inclusive, of this act:

(1) "Drug manufacturer" means the manufacturer of a drug that is: (A) Included in the information and data submitted by a health carrier

pursuant to section 38a-479qqq of the general statutes, (B) studied or listed pursuant to subsection (c) or (d) of section 19a-754b of the general statutes, or (C) in a therapeutic class of drugs that the executive director determines, through public or private reports, has had a substantial impact on prescription drug expenditures, net of rebates, as a percentage of total health care expenditures;

(2) "Executive director" means the executive director of the Office of Health Strategy;

(3) "Health care cost growth benchmark" means the annual benchmark established pursuant to section 3 of this act;

(4) "Health care quality benchmark" means an annual benchmark established pursuant to section 3 of this act;

(5) "Health care provider" has the same meaning as provided in subdivision (1) of subsection (a) of section 19a-17b of the general statutes;

(6) "Net cost of private health insurance" means the difference between premiums earned and benefits incurred, and includes insurers' costs 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;

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

(8) "Other entity" means a drug manufacturer, pharmacy benefits manager or other health care provider that is not considered a provider entity;

(9) "Payer" means a payer, including Medicaid, Medicare and governmental and nongovernment health plans, and includes any organization acting as payer that is a subsidiary, affiliate or business owned or controlled by a payer that, during a given calendar year, pays health care providers for health care services or pharmacies or provider

entities for prescription drugs designated by the executive director;

(10) "Performance year" means the most recent calendar year for which data were submitted for the applicable health care cost growth benchmark, primary care spending target or health care quality benchmark;

(11) "Pharmacy benefits manager" has the same meaning as provided in subdivision (10) of section 38a-479ooo of the general statutes;

(12) "Primary care spending target" means the annual target established pursuant to section 3 of this act;

(13) "Provider entity" means an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract;

(14) "Potential gross state product" means a forecasted measure of the economy that equals the sum of the (A) expected growth in national labor force productivity, (B) expected growth in the state's labor force, and (C) expected national inflation, minus the expected state population growth;

(15) "Total health care expenditures" means the sum of all health care expenditures in this state from public and private sources for a given calendar year, including: (A) All claims-based spending paid to providers, net of pharmacy rebates, (B) all patient cost-sharing amounts, and (C) the net cost of private health insurance; and

(16) "Total medical expense" means the total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of (A) all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates, (B) all nonclaims payments for such year,

including, but not limited to, incentive payments and care coordination payments, and (C) all patient cost-sharing amounts expressed on a per capita basis for the patient population of a payer or provider entity in this state.

Sec. 3. (NEW) (*Effective from passage*) (a) Not later than July 1, 2022, the executive director shall publish (1) the health care cost growth benchmarks and annual primary care spending targets as a percentage of total medical expenses for the calendar years 2021 to 2025, inclusive, and (2) the annual health care quality benchmarks for the calendar years 2022 to 2025, inclusive, on the office's Internet web site.

(b) (1) (A) Not later than July 1, 2025, and every five years thereafter, the executive director shall develop and adopt annual health care cost growth benchmarks and annual primary care spending targets for the succeeding five calendar years for provider entities and payers.

(B) In developing the health care cost growth benchmarks and primary care spending targets pursuant to this subdivision, the executive director shall consider (i) any historical and forecasted changes in median income for individuals in the state and the growth rate of potential gross state product, (ii) the rate of inflation, and (iii) the most recent report prepared by the executive director pursuant to subsection (b) of section 4 of this act.

(C) (i) The executive director shall hold at least one informational public hearing prior to adopting the health care cost growth benchmarks and primary care spending targets for each succeeding five-year period described in this subdivision. The executive director may hold informational public hearings concerning any annual health care cost growth benchmark and primary care spending target set pursuant to subsection (a) or subdivision (1) of subsection (b) of this section. Such informational public hearings shall be held at a time and place designated by the executive director in a notice prominently posted by the executive director on the office's Internet web site and in a form and manner prescribed by the executive director. The executive director

shall make available on the office's Internet web site a summary of any such informational public hearing and include the executive director's recommendations, if any, to modify or not to modify any such annual benchmark or target.

(ii) If the executive director determines, after any informational public hearing held pursuant to this subparagraph, that a modification to any health care cost growth benchmark or annual primary care spending target is, in the executive director's discretion, reasonably warranted, the executive director may modify such benchmark or target.

(iii) The executive director shall annually (I) review the current and projected rate of inflation, and (II) include on the office's Internet web site the executive director's findings of such review, including the reasons for making or not making a modification to any applicable health care cost growth benchmark. If the executive director determines that the rate of inflation requires modification of any health care cost growth benchmark adopted under this section, the executive director may modify such benchmark. In such event, the executive director shall not be required to hold an informational public hearing concerning such modified health care cost growth benchmark.

