**PA 23-171**—sHB 6669
*Public Health Committee*
*Appropriations Committee*
*General Law Committee*

# AN ACT PROTECTING PATIENTS AND PROHIBITING UNNECESSARY HEALTH CARE COSTS

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**SUMMARY:** This act makes various changes in laws related to prescription drugs, health care facilities, health insurance contracting, and related matters. EFFECTIVE DATE: Various, see below.

## § 1 — DRUG DISCOUNT CARD PROGRAM AND CENTRALIZED DRUG PURCHASE FEASIBILITY STUDY

*Requires the state comptroller to (1) establish a Drug Discount Card Program for state residents and allows him to join with other states and territories or a regional consortium to pool prescription drug purchasing power and (2) study the feasibility of centralizing statewide contracts to consolidate public entities' purchasing of prescription drugs*

This act requires the state comptroller to establish the Drug Discount Card Program and make it available to all state residents. Through this program, the comptroller may cooperate with other U.S. states and territories or regional consortia to pool prescription drug purchasing power to do the following:

1. lower prescription drug costs;
2. negotiate discounts with drug manufacturers;
3. centralize drug purchasing; and
4. establish volume discount contracting (i.e., a negotiated drug purchase in a large quantity for a lower cost).

The act also requires the comptroller to study the feasibility of centralizing statewide contracts to consolidate the purchasing of prescription and physician-administered drugs by state agencies, state hospitals, state-operated local mental health authorities, and other public entities, as necessary. The study must evaluate (1) the potential cost savings, administrative feasibility, and other benefits and risks of centralizing and consolidating these contracts and (2) what additional staff and resources, if any, the comptroller would need to centrally procure and administer these contracts.

By November 1, 2023, each of these entities procuring these drugs must provide the comptroller, in a form and manner he sets, with information on the drug types, amount, and cost. By February 1, 2024, the comptroller must submit the study's findings to the governor and legislature.

EFFECTIVE DATE: October 1, 2023

## § 2 — DCP REPORT ON GENERIC DRUG OUTREACH PROGRAM

*Requires DCP to report on a framework for a program to inform physicians about when drug patents expire and generic alternatives exist for drugs with recently expired patents*

The act requires the Department of Consumer Protection (DCP) commissioner to report to the Public Health Committee on recommendations for a framework to establish an outreach and education program to inform physicians when (1) drug patents will expire and become available in generic form and (2) generic alternatives exist for drugs with recently expired patents. The commissioner must report by January 1, 2025, and in consultation with UConn's School of Pharmacy.

EFFECTIVE DATE: Upon passage

## §§ 3-6 — PHARMACEUTICAL REPRESENTATIVES AND MANUFACTURERS

*Requires pharmaceutical manufacturers that employ pharmaceutical sales representatives to register annually with DCP as pharmaceutical marketing firms; requires these firms to annually give DCP a list of their sales representatives and update it more often as necessary, and prohibits*

*representatives not on the list from working in this capacity on the firm's behalf; requires related reporting and disclosures; authorizes DCP to take disciplinary actions for violations*

Starting October 1, 2023, the act requires pharmaceutical manufacturers that employ pharmaceutical sales representatives to register annually with DCP as "pharmaceutical marketing firms." The act also makes several related changes.

Under the act, a "pharmaceutical representative" is anyone, such as a sales representative, who is employed or compensated by a pharmaceutical manufacturer and who markets, promotes, or gives information on legend (i.e., prescription) drugs intended for humans to prescribing practitioners.

A "pharmaceutical manufacturer" is anyone who directly or indirectly produces, prepares, cultivates, grows, propagates, compounds, converts, or processes drugs, devices, or cosmetics by natural substance extraction, chemical synthesis, or a combination, or packages, repackages, labels, or relabels a container under the person's own or any other trademark or label, or a drug, device, or cosmetic, to sell these items. This applies whether the person is located in Connecticut or elsewhere.

A "pharmaceutical manufacturer" also includes a sterile compounding pharmacy that dispenses sterile pharmaceuticals without a prescription or a patient-specific medical order intended for human use.

The act specifies that "a virtual manufacturer" is considered to be a pharmaceutical manufacturer for these purposes. Generally, existing law defines a "virtual manufacturer" as anyone who (1) through a contract with a manufacturing organization, manufactures drugs, devices, or cosmetics for which the person owns certain rights but (2) is not involved in the physical manufacturing and does not physically possess the items at any time (CGS § 20-571).

