Senate

General Assembly

File No. 389

January Session, 2023

Substitute Senate Bill No. 1116

Senate, April 3, 2023

The Committee on Insurance and Real Estate reported through SEN. CABRERA of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

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

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

Section 1. (NEW) (*Effective from passage*) (a) For the purposes of this section:

(1) "Affordable Care Act" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Exchange" means the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes; and

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

(b) The office shall, in conjunction with the Office of Policy and Management, the Insurance Department and the Health Reinsurance Association created under section 38a-556 of the general statutes, seek a

state innovation waiver under Section 1332 of the Affordable Care Act to establish a reinsurance program pursuant to subsection (d) of this section.

(c) Subject to the approval of a waiver described in subsection (b) of this section, the office, not later than September 1, 2024, for plan year 2025, and annually thereafter for the subsequent plan year, shall:

(1) Determine the amount needed, not to exceed twenty-one million two hundred ten thousand dollars, annually, to fund the reinsurance program established pursuant to subsection (d) of this section; and

(2) Inform the Office of Policy and Management of the amount determined pursuant to subdivision (1) of this subsection.

(d) The amount set forth in subsection (c) of this section shall be utilized to establish a reinsurance program for the individual health insurance market designed to lower premiums on health benefit plans sold in such market, on and off the exchange, provided the federal government approves the waiver described in subsection (b) of this section. Any such reinsurance program shall be administered by the Health Reinsurance Association. The Treasurer shall annually pay the amount as described in subsection (c) of this section for the purpose of administering such reinsurance program.

(e) If the waiver described in subsection (b) of this section terminates and the office does not obtain another waiver pursuant to subsection (a) of this section, the Treasurer shall cease paying the amount described in subsection (c) of this section for the purpose of administering the reinsurance program established pursuant to subsection (d) of this section.

Sec. 2. Subsection (b) of section 19a-754a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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;

(7) Consulting with the Commissioner of Social Services, Insurance Commissioner and Connecticut Health Insurance Exchange on the Covered Connecticut program described in section 19a-754c; and

(8) (A) Setting an annual health care cost growth benchmark and primary care spending target pursuant to section 19a-754g, as amended

by this act, (B) developing and adopting health care quality benchmarks pursuant to section 19a-754g, as amended by this act, (C) developing strategies, in consultation with stakeholders, to meet such benchmarks and targets developed pursuant to section 19a-754g, as amended by this act, (D) enhancing the transparency of hospitals, as defined in section 19a-490, (E) enhancing the transparency of provider entities, as defined in subdivision **[**(13)**]** (14) of section 19a-754f, as amended by this act, **[**(E)**]** **(**F**)** monitoring the development of accountable care organizations and patient-centered medical homes in the state, and **[**(F)**]** **(**G**)** monitoring the adoption of alternative payment methodologies in the state.

Sec. 3. Section 19a-754f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

For the purposes of this section and sections 19a-754g to 19a-754k, inclusive, as amended by 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, (B) studied or listed pursuant to subsection (c) or (d) of section 19a-754b, 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 19a-754g, as amended by this act;

(4) "Health care quality benchmark" means an annual benchmark established pursuant to section 19a-754g, as amended by this act;

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

(6) "Hospital" means any health care facility, as defined in section 19a-630, that is licensed as a short-term general hospital by the Department of Public Health;

[(6)**]** (7) "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)**]** (8) "Office" means the Office of Health Strategy established under section 19a-754a, as amended by this act;

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

[(9)**]** (10) "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, hospitals or pharmacies or provider entities for prescription drugs designated by the executive director;

[(10)**]** (11) "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)**]** (12) "Pharmacy benefits manager" has the same meaning as provided in subdivision (10) of section 38a-479ooo;

[(12)**]** (13) "Primary care spending target" means the annual target established pursuant to section 19a-754g, as amended by this act;

[(13)**]** (14) "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)**]** (15) "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)**]** (16) "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)**]** (17) "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. 4. Section 19a-754g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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 hospitals, 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 19a-754h, as amended by 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.

(E) Notwithstanding the provisions of subparagraphs (A) to (D), inclusive, of this subdivision, if the average annual health care cost growth benchmark for a succeeding five-year period described in this subdivision differs from the average annual health care cost growth benchmark for the five-year period preceding such succeeding five-year period by more than one-half of one per cent, the executive director shall submit the annual health care cost growth benchmarks developed for such succeeding five-year period to the joint standing committee of the General Assembly having cognizance of matters relating to insurance for the committee's review and approval. The committee shall be deemed to have approved such annual health care cost growth benchmarks for such succeeding five-year period, except upon a vote to reject such benchmarks by the majority of committee members at a meeting of such committee called for the purpose of reviewing such benchmarks and held not later than thirty days after the executive director submitted such benchmarks to such committee. If the committee votes to reject such benchmarks, the executive director may submit to the committee modified annual health care cost growth benchmarks for such succeeding five-year period for the committee's review and approval in accordance with the provisions of this subparagraph. The executive director shall not be required to hold an

informational public hearing concerning such modified benchmarks. Until the joint standing committee of the General Assembly having cognizance of matters relating to insurance approves annual health care cost growth benchmarks for the succeeding five-year period, such benchmarks shall be deemed to be equal to the average annual health care cost growth benchmark for the preceding five-year period.

(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 hospitals, 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. The executive director or the executive director's contractors, in carrying out the purposes of this section and sections 19a-754f, as amended by this act, and 19a-754h to 19a754j, inclusive, as amended by this act, shall utilize currently available data sources, including data available through the all-payer claims database established under section 19a-755a.