(D) The executive director shall post each adopted health care cost growth benchmark and annual primary care spending target on the office's Internet web site.

(2) (A) Not later than July 1, 2025, and every five years thereafter, the executive director shall develop and adopt annual health care quality benchmarks for the succeeding five calendar years for provider entities and payers.

(B) In developing annual health care quality benchmarks pursuant to this subdivision, the executive director shall consider (i) quality measures endorsed by nationally recognized organizations, including, but not limited to, the National Quality Forum, the National Committee for Quality Assurance, the Centers for Medicare and Medicaid Services,

the Centers for Disease Control, the Joint Commission and expert organizations that develop health equity measures, and (ii) measures that: (I) Concern health outcomes, overutilization, underutilization and patient safety, (II) meet standards of patient-centeredness and ensure consideration of differences in preferences and clinical characteristics within patient subpopulations, and (III) concern community health or population health.

(C) (i) The executive director shall hold at least one informational public hearing prior to adopting the health care quality benchmarks for each succeeding five-year period described in this subdivision. The executive director may hold informational public hearings concerning the quality measures the executive director proposes to adopt as health care quality benchmarks. Such informational public hearings shall be held at a time and place designated by the executive director in a notice prominently posted by the executive director on the office's Internet web site and in a form and manner prescribed by the executive director. The executive director shall make available on the office's Internet web site a summary of any such informational public hearing and include the executive director's recommendations, if any, to modify or not modify any such health care quality benchmark.

(ii) If the executive director determines, after any informational public hearing held pursuant to this subparagraph, that modifications to any health care quality benchmarks are, in the executive director's discretion, reasonably warranted, the executive director may modify such quality benchmarks. The executive director shall not be required to hold an additional informational public hearing concerning such modified quality benchmarks.

(D) The executive director shall post each adopted health care quality benchmark on the office's Internet web site.

(c) The executive director may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and

other experts and consultants.

Sec. 4. (NEW) (*Effective from passage*) (a) Not later than August 15, 2022, and annually thereafter, each payer shall report to the executive director, in a form and manner prescribed by the executive director, for the preceding or prior years, if the executive director so requests based on material changes to data previously submitted, aggregated data, including aggregated self-funded data as applicable, necessary for the executive director to calculate total health care expenditures, primary care spending as a percentage of total medical expenses and net cost of private health insurance. Each payer shall also disclose, as requested by the executive director, payer data required for adjusting total medical expense calculations to reflect changes in the patient population.

(b) Not later than March 31, 2023, and annually thereafter, the executive director shall prepare and post on the office's Internet web site, a report concerning the total health care expenditures utilizing the total aggregate medical expenses reported by payers pursuant to subsection (a) of this section, including, but not limited to, a breakdown of such population-adjusted total medical expenses by payer and provider entities. The report may include, but shall not be limited to, information regarding 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 private 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 on such data, which shall include, but not be limited to, the following factors: (A) The impact of the rate of inflation and rate of medical inflation; (B) impacts, if any, on access to care; and (C) responses to public health crises or similar emergencies.

(c) The executive director shall annually submit a request to the federal Centers for Medicare and Medicaid Services for the unadjusted total medical expenses of Connecticut residents.

(d) Not later than August 15, 2023, and annually thereafter, each payer or provider entity shall report to the executive director in a form and manner prescribed by the executive director, for the preceding year, and for prior years if the executive director so requests based on material changes to data previously submitted, on the health care quality benchmarks adopted pursuant to section 3 of this act.

(e) Not later than March 31, 2024, and annually thereafter, the executive director shall prepare and post on the office's Internet web site, a report concerning health care quality benchmarks reported by payers and provider entities pursuant to subsection (d) of this section.

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

Sec. 5. (NEW) (*Effective from passage*) (a) (1) For each calendar year, beginning on January 1, 2023, the executive director shall, if the payer or provider entity subject to the cost growth benchmark or primary care spending target so requests, meet with such payer or provider entity to review and validate the total medical expenses data collected pursuant to section 4 of this act for such payer or provider entity. The executive director shall review information provided by the payer or provider entity and, if deemed necessary, amend findings for such payer or provider prior to the identification of payer or provider entities that exceeded the health care cost growth benchmark or failed to meet the primary care spending target for the performance year as set forth in section 4 of this act. The executive director shall identify, not later than May first of such calendar year, 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.

(2) For each calendar year beginning on or after January 1, 2024, the executive director shall, if the payer or provider entity subject to the health care quality benchmarks for the performance year so requests, meet with such payer or provider entity to review and validate the quality data collected pursuant to section 4 of this act for such payer or provider entity. The executive director shall review information provided by the payer or provider entity and, if deemed necessary, amend findings for such payer or provider prior to the identification of payer or provider entities that exceeded the health care quality benchmark as set forth in section 4 of this act. The executive director shall identify, not later than May first of such calendar year, each payer or provider entity that exceeded the health care quality benchmark for the performance year.