EFFECTIVE DATE: October 1, 2023

*Registration and Renewals (§ 4)*

Under the act, starting October 1, 2023, a pharmaceutical manufacturer that employs people to work as pharmaceutical sales representatives must register annually with DCP as a pharmaceutical marketing firm, in a form and manner the commissioner sets. If a manufacturer fails to register, they are prohibited from authorizing anyone to perform duties as a sales representative on their behalf.

The initial registration and annual renewal fees are each $150, and these fees are nonrefundable. Registrations expire annually on June 30. Late and lapsed registrations are subject to an additional $100 late fee per year.

*List of Sales Representatives (§ 4)*

The act requires pharmaceutical marketing firms, upon their initial registration and annually after that, to give DCP a list of their pharmaceutical sales representatives. These firms also must notify DCP, in a form and manner the commissioner sets, within two weeks after (1) hiring a pharmaceutical sales representative or (2) a representative stops working for them. The act prohibits anyone who is not on the list, or identified to the department after being hired, from

working as a pharmaceutical sales representative on the firm's behalf for any prescribing practitioner in the state.

Under the act, DCP must prominently post on its website the most recent list provided by each pharmaceutical marketing firm of its pharmaceutical sales representatives.

*Annual Reporting Requirement (§ 4)*

The act requires pharmaceutical marketing firms, starting by July 1, 2024, to annually report specified information to DCP for the previous calendar year regarding their sales representatives, in a form and manner set by the commissioner. Specifically, they must provide information on:

1. the total number of contacts (see below) each sales representative had with prescribing practitioners and pharmacists;
2. the specialties of these prescribing practitioners and pharmacists;
3. whether product samples, materials, or gifts of any value were given to prescribing practitioners or staff in their offices or to pharmacists; and
4. an aggregate report of all free samples, by drug name and strength, in a form and manner set by the commissioner.

For this purpose, a "contact" is any in-person, phone, email, text, or other electronic communication between a pharmaceutical representative and a prescribing practitioner or pharmacist to promote or provide information about a legend drug.

DCP must annually analyze the information it receives and compile a report on the activities of pharmaceutical sales representatives in the state. Starting by December 1, 2024, the department must annually post the report on its website and submit it to the Office of Policy and Management (OPM) secretary.

*Required Disclosures to Prescribers and Pharmacists (§ 5)*

The act requires pharmaceutical representatives marketing legend drugs in Connecticut to disclose certain written information to prescribing practitioners or pharmacists at the time of each contact with them. Specifically, they must disclose the following information related to these drugs:

1. when providing information about a drug to prescribing practitioners or pharmacists, the drug's list price, based on its dose and quantity as described in the medication package insert; and
2. information, if available, on whether the drug's effectiveness varies for different racial and ethnic groups.

*Disciplinary Actions (§ 6)*

The act allows the DCP commissioner to take the following actions for each violation of the above provisions:

1. refuse to issue or renew a registration;
2. revoke, suspend, or place conditions on a registration; or

3. assess a penalty of up to $1,000.

DCP may also take other actions authorized by law if the applicant or registrant fails to comply with the act's requirements, such as issuing a letter of reprimand.

The act allows the DCP commissioner to adopt regulations implementing these provisions on disciplinary action.

## § 7 — STUDY OF PHARMACY BENEFIT MANAGERS

*Requires OHS, in consultation with the Insurance Department, to report on PBMs' prescription drug distribution practices in Connecticut and other states*

The act requires the Office of Health Strategy (OHS), in consultation with the Insurance Department, to report to the Insurance and Real Estate Committee by January 1, 2025, on its analysis of pharmacy benefit managers' (PBMs) prescription drug distribution practices. This includes (1) spread pricing arrangements, manufacturing rebates and transparency, fees, and financial incentives to add drugs to insurance formularies and (2) an evaluation of PBMs' prescription drug distribution practices in other states. The report must include recommendations to reduce consumers' prescription drug costs and regulate in-state PBMs.

EFFECTIVE DATE: Upon passage

## § 8 — DRUGS WITH SUBSTANTIAL COST TO THE STATE

*Allows a wider range of drugs to be included on OHS's annual list of outpatient drugs that are provided at substantial cost to the state; requires the OHS executive director, before publishing the annual list, to prepare a preliminary list, and gives manufacturers the opportunity, following a public comment period, to show that a drug does not meet inclusion criteria*

Existing law requires the OHS executive director, in consultation with the comptroller and the commissioners of public health and social services, to annually identify up to 10 outpatient prescription drugs that are provided at substantial state cost, considering their net cost, or critical to public health. Manufacturers of identified drugs must give OHS certain information on the (1) factors that led to an increase in the drug's wholesale acquisition cost and (2) company's research and development costs and other capital costs.