Sec. 5. Section 19a-754h of the general statutes is repealed and the following is substituted in lieu thereof (*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, hospital 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, hospital 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 19a-754g, as amended by 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, hospitals 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. 6. Subsection (a) of section 19a-754i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) (1) For each calendar year, beginning on January 1, 2023, the executive director shall, if the payer, hospital or provider entity subject to the cost growth benchmark or primary care spending target so requests, meet with such payer, hospital or provider entity to review and validate the total medical expenses data collected pursuant to section 19a-754h, as amended by this act, for such payer, hospital or provider entity. The executive director shall review information provided by the payer, hospital or provider entity and, if deemed necessary, amend findings for such payer, hospital or provider prior to the identification of payer, hospital 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 19a-754h, as amended by this act. The executive director shall identify, not later than May first of such calendar year, each payer, hospital 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, hospital or provider entity subject to the health care quality benchmarks for the performance year so requests, meet with such payer, hospital or provider entity to review and validate the quality data collected pursuant to section 19a-754h, as amended by this act, for such payer, hospital or provider entity. The

executive director shall review information provided by the payer, hospital or provider entity and, if deemed necessary, amend findings for such payer, hospital or provider prior to the identification of payer, hospital or provider entities that exceeded the health care quality benchmark as set forth in section 19a-754h, as amended by this act. The executive director shall identify, not later than May first of such calendar year, each payer, hospital 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, hospital or provider entity pursuant to subdivisions (1) and (2) of this subsection, the executive director shall send a notice to each such payer, hospital or provider entity. Such notice shall be in a form and manner prescribed by the executive director, and shall disclose to each such payer, hospital or provider entity:

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

Sec. 7. Section 19a-754j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(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 19a-754g, as amended by 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 19a-754h, as amended by this act;

(B) The expenditures of hospitals, 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, hospital 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, hospital 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, hospital's or entity's contribution to future state-wide health care costs and expenditures or to increase such payer's, hospital'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, 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 19a-754h, as amended by this act;

(C) Describe a plan for monitoring any unintended adverse consequences, including, but not limited to, any impacts on funding for individuals with developmental disabilities, 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, hospitals and provider entities in the performance year to the quality benchmarks established for such year pursuant to section 19a-754g, as amended by 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 19a-754h, as amended by 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, hospital 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, hospital 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, hospital'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, 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 19a-754h, as amended by 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. 8. (NEW) (*Effective October 1, 2023*) (a) For the purposes of this section:

(1) "Campus" and "hospital-based facility" have the same meanings as provided in section 19a-508c of the general statutes; and

(2) "National provider identifier" means a standard, unique health identifier for each health care provider issued by the Centers for Medicare and Medicaid Services' National Plan and Provider

Enumeration System.

(b) On and after January 1, 2024, each hospital-based facility in this state located off-site from a hospital campus shall submit with each claim for reimbursement or payment for health care services provided at such facility, such facility's national provider identifier and federal tax identification number. Such national provider identifier and federal tax identification number shall be (1) separate from any national provider identifier and federal tax identification number issued to such hospital campus, and (2) included on any claim for reimbursement or payment for health care services provided at such facility, regardless of whether such claim or reimbursement is filed or submitted by or through a separate facility or hospital.

(c) 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.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*October 1, 2023*	19a-754a(b)
Sec. 3	*October 1, 2023*	19a-754f
Sec. 4	*October 1, 2023*	19a-754g
Sec. 5	*from passage*	19a-754h
Sec. 6	*October 1, 2023*	19a-754i(a)
Sec. 7	*October 1, 2023*	19a-754j
Sec. 8	*October 1, 2023*	New section

Statement of Legislative Commissioners:
In Section 2(b)(8)(E), an internal reference was changed for accuracy.

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 24 $	FY 25 $
Office of Health Strategy	IF – Potential Cost	See Below	See Below
Connecticut Health Insurance Exchange	Resources of the Exchange – Potential Revenue Impact	None	See Below
Resources of the General Fund	GF - Potential Revenue Gain	None	See Below

Note: GF=General Fund; IF=Insurance Fund; Various=Various

Municipal Impact: None

Explanation

The bill could result in a revenue impact to the Connecticut Health Insurance Exchange after a reinsurance program is in place, to the extent reinsurance changes the aggregate amount of premiums sold for individual market health insurance. The exchange is almost entirely funded by a marketplace assessment, charged at 1.65% of premiums sold by carriers in the individual and small group markets. While reinsurance would almost certainly reduce aggregate premiums for current enrollees (leading to a revenue loss for the exchange), additional premium related to new enrollment at lower premium prices could offset that effect.

The bill may also result in a revenue gain to the General Fund beginning as early as FY 25. Generally, Section 1332 waiver programs generate new state revenue from the federal government (known as "pass-through" funding) which can partially fund the program. The

amount is based on how much the program reduces federal premium tax credits for Connecticut exchange enrollees. Previous research has estimated that a reinsurance program with a state investment of $19.5 million could generate $23 million or more in federal pass-through funding.[1] Any such revenue would be received annually while the waiver was in effect, after the waiver was applied for and approved.

The bill may also result in a potential cost to the Insurance Fund to the extent that additional Office of Health Strategy personnel are necessary to fulfill the provisions of the bill.

The Out Years

The annualized ongoing fiscal impact described above would continue into the future subject to the change in total premium in the individual health insurance market and federal approval of a Section 1332 waiver.

[1] Research by Wakely Consulting Group, LLC. commissioned by the exchange and reported in February 2020. Note that such estimates may no longer be accurate due to significant shifts in the individual insurance market from the COVID-19 pandemic and changes to federal subsidies under the American Rescue Plan.

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)