House of Representatives

General Assembly

File No. 472

January Session, 2025

Substitute House Bill No. 7115

House of Representatives, April 2, 2025

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING REVISIONS TO THE HEALTH CARE COST GROWTH BENCHMARK PROGRAM.

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

Section 1. Section 19a-754h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(a) (1) Not later than August 15, 2022, and annually thereafter, each payer shall report to the commissioner, in a form and manner prescribed by the commissioner, for the preceding or prior years, if the commissioner so requests based on material changes to data previously submitted, aggregated data, including aggregated self-funded data as applicable, necessary for the commissioner 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 commissioner, payer data required for adjusting total medical expense calculations to reflect changes in the patient population.

(2) Except as provided in subdivision (3) of this subsection, each payer required to report data pursuant to the provisions of subdivision (1) of this subsection shall provide to each employer of a self-funded employee health plan a form, in a form and manner prescribed by the commissioner and made available on the Office of Health Strategy's Internet web site, that such employer may complete to opt in to the submission of such employer's self-funded employee health plan data to such payer.

(3) Notwithstanding the provisions of subdivision (2) of this subsection, any payer may provide to each employer of a self-funded employee health plan a form developed by the insurer for multistate use, provided the commissioner determines that such form is substantially similar to the form prescribed by the commissioner pursuant to the provisions of subdivision (2) of this subsection.

(4) Each form provided by such payer to any such employer of a self-funded employee health plan pursuant to the provisions of subdivision (2) or (3) of this subsection shall be provided not later than fifteen days after claim administration services are retained and after such payer determines that such employer satisfies the requirements of this section.

(5) (A) Except as provided in subdivision (4) of this subsection, each form completed by an employer of a self-funded employee health plan pursuant to the provisions of this subsection shall be effective for the current data reporting period and shall remain effective for all future data reporting periods pursuant to the requirements of this section.

(B) No such employer of a self-funded employee health plan may complete such form to opt in for a partial data reporting period.

(C) Any such employer of a self-funded employee health plan who completes such form to opt in for a data reporting period may opt out of all subsequent data reporting periods by providing written notice to such payer not less than thirty days before the start of the next data reporting period.

(6) For any self-funded employee health plan whose employer completes a form to opt in for the submission of such employer's self-funded health plan data to such payer, such payer shall include such self-funded health plan data as part of such payer's data submission required pursuant to the provisions of this section.

(7) Not later than January 31, 2026, and annually thereafter, each payer shall report to the commissioner, in a form and manner prescribed by the commissioner, for the preceding year:

(A) A list of self-funded employee health plans whose employer opted in for the submission of such employer's self-funded employee health plan data in accordance with the provisions of this subsection;

(B) A list of employers who previously opted in for the submission of such employer's self-funded employee health plan data who subsequently elected to opt out of all subsequent data reporting periods in accordance with the provisions of subparagraph (C) of subdivision (5) of this subsection;

(C) A certification signed by an officer of such payer certifying that such payer has taken reasonable efforts to provide the form required pursuant to subdivision (2) or (3) of this subsection to each employer of a self-funded employee health plan to complete to opt in to the submission of such employer's self-funded health plan data; and

(D) A list identifying each employer, by name and mailing address, to which such payer provided such form.

(8) Such opt-in form required pursuant to the provisions of this subsection shall only be provided to employers of self-funded employee health plans and shall not affect mandatory reporting requirements otherwise required pursuant to this section.

(9) Except for the actual cost incurred to each payer for the submission of an employer's self-funded data to the commissioner pursuant to the provisions of this section, no payer shall impose any cost or fee on any such employer whose self-funded data is included in such

payer's reporting of aggregate data submitted to the commissioner.

(b) Not later than March 31, 2023, and annually thereafter, the commissioner 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 commissioner 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 commissioner 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 commissioner in a form and manner prescribed by the commissioner, for the preceding year, and for prior years if the commissioner so requests based on material changes to data previously submitted, on the health care quality benchmarks adopted pursuant to section 19a-754g.