Prior law established certain parameters for what drugs could be included on this list, requiring both a minimum wholesale (1) cost increase percentage in prior years and (2) total cost for a specified supply or course of treatment. As shown in the table below, the act lowers the minimum required cost increase and total cost that qualifies for inclusion.

**Minimum Requirements for List of Outpatient Prescription Drugs**

| | ***Prior Law*** | ***The Act*** |
|---|---|---|
| Cost Increase | At least 20% during the prior year or 50% during the prior three years | At least 16% cumulatively during the prior two years |
| Cost for | At least $60 for a 30-day supply | At least $40 for a course of |

| | *Prior Law* | *The Act* |
|---|---|---|
| Course of Treatment | or shorter course of treatment | treatment (of unspecified duration) |

As under existing law, drugs are evaluated based on their wholesale acquisition cost, minus all associated rebates paid to the state during the prior year.

The act requires the OHS executive director, before publishing the annual list, to prepare a preliminary list and make it available for public comment for at least 30 days. During that period, the manufacturer of any drug on the preliminary list may give OHS documentation, as allowed by federal law, showing that the drug's wholesale acquisition cost, less all rebates paid to the state for it during the prior calendar year, did not exceed the act's limits shown in the table above. If this documentation establishes this to the executive director's satisfaction, then she must remove the drug from the list before publishing the annual list. She must remove it within 15 days after the comment period closes.

EFFECTIVE DATE: October 1, 2023

## § 9 — FACILITY FEES

*Makes various changes affecting facility fees, such as (1) starting July 1, 2024, generally prohibiting hospitals and health systems from charging these fees for certain on-campus outpatient procedures that are provided outside of the emergency department; (2) repealing a provision that previously made a violation of facility fee limits an unfair trade practice, and instead generally allowing OHS to impose civil penalties for violations of fee limits starting July 1, 2024; and (3) making related changes to existing reporting requirements*

Existing law limits when hospitals, health systems, and hospital-based facilities may charge facility fees for outpatient services provided off-site from a hospital campus. Starting July 1, 2024, the act also prohibits hospitals or health systems from charging facility fees for certain on-campus outpatient procedures that are not provided in the emergency department. It repeals a provision that made it an unfair trade practice to violate facility fee limits, and instead allows OHS to impose civil penalties of up to $1,000 for certain violations of these limits.

Among other related changes, the act also modifies certain facility fee-related reporting requirements to (1) change the deadline for the next report and (2) expand the scope of the reporting to also include facility fees charged on the hospital campus.

EFFECTIVE DATE: July 1, 2023

### *Facility Fee Limits*

By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee.

Existing law limits when hospitals, health systems, and hospital-based facilities may charge facility fees for outpatient services provided off-site from a hospital campus. Among other thing, this includes a general prohibition on charging these

fees for these services that use a current procedural terminology evaluation and management (CPT E/M) code or CPT assessment and management (CPT A/M) code.

Starting July 1, 2024, the act also sets limits on hospital or health system facility fees for outpatient services provided on the hospital campus. It generally prohibits them from charging facility fees for these services that use a CPT E/M or CPT A/M code.

This new limit does not apply to emergency departments located on the hospital campus. It also does not apply to observation stays on a hospital campus and CPT E/M and CPT A/M codes when billed for wound care, orthopedics, anticoagulation, oncology, obstetrics, and solid organ transplant. For this purpose, the act defines "observation" as services a hospital provides on its campus, regardless of length of stay, including use of a bed and periodic monitoring by nursing or other staff to evaluate an outpatient's condition or determine the need for inpatient admission.

Existing law allowed hospitals or health systems to continue to collect insurance reimbursement for otherwise-prohibited facility fees if an insurance contract in effect on July 1, 2016, reimbursed these fees. They could continue to do so until the earlier of the contract's expiration, renewal, or amendment. In relation to the act's new limit on certain on-campus fees, the act extends this provision to insurance contracts in effect on July 1, 2024.

As under existing law, the act's facility fee limits do not apply to Medicare and Medicaid patients, patients receiving services under a workers' compensation plan, or freestanding emergency departments.

*Penalties for Violating Fee Limits*

The act repeals a prior provision that made it an unfair trade practice to violate the law's facility fee limits. Instead, starting July 1, 2024, it provides a process for OHS to issue civil penalties of up to $1,000 and cease and desist orders for violations.

