



# House of Representatives

General Assembly

**File No. 409**

January Session, 2025

House Bill No. 7116

*House of Representatives, April 1, 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 bill ought to pass.

## **AN ACT CONCERNING INSURANCE ACCOUNTABILITY AND TRANSPARENCY.**

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

1 Section 1. Section 38a-477i of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective July 1, 2025*):

3 (a) As used in this section:

4 (1) "All-or-nothing clause" means any provision in a health care  
5 contract that:

6 (A) Requires the health carrier or health plan administrator to include  
7 all members of a health care provider in a network plan; or

8 (B) Requires the health carrier or health plan administrator to enter  
9 into any additional contract with an affiliate of the health care provider  
10 as a condition to entering into a contract with such health care provider;

11 (2) "Anti-steering clause" means any provision in a health care

12 contract that restricts the ability of the health carrier or health plan  
13 administrator from encouraging an enrollee to obtain a health care  
14 service from a competitor of a hospital or health system, including  
15 offering incentives to encourage enrollees to utilize specific health care  
16 providers such as centers of excellence or any other pay-for-  
17 performance program;

18 (3) "Anti-tiering clause" means any provision in a health care contract  
19 that:

20 (A) Restricts the ability of the health carrier or health plan  
21 administrator to introduce and modify a tiered network plan or assign  
22 health care providers into tiers, including a network that tiers providers  
23 by cost or quality; or

24 (B) Requires the health carrier or health plan administrator to place  
25 all members of a health care provider in the same tier of a tiered network  
26 plan;

27 (4) "Gag clause" means any provision in a health care contract that:

28 (A) Restricts the ability of the health care provider, health carrier or  
29 health plan administrator to disclose any price or quality information,  
30 including, but not limited to, the allowed amount, negotiated rates or  
31 discounts, any fees for services or any other claim-related financial  
32 obligations included in the provider contract, to any governmental  
33 entity as authorized by law or such government entity's contractors or  
34 agents, any enrollee, any treating health care provider of an enrollee,  
35 plan sponsor or potential eligible enrollees and plan sponsors; or

36 (B) Restricts the ability of either any health care provider, health  
37 carrier or health plan administrator to disclose out-of-pocket costs to  
38 any enrollee;

39 (5) "Health benefit plan", "network", "network plan" and "tiered  
40 network" have the same meanings as provided in section 38a-472f;

41 (6) "Health care contract" means any contract, agreement or

42 understanding, either orally or in writing, entered into, amended,  
43 restated or renewed between a health care provider and a health carrier,  
44 health plan administrator, plan sponsor or its contractors or agents for  
45 delivery of health care services to an enrollee of a health benefit plan;

46 (7) "Health care provider" means any for-profit or nonprofit entity,  
47 corporation or organization, parent corporation, member, affiliate,  
48 subsidiary or entity under common ownership that is or whose  
49 members are licensed or otherwise authorized by this state to furnish,  
50 bill for or receive payment for health care service delivery in the normal  
51 course of business, including, but not limited to, a health system,  
52 hospital, hospital-based facility, freestanding emergency department,  
53 imaging center, physician group with eight or more physicians, urgent  
54 care center, as defined in section 19a-493d, and any physician or  
55 physician group in a practice of fewer than eight physicians that is  
56 employed by or an affiliate of any hospital, medical foundation or  
57 insurance company;

58 (8) "Health carrier" has the same meaning as provided in section 38a-  
59 591a; [and]

60 (9) "Health plan administrator" means any third-party administrator  
61 who acts on behalf of a plan sponsor to administer a health benefit plan;  
62 and

63 (10) "Revenue neutrality clause" means any provision in a health care  
64 contract that requires a health carrier or health plan administrator to  
65 indemnify or hold harmless a health care provider.

66 (b) No health care provider, health carrier, health plan administrator  
67 or any agent or other entity that contracts on behalf of a health care  
68 provider, health carrier, or health plan administrator, may offer, solicit,  
69 request, amend, renew or enter into a health care contract on or after  
70 July 1, [2024] 2025, that directly or indirectly includes any of the  
71 following provisions:

72 (1) An all-or-nothing clause;

73 (2) An anti-steering clause;

74 (3) An anti-tiering clause; [or]

75 (4) A gag clause; or

76 (5) A revenue neutrality clause.

