General Assembly **Substitute Bill No. 6871**

January Session, 2025

AN ACT LIMITING OUT-OF-NETWORK HEALTH CARE COSTS.

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

1 Section 1. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

2 (1) "Commissioner" means the commissioner of the Office of Health
3 Strategy;

4 (2) "Health benefit plan" means any agreement, including, but not
5 limited to, a nonfederal governmental plan, as defined in 29 USC
6 1002(32), a policy, a contract, a certificate or an agreement entered into,
7 offered or issued by a health carrier or health plan administrator acting
8 on behalf of a plan sponsor to provide, deliver, arrange for, pay for or
9 reimburse any of the costs of health care services, but does not include
10 any coverage for health care services by Medicare, Medicaid, TriCare,
11 the United States Department of Veterans Affairs, the Indian Health
12 Services or the Federal Employees Health Benefits Program;

13 (3) "Health care provider" means any individual, for-profit or
14 nonprofit entity, corporation or organization, including, but not limited
15 to, any health system, hospital or hospital-based facility that furnishes,
16 bills for or is paid for the delivery of health care services in the normal
17 course of business;

18 (4) "Health carrier" means any entity subject to the insurance laws
19 and regulations of this state or subject to the jurisdiction of the Insurance
20 Commissioner that offers health insurance, health benefits or contracts
21 for health care services, including, but not limited to, prescription drug
22 coverage, to large groups, small groups or individuals on or outside the
23 insurance marketplace;

24 (5) "Health plan administrator" means any third-party administrator
25 who acts on behalf of a plan sponsor to administer a health benefit plan;

26 (6) "Health system" means: (A) A parent corporation of one or more
27 hospitals and any entity affiliated with such parent corporation through
28 ownership, governance, membership or other means, or (B) a hospital
29 and any entity affiliated with such hospital through ownership,
30 governance or membership;

31 (7) "Hospital" has the same meaning as provided in section 19a-490
32 of the general statutes;

33 (8) "Hospital-based facility" means any facility (A) owned or
34 operated, in whole or in part, by a hospital, and (B) where hospital or
35 professional medical services are provided; and

36 (9) "Hospital price transparency laws" means Section 2718(e) of the
37 Public Health Service Act, 42 USC 256b, as amended from time to time,
38 and rules adopted by the United States Department of Health and
39 Human Services implementing said section.

40 (b) (1) The total out-of-network costs assessed by any health care
41 provider for an inpatient or outpatient hospital service furnished to any
42 person covered by a health benefit plan entered into, renewed or
43 amended on or after January 1, 2027, with whom the health care
44 provider does not participate shall not exceed two hundred forty per
45 cent of the reimbursement rate payable under Medicare for the same
46 service provided in the same geographic area.

47 (2) No health care provider who is reimbursed in accordance with

48 subdivision (1) of this subsection shall charge or collect from the patient,
49 or any person who is financially responsible for the patient, any amount
50 greater than cost-sharing amounts authorized by the terms of the health
51 benefit plan and allowed under applicable law. The total cost, including
52 amounts paid by such health benefit plan and individual cost-sharing,
53 shall not exceed the assessed costs specified in subdivision (1) of this
54 subsection or a separate amount as determined by the Office of Health
55 Strategy in regulations adopted pursuant to subsection (f) of this section.

56 (3) If a health benefit plan does not reimburse claims on a fee-for-
57 service basis, the payment method used shall take into account the limit
58 on the assessed costs specified in subdivision (1) of this subsection. Such
59 payment methods include, but are not limited to, value-based
60 payments, capitation payments and bundled payments.

61 (4) A health benefit plan shall pass on any savings from any reduction
62 in health care provider payments pursuant to this subsection to
63 consumers. Any savings by a health carrier from any reduction in health
64 care provider payments shall be reflected in such health carrier's annual
65 rate filing for such health benefit plan.

66 (5) This subsection shall not apply to (A) a hospital located in a rural
67 town, as designated by the State Office of Rural Health, or (B) a federally
68 qualified health center, as described in section 17b-245b of the general
69 statutes.

70 (c) (1) Each health care provider shall provide the Office of Health
71 Strategy, in a form and manner prescribed by the commissioner, any
72 information and data covered under hospital price transparency laws
73 and any additional data that the Office of Health Strategy determines is
74 necessary to calculate the costs of in-network and out-of-network
75 hospital services and to monitor compliance with the limit on out-of-
76 network costs established in subsection (b) of this section.