Starting on that date, the act allows the OHS executive director to issue a notice to any hospital, health system, or hospital-based facility (collectively, "facility") if she has received information and reasonably believes (after evaluating that information) that the facility has charged facility fees in violation of the law or related rules or regulations. This does not apply if the facility only charged the fees through isolated clerical or electronic billing errors.

She must notify the facility by first-class mail or personal service. The notice must include the following:

1. a reference to the laws, regulations, or rules allegedly violated;
2. a short and plain language statement of the matter;
3. a description of the activity that the facility must cease;
4. the amount of the penalty; and
5. a statement on the facility's right to a hearing and the deadline to request one.

Under the act, the facility has 10 business days after receiving the violation notice to request a hearing. To do so, they must apply in writing to OHS. The

hearing must be conducted under the Uniform Administrative Procedure Act (UAPA).

OHS must issue a cease and desist order or civil penalty if the facility does not request a hearing by the deadline. OHS must also issue a final cease and desist order, in addition to any civil penalty it orders, if the office finds, by a preponderance of the evidence after the hearing, that the violation occurred or is occurring.

*Annual Reporting Requirements*

Existing law requires each hospital and health system to annually report to OHS on the facility fees it charged or billed the prior year at hospital-based facilities outside a hospital campus. The act expands this reporting requirement to include facility fees billed on a hospital campus. It makes related changes by requiring that the reports:

1. indicate whether each facility the hospital or health system owns or operates and that charges facility fees is located on or off a hospital campus and
2. disaggregate certain information on facility fee revenue and patient volume by on-campus and off-campus.

Under existing law, these reports are due annually by July 1. The act extends the deadline of the next report from July 1, 2023, to October 1, 2023, and after that requires annual reports by July 1.

## §§ 10-14 — CERTIFICATE OF NEED

*Makes various changes to the CON program, such as (1) allowing OHS to issue notices for suspected violations and, following a hearing, issue cease and desist orders; (2) requiring CON applicants to provide additional notice to the public about CON applications and public hearings; (3) allowing OHS to retain independent expert consultants when necessary in the CON review process; and (4) providing for civil penalties for negligent, not just willful, failure to seek CON approval when required or file within set deadlines and extending civil penalties to negligent failure to comply with a settlement agreement*

Generally, existing law requires certain health care facilities to apply for and receive a certificate of need (CON) from OHS's Health Systems Planning Unit when proposing to (1) establish a new facility or provide new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services. The act makes various changes to this process, as described below.
EFFECTIVE DATE: October 1, 2023

*Cease and Desist Orders (§ 10)*

The act allows the OHS executive director, or her agent, to issue a notice to any person, health care facility, or institution ("person or facility") if she or her agent has received information and reasonably believes that the person or facility has violated or is violating the CON law, other related laws, or the Health Systems Planning Unit's regulations or orders.

The unit must notify the person or facility by first-class mail or personal service.

The notice must include the following:

1. a reference to the laws, regulations, or orders allegedly violated;
2. a short and plain language statement of the matter;
3. a description of the activity alleged to have violated a law or regulation; and
4. a statement on the person's or facility's right to a hearing and the deadline and way to request one.

Under the act, the person or facility has 10 business days after receiving the violation notice to request a hearing. To do so, they must apply in writing to the Health Systems Planning Unit. At the hearing, the person or facility may attempt to demonstrate that (1) the violation did not occur, (2) a CON was not required, or (3) the required CON was obtained. The hearing must be conducted as a contested case proceeding under the UAPA.

The unit must issue a cease and desist order if (1) the person or facility does not request a hearing by the deadline or (2) after the hearing, the unit finds, by a preponderance of the evidence, that the violation occurred or is occurring. The order is a final decision and may be appealed to Superior Court under the UAPA. The attorney general may go to court to enforce the order.

*Deadline for CON Determination Letter (§§ 11 & 13)*

Under existing law, if any person, health care facility, or institution is unsure whether a CON is required, they must request a determination from the Health Systems Planning Unit. A health care facility subject to the CON law must also request this determination if it plans to relocate.

The act sets a 30-day deadline for the unit to issue this determination after receiving the request.

*Replacement Scanners and Other Equipment (§ 11)*

Existing law exempts from CON requirements the acquisition of MRI, CT, PET, and PET/CT scanners if they are replacements for scanners (1) previously approved through the CON process or (2) for which there was a determination that CON approval was not needed. The act specifies that this includes replacement scanners with dual modalities or functionalities if the applicant already offers similar imaging services for each of the scanner's modalities or functionalities.