77 (c) Any clause in a health care contract, written policy, written  
78 procedure or agreement entered into, renewed or amended on or after  
79 July 1, [2024] 2025, that is contrary to the provisions set forth in  
80 subsection (b) of this section shall be null and void. All remaining  
81 clauses of such health care contract, written policy, written procedure  
82 or agreement shall remain in effect for the duration of the contract term.

83 (d) Nothing in this section shall be construed to modify, reduce or  
84 eliminate the existing privacy protections and standards pursuant to the  
85 federal Health Insurance Portability and Accountability Act of 1996, P.L.  
86 104-191, as amended from time to time, the federal Genetic Information  
87 Nondiscrimination Act of 2008, P.L. 110-233, as amended from time to  
88 time, or the federal Americans with Disabilities Act of 1990, 42 USC  
89 12101, as amended from time to time.

90 Sec. 2. Section 19a-754f of the general statutes is repealed and the  
91 following is substituted in lieu thereof (*Effective from passage*):

92 For the purposes of this section, and sections 19a-754g to 19a-754k,  
93 inclusive, and section 3 of this act:

94 (1) "Drug manufacturer" means the manufacturer of a drug that is:  
95 (A) Included in the information and data submitted by a health carrier  
96 pursuant to section 38a-479qqq, (B) studied or listed pursuant to  
97 subsection (c) or (d) of section 19a-754b, or (C) in a therapeutic class of  
98 drugs that the Commissioner of Health Strategy determines, through  
99 public or private reports, has had a substantial impact on prescription  
100 drug expenditures, net of rebates, as a percentage of total health care  
101 expenditures;

- 102 (2) "Commissioner" means the Commissioner of Health Strategy;
- 103 (3) "Health care cost growth benchmark" means the annual  
104 benchmark established pursuant to section 19a-754g;
- 105 (4) "Health care quality benchmark" means an annual benchmark  
106 established pursuant to section 19a-754g;
- 107 (5) "Health care provider" has the same meaning as provided in  
108 subdivision (1) of subsection (a) of section 19a-17b;
- 109 (6) "Net cost of private health insurance" means the difference  
110 between premiums earned and benefits incurred, and includes insurers'  
111 costs of paying bills, advertising, sales commissions, and other  
112 administrative costs, net additions or subtractions from reserves, rate  
113 credits and dividends, premium taxes and profits or losses;
- 114 (7) "Office" means the Office of Health Strategy established under  
115 section 19a-754a;
- 116 (8) "Other entity" means a drug manufacturer, pharmacy benefits  
117 manager or other health care provider that is not considered a provider  
118 entity;
- 119 (9) "Payer" means a payer, including Medicaid, Medicare and  
120 governmental and nongovernment health plans, and includes any  
121 organization acting as payer that is a subsidiary, affiliate or business  
122 owned or controlled by a payer that, during a given calendar year, pays  
123 health care providers for health care services or pharmacies or provider  
124 entities for prescription drugs designated by the Commissioner of  
125 Health Strategy;
- 126 (10) "Performance year" means the most recent calendar year for  
127 which data were submitted for the applicable health care cost growth  
128 benchmark, primary care spending target or health care quality  
129 benchmark;
- 130 (11) "Pharmacy benefits manager" has the same meaning as provided

131 in subdivision (10) of section 38a-479o;

132 (12) "Primary care spending target" means the annual target  
133 established pursuant to section 19a-754g;

134 (13) "Provider entity" means an organized group of clinicians that  
135 come together for the purposes of contracting, or are an established  
136 billing unit that, at a minimum, includes primary care providers, and  
137 that collectively, during any given calendar year, has enough attributed  
138 lives to participate in total cost of care contracts, even if they are not  
139 engaged in a total cost of care contract;

140 (14) "Potential gross state product" means a forecasted measure of the  
141 economy that equals the sum of the (A) expected growth in national  
142 labor force productivity, (B) expected growth in the state's labor force,  
143 and (C) expected national inflation, minus the expected state population  
144 growth;

145 (15) "Total health care expenditures" means the sum of all health care  
146 expenditures in this state from public and private sources for a given  
147 calendar year, including: (A) All claims-based spending paid to  
148 providers, net of pharmacy rebates, (B) all patient cost-sharing amounts,  
149 and (C) the net cost of private health insurance; and

150 (16) "Total medical expense" means the total cost of care for the  
151 patient population of a payer or provider entity for a given calendar  
152 year, where cost is calculated for such year as the sum of (A) all claims-  
153 based spending paid to providers by public and private payers, and net  
154 of pharmacy rebates, (B) all nonclaims payments for such year,  
155 including, but not limited to, incentive payments and care coordination  
156 payments, and (C) all patient cost-sharing amounts expressed on a per  
157 capita basis for the patient population of a payer or provider entity in  
158 this state.