(3) Not later than thirty days after the executive director identifies each payer or provider entity pursuant to subdivisions (1) and (2) of this subsection, the executive director shall send a notice to each such payer or provider entity. Such notice shall be in a form and manner prescribed by the executive director, and shall disclose to each such payer or provider entity:

(A) That the executive director has identified such payer or provider entity pursuant to subdivision (1) or (2) of this subsection; and

(B) The factual basis for the executive director's identification of such payer or provider entity pursuant to subdivision (1) or (2) of this subsection.

(b) (1) For each calendar year beginning on and after January 1, 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 for such year, the executive director shall identify, not later than May first of such calendar year, any other entity that significantly contributed to exceeding such benchmark. Each identification shall be based on:

(A) The report prepared by the executive director pursuant to

subsection (b) of section 4 of this act for such calendar year;

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

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

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

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

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

Sec. 6. (NEW) (*Effective from passage*) (a) (1) Not later than June 30, 2023, and annually thereafter, the executive director shall hold an informational public hearing to compare the growth in total health care expenditures in the performance year to the health care cost growth benchmark established pursuant to section 3 of this act for such year. Such hearing shall involve an examination of:

(A) The report most recently prepared by the executive director pursuant to subsection (b) of section 4 of this act;

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

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

(2) The executive director may require any payer or provider entity that, for the performance year, is found to be a significant contributor to

health care cost growth in the state or has failed to meet the primary care spending target, to participate in such hearing. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director and provide additional information on actions taken to reduce such payer's or entity's contribution to future state-wide health care costs and expenditures or to increase such payer's or provider entity's primary care spending as a percentage of total medical expenses.

(3) The executive director may require that any other entity that is found to be a significant contributor to health care cost growth in this state during the performance year participate in such hearing. Any other entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director and provide additional information on actions taken to reduce such other entity's contribution to future state-wide health care costs. If such other entity is a drug manufacturer, and the executive director requires that such drug manufacturer participate in such hearing with respect to a specific drug or class of drugs, such hearing may, to the extent possible, include representatives from at least one brand-name manufacturer, one generic manufacturer and one innovator company that is less than ten years old.

(4) Not later than October 15, 2023, and annually thereafter, the executive director shall prepare and submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the executive director's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care spending trends in this state, including, but not limited to, trends in primary care spending as a percentage of total medical expense, and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (b) of section 4 of this act;

(C) Describe a plan for monitoring any unintended adverse consequences resulting from the adoption of cost growth benchmarks and primary care spending targets and the results of any findings from the implementation of such plan; and

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

(b) (1) Not later than June 30, 2024, and annually thereafter, the executive director shall hold an informational public hearing to compare the performance of payers and provider entities in the performance year to the quality benchmarks established for such year pursuant to section 3 of this act. Such hearing shall include an examination of:

(A) The report most recently prepared by the executive director pursuant to subsection (e) of section 4 of this act; and

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

(2) The executive director may require any payer or provider entity that failed to meet any health care quality benchmarks in this state during the performance year to participate in such hearing. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director and provide additional information on actions taken to improve such payer's or provider entity's quality benchmark performance.

(3) Not later than October 15, 2024, and annually thereafter, the executive director shall prepare and submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of

the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the executive director's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care quality trends in this state and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (e) of section 4 of this act; and

(C) Disclose the executive director's recommendations, if any, concerning strategies to improve the quality of the state's health care system, including, but not limited to, any recommended legislation concerning the state's health care system.

Sec. 7. (NEW) (*Effective from passage*) The executive director may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of section 19a-754a of the general statutes, as amended by this act, and sections 2 to 6, inclusive, of this act.

Sec. 8. (NEW) (*Effective January 1, 2023*) (a) For the purposes of this section, "health enhancement program" means a health benefit program that ensures access and removes barriers to essential, high-value clinical services.

(b) (1) Not later than January 1, 2024, each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall develop not less than two health enhancement programs under such policy.

(2) Each health enhancement program developed pursuant to subdivision (1) of this subsection shall:

(A) Be available to each insured under the individual or group health insurance policy; and

(B) Provide to each insured under the individual or group health insurance policy incentives that are directly related to the provision of health insurance coverage, provided such insured chooses to complete certain preventive examinations and screenings recommended by the United States Preventive Services Task Force with a rating of "A" or "B".

(3) No health enhancement program developed pursuant to subdivision (1) of this subsection shall impose any penalty or other negative incentive on an insured under the individual or group health insurance policy nor shall any insured be required to participate in a health enhancement program.