The act additionally exempts from CON requirements the acquisition of nonhospital based linear accelerators if they are replacing accelerators that were previously approved (by receiving a CON or a determination that it was not required).

The act makes a corresponding change to an existing provision on CON exemptions for replacing certain equipment, specifying that this applies to the scanners listed above as well as nonhospital based linear accelerators. As under prior law, the act requires the health care facility, provider, physician, or other person acquiring this equipment to notify the unit of the date on which the equipment is replaced and how they disposed of the replaced equipment.

*Application and Public Hearing Notices (§ 12)*

*Application Notice.* Under existing law, before filing a CON application, the applicant must give public notice in a newspaper with substantial circulation in the area. The applicant must publish the notice for at least three consecutive days, no later than 20 days before applying. The act specifies that the final date of publishing this notice must be no later than 20 days before the application is filed.

The act also requires an applicant to:

1. publish notice of the impending application on its website, in a clear and conspicuous location that is easily accessed by the public;
2. request that the notice be published (a) in at least two sites in the affected community that are commonly accessed by the public, such as a town hall or library, and (b) on any existing website of the municipality or local health department; and
3. submit the notice to the Health Systems Planning Unit for posting on its website.

The act specifies that (1) the notice must remain posted in the affected community and on the applicant's website until the decision on the application is made but (2) the unit cannot invalidate any notice due to changes or removal from a community website that the applicant does not control.

By law, within five days after receiving a properly filed CON application, the unit must publish notice of the application on its website.

*Hearing Notice.* By law, the Health Systems Planning Unit must hold a public hearing for CON applications in certain circumstances; the unit has the discretion to hold hearings in other cases. Existing law requires the unit to give the applicant at least two weeks' notice before the hearing and publish a related newspaper notice. Similar to the application notice, the act requires the applicant to post the hearing notice on its website and request that it be published in the other places noted above (i.e., two sites within the affected community and certain local websites). The act also prohibits the unit from invalidating any notice due to changes or removal from a community website that the applicant does not control.

*Requests for Additional Information and Deeming Application Complete (§ 12)*

By law, the Health Systems Planning Unit, within 30 days after a CON application is filed, may request additional information from the applicant as necessary. The applicant has 60 days to provide the requested information.

The act requires the unit to (1) make reasonable efforts to limit requests for additional information to two requests and (2) in all cases, not request additional information later than six months after receiving the application.

By law, the unit must notify the applicant when it considers the application to be complete and post the notice on its website. The act sets a five-day deadline for the unit to notify the applicant and post the notice.

*Independent Consultants (§ 12)*

The act allows the unit, for CON applications submitted on or after October 1, 2023, to retain an independent consultant for assistance if it cannot reasonably review and analyze the application without the expertise of an industry analyst or other actuarial consultant. The consultant must have expertise in the specific health care area under review.

If the unit retains a consultant, it must bill the applicant for the person's services, and the applicant must pay within 30 days after receipt. These bills must be a reasonable amount per application.

The act specifies that these retainer agreements are not subject to specified existing laws on (1) the Department of Administrative Services, (2) consultant and personal service agreements, and (3) methods for awarding state contracts.

*Civil Penalties (§ 14)*

Prior law imposed a civil penalty of up to $1,000 per day for any person, health care facility, or institution ("person or facility") that willfully failed to (1) seek CON approval when required or (2) timely file required data or information under the CON law, other laws (such as those on nonprofit hospital conversions or various required filings with OHS), and related regulations and orders. The act eliminates the prior condition that the failure must be willful for the penalty to apply, instead imposing the penalty for negligent failures to meet these requirements.

It also extends the penalty to any person or facility that has agreed to resolve a CON application through a settlement and negligently fails to comply with any of the agreement's terms or conditions. It extends existing procedures (and related deadlines) to these penalties, such as prior notice, the right to a hearing, and the right to appeal. It similarly extends an existing provision that makes failing to pay the penalty after the final assessment grounds for deducting Medicaid payments.

## §§ 15 & 16 — 340B PROGRAM

*Makes various changes affecting participants in the federal 340B drug pricing program, such as (1) prohibiting certain provisions in contracts between 340B covered entities (including pharmacies) and PBMs, including lower reimbursement rates than for non-participants and (2) requiring DSS to convene a working group to study various issues related to the program*

Section 340B of the federal Public Health Service Act (i.e., the 340B Drug Pricing Program) requires drug manufacturers participating in Medicaid to sell certain outpatient prescription drugs at discounted prices to health care organizations that care for uninsured and low-income patients. These organizations include federally qualified health centers (FQHCs), children's hospitals, hospitals that serve a disproportionate number of low-income patients, and other safety net providers. Under the act, "340B covered entities" are those entities authorized to participate in the program, including pharmacies under contract to dispense drugs on their behalf.