159 Sec. 3. (NEW) (*Effective from passage*) (a) Not later than March 1, 2026,  
160 and annually thereafter, the Commissioner of Health Strategy shall  
161 submit to the Insurance Commissioner aggregated data, including

162 aggregated self-funded data, as applicable, provided by each payer for  
 163 the preceding year pursuant to section 19a-754h of the general statutes,  
 164 necessary for the Commissioner of Health Strategy to calculate total  
 165 health care expenditures, primary care spending as a percentage of total  
 166 medical expenses and net cost of private health insurance.

167 (b) Upon receipt of such data from the Commissioner of Health  
 168 Strategy, the Insurance Commissioner may engage the services of any  
 169 actuary, actuarial firm or any other independent expert as the Insurance  
 170 Commissioner deems necessary to conduct an audit of such data  
 171 provided to the Insurance Commissioner pursuant to the provisions of  
 172 subsection (a) of this section. Upon completion of such audit conducted  
 173 pursuant to this subsection, the auditor shall submit a written audit  
 174 report to the Insurance Commissioner, the Commissioner of Health  
 175 Strategy and the joint standing committees of the General Assembly  
 176 having cognizance of matters relating to insurance and public health, in  
 177 accordance with the provisions of section 11-4a of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2025</i>	38a-477i
Sec. 2	<i>from passage</i>	19a-754f
Sec. 3	<i>from passage</i>	New section

**INS**      *Joint Favorable*

*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.*

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**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 26 \$	FY 27 \$
Insurance Dept.	IF - Potential Cost	Up to 100,000	Up to 100,000

Note: IF=Insurance Fund

**Municipal Impact:** None

**Explanation**

The bill requires the Office of Health Strategy (OHS) to submit data to the Insurance Commissioner and allows, rather than requires, the Insurance Department to engage the services of a contractor to audit the data. This results in a potential cost to the Insurance Department of up to \$100,000 beginning in FY 26, and annually thereafter, for costs associated with the audits.

The bill does not result in a fiscal impact to OHS since the agency already collects this data.

**The Out Years**

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

**OLR Bill Analysis****HB 7116*****AN ACT CONCERNING INSURANCE ACCOUNTABILITY AND TRANSPARENCY.*****SUMMARY**

This bill prohibits revenue neutrality clauses in health care contracts beginning July 1, 2025. Specifically, it 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, 2025, that includes a revenue neutrality clause. The bill makes null and void any such clause in a health care contract, written policy or procedure, or agreement entered into, renewed, or amended on or after July 1, 2025. Under the bill, a “revenue neutrality clause” is a health care contract provision that requires a health carrier or health plan administrator to indemnify or hold harmless a health care provider.

Separately, the bill requires the Office of Health Strategy (OHS) commissioner to annually, beginning by March 1, 2026, give the insurance commissioner the prior year’s aggregated payer data, including aggregated self-funded data, submitted to OHS for purposes of calculating the healthcare cost growth benchmark and primary care spending target (see BACKGROUND). Under the bill, the insurance commissioner may hire a third party (i.e. actuary, actuarial firm, or other independent expert) as needed to audit the data. Upon completion of an audit, the auditor must submit a written audit report to the insurance and OHS commissioners and the Insurance and Real Estate and Public Health committees.

EFFECTIVE DATE: Upon passage, except the provisions on revenue neutrality clauses are effective July 1, 2025.

**BACKGROUND*****Health Care Benchmarks***

State law requires OHS to establish benchmarks for health care quality and cost growth and primary care spending targets. It also requires health care payers to provide the OHS commissioner with specified health care cost and quality data, which she must use to publish annual reports on the total health care expenditures in Connecticut, health care quality benchmarks, and information on payers and provider entities that meet or exceed these metrics (CGS §§ 19a-754g & 19a-754h).

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 11    Nay 2    (03/13/2025)