OLR Bill Analysis

sSB 1116

AN ACT CONCERNING A STATE-OPERATED REINSURANCE PROGRAM AND HEALTH CARE COST GROWTH.

SUMMARY

This bill incorporates hospitals into the state's healthcare benchmarking and spending target law. In doing so, it requires the hospitals to give the Office of Health Strategy (OHS) certain spending and cost data and requires OHS to use this data to set benchmarks and spending targets in the same way that existing law requires it do for payers (e.g., health insurance plans) and provider entities (e.g., certain clinician groups). Similarly, it allows OHS to identify hospitals that exceed the benchmarks or spending targets in the same way it identifies other entities and potentially require them to participate in a public hearing.

The bill makes two other changes to the healthcare benchmarking and spending target law. First, it requires OHS's executive director, or contractors, in carrying out the benchmarking and spending target process, to use currently available data sources (including data available through the all-payer claims database). Second, it requires OHS to include in an annual report monitoring potential impacts of benchmarks, any adverse impacts on funding for people with developmental disabilities.

The bill also:

1. requires off-campus hospital-based facilities to bill independently from the hospital or hospital system they are associated with (i.e., "site of service billing") (§ 8);

2. requires OHS to apply for and fund a Section 1332 waiver to establish a reinsurance program to lower premiums on the

individual health insurance market (§ 1); and

3. adds enhancing the transparency of hospitals to OHS's statutory duties (§ 2);

EFFECTIVE DATE: October 1, 2023, except the reinsurance waiver provisions and a technical change are effective upon passage.

§§ 3-7 — INCORPORATES HOSPITALS INTO HEALTH CARE BENCHMARKS

By law, OHS must set annual health care quality and cost growth benchmarks, as well as primary care spending targets for payers (e.g., health plans) and provider entities (e.g., certain clinician groups). The bill requires that OHS also adopt these benchmarks and spending targets for hospitals. As under current law, these annual benchmarks and spending targets are adopted every five years and must be posted on OHS's website.

The bill subjects hospitals to the same spending target and quality and cost growth benchmarking process that existing law applies to providers and payers. Among other things, this means that:

1. hospitals must report spending and cost data to OHS;

2. primary care spending targets for hospitals must consider the same sort of data that are considered for other payers and providers (e.g., historical and forecasted personal income growth and inflation);

3. the executive director must hold public hearings before adopting the hospital benchmark; and

4. OHS's annual report on health care spending trends informational hearings must include data on hospital spending.

Additionally, the bill requires the executive director to identify hospitals that exceed the health care cost growth and quality benchmarks or fail to meet the primary care spending target in the same way she must identify providers and payers under existing law. Under the bill, she can similarly require hospitals to participate in a public

hearing and discuss, among other topics, ways to reduce their contribution to future health costs.

Potential Adverse Impact on Funding for Individuals With Developmental Disabilities

Existing law requires the OHS executive director to annually report to the Insurance and Real Estate and Public Health committees on certain aspects of the benchmarking and spending target process, including on a plan to monitor any unintended adverse consequences resulting from adopting the benchmarks or spending targets. The bill also requires this plan to specifically monitor any adverse impacts on funding for people with developmental disabilities.

§ 8 — SITE OF SERVICE BILLING

Beginning January 1, 2024, this bill requires a hospital-based facility that is located away from a hospital campus to submit the facility's national provider identifier (NPI) and tax identification number with each claim. Additionally, the NPI and tax identification number must be:

1. separate from those issued to the hospital campus, and
2. included in any reimbursement claim for services the facility provided, regardless of whether the facility or the hospital (or another facility) submits the claim.

Under the bill and existing law, a "hospital-based facility" is a facility that is owned or operated, at least in part, by a hospital or health system (e.g., a hospital's parent corporation) where hospital or professional medical services are provided. A "campus" is the physical area immediately adjacent to a hospital's main building and other related structures within 250 yards, as well as any area determined to be part of a hospital's campus by the federal Centers for Medicare and Medicaid Services.

The bill authorizes the commissioner to adopt implementing regulations.

§ 1 — SECTION 1332 REINSURANCE WAIVER

The bill requires OHS, with the Office of Policy and Management (OPM), the Insurance Department, and the Health Reinsurance Association, to seek a Section 1332 state innovation waiver to establish a reinsurance program to reduce individual health insurance premiums. Federal law allows a state to request these waivers to forgo certain federal Affordable Care Act requirements as long as the program (1) provides coverage that is at least as comprehensive as what is provided without the waiver, (2) provides coverage and cost sharing protections that are at least as affordable as without the waiver, (3) covers at least a comparable number of people, and (4) does not increase the federal deficit.

Under the bill, the Health Reinsurance Association administers the program under federal law. The reinsurance program must be designed to lower premiums in the individual health insurance market, both for plans sold on and off the exchange (i.e., Access Health CT).

Funding

Under the bill, if the federal Centers for Medicare and Medicaid Services approves the waiver, beginning September 1, 2024 (for the 2025 plan year), OHS must annually determine the amount necessary to fund it, up to $21,210,000, and inform OPM. The treasurer must correspondingly pay this amount to administer the program. If the waiver ends (and a new one is not received), the treasurer must stop the payments.

BACKGROUND

Related Bill

sHB 6634, favorably reported by the Insurance and Real Estate Committee, also requires off-site hospital-based facilities to bill independently from the hospital they are affiliated with.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 12 Nay 0 (03/16/2023)