Starting January 1, 2024, the act prohibits certain provisions in contracts between 340B covered entities and PBMs (including PBM subsidiaries). For example, it prohibits these contracts from providing lower reimbursement rates for

prescription drugs than the rate paid to pharmacies that are not 340B covered entities.

The act also prohibits PBMs from:

1. considering whether an entity is a 340B covered entity when determining reimbursement rates, except to the extent allowed by law; and
2. retaliating against a 340B covered entity because it exercises a right or remedy under these provisions.

For contracts between PBMs and 340B covered entities, the act makes any contract provisions that violate the above provisions void and unenforceable. This applies to contracts entered into, amended, or renewed after January 1, 2024. The act also authorizes the insurance commissioner to adopt regulations to implement the above provisions.

Lastly, the act requires the Department of Social Services (DSS) commissioner to convene a working group to evaluate various issues related to the 340B program. EFFECTIVE DATE: October 1, 2023, except the working group provisions take effect upon passage.

*Prohibited Contract Provisions*

Starting January 1, 2024, the act prohibits contracts between 340B covered entities and PBMs from containing any of the following provisions:

1. a lower prescription drug reimbursement rate than the rate paid to pharmacies that are not 340B covered entities;
2. a fee or adjustment that is not imposed on providers or pharmacies that are not 340B covered entities, or is higher than the fee imposed on these other entities;
3. any provision that prevents or interferes with a patient's choice to receive a prescription drug from a 340B covered entity, including the drug's administration; and
4. any provision that excludes a 340B covered entity from PBM networks based on the entity's participation in the 340B program.

*Working Group*

The act requires the DSS commissioner to convene a working group to evaluate the following:

1. the current status of the 340B program;
2. national efforts to strengthen and sustain it; and
3. how the state can protect FQHCs' 340B revenue from unfair administrative barriers or unnecessary conditions based on these centers' status as 340B covered entities.

The evaluation must consider (1) the ability of and any legal precedent for states to regulate the conduct of drug manufacturers and PBMs, (2) opportunities to establish on-site pharmacies at FQHCs and facilitate patient access to these pharmacies, and (3) national trends to sustain the program.

By January 31, 2024, the DSS commissioner must report on the working

group's findings and recommendations to the Human Services, Insurance and Real Estate, and Public Health committees.

## § 17 — HUSKY HEALTH IMPROVEMENT STRATEGY

*Requires DSS, in consultation with other agencies, to develop a strategy to improve health outcomes, community health, and health equity to support HUSKY Health members; requires DSS to submit related recommendations to MAPOC by January 1, 2025*

The act requires the DSS commissioner, in consultation with the OHS executive director, OPM secretary, and other agencies as appropriate, to develop a strategy to improve health care outcomes, community health, and health equity to support HUSKY Health members (i.e., people covered by Medicaid or the Children's Health Insurance Program). In addition, DSS must consult with an association of in-state hospitals, Connecticut acute care and children's hospitals, and other community health care providers and stakeholders to inform community-based prevention policies and wellness, care delivery, and financing strategies.

By January 1, 2025, the DSS commissioner must submit recommendations for reform to the Medical Assistance Program Oversight Council (MAPOC).

EFFECTIVE DATE: Upon passage

### *Strategy Components and Goals*

Under the act, the required strategy must address improved health equity by identifying barriers and influences impacting health and health care outcomes for HUSKY Health members. The strategy must also include options to achieve the following goals:

1. improving health care access and outcomes;
2. increasing adoption of interventions to support improved access to preventive care services;
3. identifying and addressing social, economic, and environmental drivers of health to advance long-term preventive health and health care outcomes;
4. exploring innovative financing reforms that support high quality care, promote integration of primary, preventive, and behavioral health care, and address health-related social needs and long-term preventive outcomes;
5. improving collaboration and coordination among health care providers and cross-sector community partners; and
6. improving Medicaid reimbursement and performance to achieve a sustainable health care delivery system and make health care more affordable for everyone.

The strategy must include approaches designed to improve performance in prevention measures, clinical outcomes, improved access to preventative services, and health equity measures recommended by the Connecticut Medicaid Transparency Advisory Board established through the governor's Executive Order 6 (2020). In that executive order, among other things, the governor directed the DSS commissioner to (1) develop and report on a public transparency strategy for Medicaid cost and quality reporting and (2) convene an advisory board to provide

advice and input on the content, metrics, and goals of this reporting.