(c) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall include coverage for the health enhancement programs that the insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivered, issued, renewed, amended or continued such policy developed pursuant to this section.

(d) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall include coverage for the health enhancement programs that the insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivered, issued, renewed, amended or continued such policy developed pursuant to this section.

(e) The Insurance Commissioner may adopt regulations, in

accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 9. Subsection (a) of section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) An application for a certificate of need shall be filed with the unit in accordance with the provisions of this section and any regulations adopted by the Office of Health Strategy. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee **[**of five hundred dollars**]** based on the cost of the project. The amount of the fee shall be as follows: (A) One thousand dollars for a project that will cost not greater than fifty thousand dollars; (B) two thousand dollars for a project that will cost greater than fifty thousand dollars but not greater than one hundred thousand dollars; (C) three thousand dollars for a project that will cost greater than one hundred thousand dollars but not greater than five hundred thousand dollars; (D) four thousand dollars for a project that will cost greater than five hundred thousand dollars but not greater than one million dollars; (E) five thousand dollars for a project that will cost greater than one million dollars but not greater than five million dollars; (F) eight thousand dollars for a project that will cost greater than five million dollars but not greater than ten million dollars; and (G) ten thousand dollars for a project that will cost greater than ten million dollars.

Sec. 10. Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in this chapter, unless the context otherwise requires:

(1) "Affiliate" means a person, entity or organization controlling, controlled by or under common control with another person, entity or organization. Affiliate does not include a medical foundation organized under chapter 594b.

(2) "Applicant" means any person or health care facility that applies for a certificate of need pursuant to section 19a-639a, as amended by this act.

(3) "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive.

(4) "Capital expenditure" means an expenditure that under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation or maintenance and includes acquisition by purchase, transfer, lease or comparable arrangement, or through donation, if the expenditure would have been considered a capital expenditure had the acquisition been by purchase.

(5) "Certificate of need" means a certificate issued by the unit.

(6) "Days" means calendar days.

(7) "Executive director" means the executive director of the Office of Health Strategy.

(8) "Free clinic" means a private, nonprofit community-based organization that provides medical, dental, pharmaceutical or mental health services at reduced cost or no cost to low-income, uninsured and underinsured individuals.

(9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of

the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

(10) "Health care facility" means (A) hospitals licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C) freestanding emergency departments; (D) outpatient surgical facilities, as defined in section 19a-493b and licensed under chapter 368v; (E) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; (F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

(11) "Nonhospital based" means located at a site other than the main campus of the hospital.

(12) "Office" means the Office of Health Strategy.

(13) "Person" means any individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

(14) "Physician" has the same meaning as provided in section 20-13a.

(15) "Termination of services" means the cessation of any services for

a period greater than one hundred eighty days.

[(15)**]** (16) "Transfer of ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility, institution or large group practice, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a health care facility.

[(16)**]** (17) "Unit" means the Health Systems Planning Unit.

Sec. 11. Section 4-5 of the 2022 supplement to the general statutes, as amended by section 6 of public act 17-237, section 279 of public act 17-2 of the June special session, section 20 of public act 18-182, section 283 of public act 19-117 and section 254 of public act 21-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, the executive director of the Office of Health Strategy, the executive director of the Office of Military Affairs, the executive director of the Technical Education and Career System and the Chief Workforce Officer. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-754a
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section
Sec. 8	*January 1, 2023*	New section
Sec. 9	*from passage*	19a-639a(a)
Sec. 10	*from passage*	19a-630
Sec. 11	*July 1, 2022*	4-5

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: See Below

Municipal Impact: None

Explanation

This bill, which 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, codifying provisions of Executive Order 5, does not result in a fiscal impact to OHS or municipalities.

The bill, which requires private health carriers in Connecticut to develop at least two health enhancement programs (HEPs) under their policies, does not result in a fiscal impact to the state. It is anticipated that the Insurance Department, which may adopt implementing regulations under the bill, can review compliance within existing resources. It is unknown if there will be a fiscal impact to fully insured municipalities as a result of HEP provisions of the bill.

The bill also changes the CON application fee from $500 to a range of $1,000 to $10,000 depending on the proposed project's cost. Based on a four-year average of CON proposals, the bill's fee schedule is anticipated to generate an additional $100,000 in annual revenue. The current fee of $500 generates approximately $12,500 annually. This increase in the application fee results in a cost to UConn Health Center each time the entity applies for a CON. The health center expects to apply for one CON in either FY 23 or FY 24. The cost will be equal to the difference between the current fee ($500) and the new fees based on

project costs ($1,000 to $10,000).

Lastly, the bill adds the executive director of OHS to the statutory definition of a department head. This has no fiscal impact.

House "A" strikes the original bill and its associated fiscal impact, thus becoming the bill with the above referenced fiscal impact.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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
$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)