77 (2) The Office of Health Strategy shall keep confidential all nonpublic
78 information and data obtained under subdivision (1) of this subsection
79 and shall not disclose such information or documents to any person

80 without the consent of the party that produced such information or
81 documents, except such information or documents may be disclosed to
82 an expert or consultant under contract with said office, provided such
83 expert or consultant is bound by the same confidentiality requirements
84 as said office. Such information and documents shall not be public
85 records and shall be exempt from disclosure pursuant to the provisions
86 of chapter 14 of the general statutes.

87 (3) Not later than January 1, 2028, and biannually thereafter, the
88 Office of Health Strategy shall report, in accordance with the provisions
89 of section 11-4a of the general statutes, to the joint standing committee
90 of the General Assembly having cognizance of matters relating to
91 insurance on trends of health care provider in-network and out-of-
92 network costs and compliance with the provisions of this section. The
93 Office of Health Strategy may include in such report recommendations
94 for further action to make health care more affordable and accessible to
95 residents of this state.

96 (d) Any health care provider who violates any provision of this
97 section may be (1) required to refund to the patient, or any person who
98 is financially responsible for the patient, or to the health benefit plan, as
99 applicable, any amount received by such health care provider that
100 exceeds the amounts established pursuant to the provisions of
101 subsection (b) of this section, and (2) liable for a civil penalty of not more
102 than one thousand dollars, provided the commissioner complies with
103 the requirements pursuant to the provisions of subsection (e) of this
104 section.

105 (e) (1) (A) If the commissioner receives information or has a
106 reasonable belief that any person, health care provider or health carrier
107 violated or is violating any provision of this section, or rule or regulation
108 adopted thereunder, the commissioner may issue a notice of violation
109 and civil penalty pursuant to this section by first-class mail or personal
110 service. Such notice shall include: (i) A reference to the section of the
111 general statutes, rule or section of the regulations of Connecticut state
112 agencies believed or alleged to have been violated; (ii) a short and plain

113 language statement of the matters asserted or charged; (iii) a description
114 of the activity to cease; (iv) a statement of the amount of the civil penalty
115 or penalties to be imposed; (v) a statement concerning the right to a
116 hearing; and (vi) a statement that such person, health care provider or
117 health carrier may, not later than ten business days after receipt of such
118 notice, make a request for a hearing on the matters asserted.

119 (B) The person, health care provider or health carrier to whom such
120 notice is provided pursuant to subparagraph (A) of this subdivision
121 may, not later than ten business days after receipt of such notice, make
122 written application to the Office of Health Strategy to request a hearing
123 to demonstrate that such violation did not occur. The failure to make a
124 timely request for a hearing shall result in the issuance of a cease and
125 desist order or civil penalty. All hearings held under this subsection
126 shall be conducted in accordance with the provisions of chapter 54 of
127 the general statutes.

128 (C) Following any hearing before the Office of Health Strategy
129 pursuant to this subsection, if the Office of Health Strategy finds by a
130 preponderance of the evidence that such person, health care provider or
131 health carrier violated or is violating any provision of this section, any
132 rule or regulation adopted thereunder or any order issued by the Office
133 of Health Strategy, the Office of Health Strategy shall issue a final cease
134 and desist order in addition to any civil penalty the Office of Health
135 Strategy imposes.

136 (2) The commissioner, or the commissioner's designee, may audit any
137 person, health care provider or health carrier subject to the provisions
138 of this section for compliance with the requirements of this section. Until
139 the expiration of four years after the furnishing of any services for which
140 an out-of-network cost was charged, billed or collected, each person,
141 health care provider or health carrier subject to any such audit shall
142 make available, upon written request of the Commissioner of the Office
143 of Health Strategy, or the commissioner's designee, copies of any books,
144 documents, records or data that are necessary for completing such audit.

145 (f) The Office of Health Strategy may adopt regulations, in
146 accordance with the provisions of chapter 54 of the general statutes, to
147 implement the provisions of this section. The commissioner may
148 implement policies and procedures necessary to administer the
149 provisions of this section while in the process of adopting such policies
150 and procedures in regulation form, provided notice of intent to adopt
151 regulations is published by the commissioner on the Office of Health
152 Strategy's Internet web site and the eRegulations System not later than
153 twenty days after implementing such policies and procedures. Policies
154 and procedures implemented pursuant to this subsection shall be valid
155 until final regulations are adopted in accordance with the provisions of
156 chapter 54 of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2026*	New section

INS *Joint Favorable Subst.*

APP *Joint Favorable*