*Submission of Recommendations*

The act requires the DSS commissioner, by January 1, 2025, to submit recommendations for reform to MAPOC. This must at least include recommendations for filing any state plan amendments or federal waivers with the Centers for Medicare and Medicaid Services to achieve the goals identified above and agreed upon through the strategy developed under the act. Through the end of 2024, the commissioner may give the council updates and other status reports on the department's progress toward the strategic work on these goals.

## § 18 — MEDICARE ADVANTAGE PLANS REPORT

*Requires the Insurance Department, in consultation with OHS, to report by January 1, 2025, on utilization management and provider payment practices of Medicare Advantage Plans*

Medicare Advantage Plans are managed care plans administered by federally approved private insurers. These plans must cover all services covered by traditional Medicare; some offer additional benefits.

The act requires the Insurance Department, by January 1, 2025, and in consultation with OHS, to report to the Insurance and Real Estate Committee on (1) an analysis of Medicare Advantage plans' utilization management and provider payment practices and (2) related recommendations.

The act allows the Insurance Department, as the commissioner deems necessary, to engage the services of third-party professionals and specialists to help meet these requirements, with any costs paid from the General Fund within available appropriations.

EFFECTIVE DATE: Upon passage

*Required Analysis and Recommendations*

Under the act, the Insurance Department, consulting with OHS, must report on an analysis of Medicare Advantage plans' utilization management and provider payment practices. The act specifically requires the report to cover the following topics:

1. how these practices impact the delivery of hospital outpatient and inpatient services, including patient placement, discharges, transfers, and other clinical care plans;
2. the costs to hospitals and plan members associated with these practices;
3. how these practices affect commercial, non-Medicare payment rates and access to services, including behavioral health services; and
4. a comparison of claims denials, modifications, and reversals on appeal among Medicare Advantage plans and with traditional Medicare, Medicaid, and commercial non-Medicare product lines.

If applicable, the report must indicate the extent to which information and data are unavailable to support specified areas of this analysis.

Based on the findings of the analysis, the report must provide recommendations

on the following:

1. improving care quality, access, and timely delivery;
2. reducing provider administrative costs associated with utilization management;
3. addressing payment practices that inappropriately reduce provider payments;
4. improving any identified practices contributing to unwarranted changes to clinical care plans;
5. considering quarterly monitoring of prior authorization requests, service denials, and payment denials by Medicare Advantage plans and comparing this data to commercial plans and Medicaid;
6. addressing the broad effect of Medicare Advantage plan practices on the health care delivery system, including costs borne by non-Medicare Advantage consumers and plan sponsors;
7. reducing consumers' costs; and
8. the extent to which states can regulate Medicare Advantage plans.

The report must indicate the extent to which the analysis does not support recommendations in any of these areas.

## § 19 — PROHIBITED HEALTH CARE CONTRACTING PRACTICES

*Prohibits all-or-nothing, anti-steering, anti-tiering, and gag clauses in contracts involving health carriers, providers, and health plan administrators*

The act prohibits health care providers, health carriers (e.g., insurers or HMOs), health plan administrators, and any agent or entity contracting on their behalf from offering, soliciting, requesting, amending, renewing, or entering a health care contract on or after July 1, 2024, that includes an all-or-nothing clause, anti-steering clause, anti-tiering clause, or gag clause.

The act makes null and void any of these clauses in a health care contract, written policy or procedure, or agreement entered into, renewed, or amended on or after July 1, 2024. However, it specifies that (1) all remaining clauses remain in effect for the contract's duration and (2) it does not modify, reduce, or eliminate any existing privacy protections and standards under the federal Health Insurance Portability and Accountability, Genetic Information Nondiscrimination, or Americans with Disabilities acts.

EFFECTIVE DATE: July 1, 2024

### *Prohibited Clauses*

The act defines an "all-or-nothing clause" as a health care contract provision requiring health carriers or health plan administrators to (1) include all members of a health care provider in a network plan or (2) contract with a provider's affiliate as a condition of contracting with the provider. An "anti-steering clause" restricts a carrier or administrator from encouraging an enrollee to get health care services from a competing hospital or health system, including by offering incentives for enrollees to use specific health care providers (such as centers of excellence or other

pay-for-performance programs).