(e) Not later than March 31, 2024, and annually thereafter, the commissioner 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 commissioner 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.

(g) The commissioner may impose a penalty of not more than ten dollars per covered individual enrolled in a self-funded employee health plan on any payer that fails to provide any employer of a self-funded employee health plan the opt-in form required pursuant to the provisions of subdivision (2) or (3) of subsection (a) of this section.

Sec. 2. Subsection (a) of section 19a-754j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(a) (1) Not later than June 30, 2023, and annually thereafter, the commissioner 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 19a-754g for such year. Such hearing shall involve an examination of:

(A) The report most recently prepared by the commissioner pursuant to subsection (b) of section 19a-754h;

(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 commissioner, in the commissioner's discretion, deems relevant for the purposes of this section.

(2) The commissioner 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 in a form and manner specified by the commissioner. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the commissioner 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 commissioner 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 in a form and manner specified by the commissioner. Any other entity that is required to participate in such hearing shall provide written and oral testimony, as requested by the commissioner, on issues identified by the commissioner 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 commissioner 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 commissioner shall prepare and submit a report, in accordance with section 11-4a, 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 commissioner's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the commissioner, in the commissioner'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 19a-754h;

(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 commissioner'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.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2025*	19a-754h
Sec. 2	*October 1, 2025*	19a-754j(a)

INS *Joint Favorable Subst.*

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

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Office of Health Strategy	GF - Potential Revenue Gain	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a potential revenue gain to the Office of Health Strategy (OHS), as it permits the OHS commissioner to impose penalties on employers that do not comply with the bill's requirements. The revenue gain will be to the extent that the commissioner imposes penalties of $10 per covered individual on employers with self-funded employee health plans.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the number and scale of penalties imposed.

OLR Bill Analysis

sHB 7115

AN ACT CONCERNING REVISIONS TO THE HEALTH CARE COST GROWTH BENCHMARK PROGRAM.

SUMMARY

This bill makes changes in laws related to payers' (e.g., private health insurers) annual reporting of aggregated data the Office of Health Strategy (OHS) uses to calculate total health care expenditures, primary care spending as a percentage of total medical expenses, and the net cost of private health insurance in the state.

Specifically, the bill requires payers to include self-funded employee health plan data in their annual data submission to OHS, if the employer of the self-funded employee health plan completes an opt-in form, which the commissioner must prescribe. Regarding the opt-in process, the bill does the following:

1. generally requires payers to give employers the form within 15 days after the claim administration services are retained and imposes a penalty for failing to do so;

2. keeps all completed opt-in forms in effect for all future data reporting periods, but allows an employer to opt out by providing written notice;

3. requires the payer to include, as part of its required data submission, the self-funded health plan data for employers that opted in; and

4. generally prohibits the payer from imposing a cost or fee on an employer whose self-funded health benefit plan data is included in the payer's submission to the commissioner.

The bill also requires each payer, starting by January 31, 2026, to annually report to the commissioner specified information for the preceding year, such as a list of the employers that opted in and a list of those that opted out.

Existing law requires the OHS commissioner to hold annual informational hearings that certain payers, provider entities, and other entities must participate in. The bill (1) authorizes the commissioner to specify how these entities must participate and (2) specifies that the participant's required testimony can be written and oral, as the commissioner requests.

EFFECTIVE DATE: October 1, 2025

PAYER REPORTING REQUIREMENTS

Payer Defined

By law, a "payer" is an entity 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 OHS commissioner. It includes Medicaid, Medicare, governmental and nongovernment health plans, and any organization acting as payer that is a subsidiary, affiliate, or business owned or controlled by a payer (CGS § 19a-754f(9)).