An "anti-tiering clause" (1) restricts health carriers from introducing or modifying a tiered network plan or assigning providers to tiers or (2) requires a health carrier to assign all health care provider members to the same tier. A "gag clause" restricts a health care provider, carrier, or administrator from disclosing (1) out-of-pocket costs to enrollees or (2) certain information to a government entity (or its contractors or agents), enrollee or their treating provider, plan sponsor, or potential eligible enrollees. The information is any price or quality information, including allowed amounts, negotiated rates or discounts, fees for services, or other claim-related financial obligations.

*Applicability to Health Care Providers*

The act defines a health care provider as a:

1. physician group with (a) eight or more members or (b) less than eight members that are employed by or are an affiliate of a hospital, medical foundation, or insurance company or
2. for-profit or nonprofit entity, corporation, or organization, parent corporation, member, affiliate, subsidy, or entity under common ownership that is authorized by Connecticut to furnish or bill or receive payment for health care services in the normal course of business, including hospitals, hospital-based facilities, health systems, freestanding emergency departments, imaging centers, and urgent care centers.

## § 20 — HEALTH CARE NETWORK TIERING PRACTICES

*Requires health carriers to disclose how they sort health care providers into tiers*

The act requires health carriers to disclose how they select providers for different tiers and evaluate providers within each tier. In practice, tiers determine different benefit levels within a health insurance plan. By law, health carriers must develop standards for selecting and tiering participating providers and health care provider specialties. The act requires these standards to remain in effect for at least a year. It also requires carriers to:

1. provide at least 90 days' written notice to each participating provider before changing the standards and measures and
2. establish a grievance process for providers to appeal their tiering decisions and performance measures.

The act requires contracts involving a tiered network entered into, renewed, or amended on or after July 1, 2024, between a health carrier and participating provider to require the carrier to give the provider, upon request, his or her calculated score, any available related data, and a description of the standards used for selecting and tiering providers. This includes:

1. definitions and specifications related to quality, cost, efficiency, satisfaction, and any other factors used to develop standards and measure performance, including delineating any inclusions or exclusions under each measure;

2. a defined time period of at least one year to measure performance based on the standards; and
3. a summary of the grievance process.

By law, carriers must make the standards for tiers publicly available in plain language, including on their websites, as well as to the insurance commissioner for review. The act specifies that these disclosures must include (1) all measures and corresponding definitions and specifications used to tier participating providers and evaluate performance within each tier and (2) the grievance process for a health care provider to appeal a health carrier's tiering decision or performance measure.
EFFECTIVE DATE: July 1, 2024

## § 21 — ELECTRONIC NOTIFICATION TO INSUREDS

*Requires health carriers to let covered individuals elect to receive coverage documents electronically*

The act requires health carriers (e.g., insurers and HMOs) that deliver, issue, renew, amend, or continue health insurance policies to allow insured individuals who are legally capable of consenting to a policy's covered benefits to elect, in writing, to receive insurance coverage documents electronically. When providing documents electronically, the carriers must comply with all applicable federal and state data security laws.
EFFECTIVE DATE: October 1, 2023

## § 22 — TERMINATING HEALTH CARE CONTRACTS

*Requires a health carrier and participating provider to give each other at least 90 days' written notice of an intent to terminate or not renew their contract; generally requires the carrier to make a good faith effort to notify affected patients at least 30 days before a termination; extends termination requirements that apply to hospitals to hospital intermediaries*

The act requires that health carriers and providers participating in their network (i.e., participating providers) give each other at least 90 days' written notice of an intent to terminate a contract before the proposed termination date or, if a nonrenewal, the end of the contract period. The act also requires that the carrier make a good faith effort to notify all insured individuals who are regular patients of the participating provider at least 30 days before the proposed termination date or, if a nonrenewal, the end of the contract period. (Prior law imposed these requirements if a provider was being removed from or leaving a network.) Under the act, patient notification is not required if the carrier and participating provider agree in writing to extend the contract up to one year. The act also eliminates a requirement that a provider leaving or removed from a network give the carrier a list of its covered patients.

By law, when a contract between a health carrier and a participating hospital or its parent corporation is terminated or not renewed, the carrier and hospital must continue to abide by the contract for an additional 60 days. For contracts entered into, renewed, amended, or continued on or after July 1, 2023, the act (1) applies

this requirement to hospital intermediaries and (2) specifically requires the parties to continue abiding by the contract's reimbursement terms for all health care services during this 60-day period. (As under existing law, these provisions do not apply if the carrier and hospital agree in writing to the contract termination and make the notices described above.)

EFFECTIVE DATE: Upon passage