Payer Annual Reporting Requirement

Existing law requires each payer to annually report to the OHS commissioner certain aggregated data for the preceding year, including for self-funded plans. The commissioner uses this data to calculate total health care expenditures, primary care spending as a percentage of total medical expenses, and the net cost of private health insurance.

The bill makes the changes below to this law as it pertains to reporting self-funded health plan data.

Opt-in Form. Under the bill, each payer required to report data must give employers with self-funded employee health plans a form that an employer may complete to opt in to submitting its employee health plan data to the payer, which the payer includes in its submission to OHS.

The opt-in form must be prescribed by the OHS commissioner and available on the office's website. The bill allows the payer to use a form developed for multistate use, if the commissioner determines that it is substantially like the form she prescribes.

Penalty for Failure to Provide the Opt-in Form. The bill authorizes the commissioner to impose a penalty on any payer that fails to give the opt-in form to an employer with a self-funded employee health plan. The penalty may be up to $10 per covered person enrolled in a self-funded employee health plan.

Delivery and Effective Date. The payer must give the employer the form within 15 days after the claim administration services are retained and the payer determines that the employer satisfies the bill's requirements. A completed opt-in form is effective for the current data reporting period and stays effective for all future data reporting periods (unless the employer opts out, see below). Also, an employer cannot opt in for a partial data reporting period.

Opting Out. An employer who opts in for a data reporting period may opt out of all subsequent data reporting periods by providing written notice at least 30 days before the next data reporting period starts.

Reporting Self-Funded Health Plan Data. The payer must include the self-funded health plan data as part of the payer's required data submission.

Payer's Report to the OHS Commissioner

Starting by January 31, 2026, each payer must annually report to the commissioner, in a form and manner she prescribes, the following for the preceding year:

1. a list of self-funded employee health plans whose employer opted in for submitting self-funded health plan data as described above;

2. a list of employers who previously opted in for submitting the data but subsequently opted out;

3. a signed certification by a payer's officer certifying that the payer has taken reasonable efforts to give each employer the opt-in form; and

4. a list identifying each employer, by name and mailing address, to whom the payer gave the form.

Other Provisions

The bill specifies that the opt-in form can only be given to employers with self-funded employee health plans. It also specifies that providing the form in compliance with the bill does not affect any other required reporting.

The bill generally prohibits any payer from imposing a cost or fee on an employer whose self-funded data is included in the payer's reporting of aggregate data to the commissioner. However, the bill allows a payor to impose the actual cost incurred for the data submission.

INFORMATIONAL PUBLIC HEARING

By law, the OHS commissioner must hold an informational public hearing annually to compare the growth in total health care expenditures in the performance year to the health care cost growth benchmark (see BACKGROUND) for that year.

The bill authorizes the commissioner to specify how payers, provider entities, and other entities (see below) participate in the informational hearing.

The bill also requires the other entities that may be required to participate in the hearing to provide written and oral testimony as the commissioner requests.

Under existing law, the commissioner may require the following persons to participate in the hearing:

1. payers and provider entities found to be significant contributors to healthcare cost growth in the state for the performance year, or that failed to meet the primary care spending target, and

2. any other entity found to be a significant contributor to health care cost growth in the state during the performance year.

By law, an "other entity" is a drug manufacturer, pharmacy benefits manager, or other health care provider that is not a provider entity (CGS § 19a-754f(8)). A "provider entity" is an organized group of clinicians that (1) come together for contracting purposes or (2) are an established billing unit that at least 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 (CGS § 19a-754f(13)).

BACKGROUND

Healthcare Cost Benchmark

By law, the OHS commissioner must publish on the office's Internet web site the (1) 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) annual health care quality benchmarks for the calendar years 2022 to 2025, inclusive.

By July 1, 2025, and every five years after that, the commissioner must develop and adopt annual health care cost growth benchmarks and annual primary care spending targets for the following five calendar years for provider entities and payers (CGS § 19a-754g).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 13 Nay 0 (03/13/2025)