General Assembly

Governor's Bill No. 5054

February Session, 2024

LCO No. **582**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
Request of the Governor Pursuant
to Joint Rule 9

AN ACT ADDRESSING HEALTH CARE AFFORDABILITY.

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

Section 1. (NEW) (*Effective October 1, 2024*) (a) There is hereby established the Prescription Drug Affordability Board to advise the executive director of the Office of Health Strategy on decisions regarding the affordability of prescription drugs. The board shall be within the Office of Health Strategy for administrative purposes only.

(b) The purposes of the Prescription Drug Affordability Board shall be to (1) explore strategies to reduce out-of-pocket drug costs to consumers while supporting innovations in biotechnology and scientific discovery; (2) study the prescription drug supply chain and pharmaceutical pricing strategies to identify opportunities for consumer savings; (3) monitor prescription drug prices in the state; (4) promote innovative strategies for the use of more affordable drugs; and (5) recommend a range of options of prescription drug cost affordability tools to the executive director of the Office of Health Strategy.

(c) The board shall consist of five members, each of whom shall have an advanced degree and experience or expertise in health care economics, health services research, pharmoeconomics, pharmacology or clinical medicine. At least one such member shall have direct experience with consumer advocacy and health equity. The members shall be appointed by the Governor with the advice and consent of either house of the General Assembly. The Governor shall make all initial appointments not later than ninety days after the effective date of this section. Any vacancy shall be filled for the remainder of the unexpired term by the Governor.

(d) Each member of the board shall serve a term of three years, except as to the terms of the members who are first appointed to the board. Two such members shall serve an initial term of three years, two such members shall serve an initial term of two years, and one such member shall serve an initial term of one year, to be determined by the Governor. The Governor may remove any appointed member of the board for malfeasance in office, failure to regularly attend meetings or any cause that renders the member incapable or unfit to discharge the duties of the member's office. Any such removal is not subject to review.

(e) The Governor shall designate one member of the board to serve as the chairperson of the board. Such chairperson shall schedule the first meeting of the board, which shall be held not later than one hundred twenty days after the effective date of this section.

(f) The board shall meet not less than four times annually to carry out its purposes as set forth in subsection (b) of this section. A majority of the board constitutes a quorum. The concurrence of a majority of the board in any matter within its powers and duties is required for any determination made by the board. Any conflict of interest involving a member of the board shall be disclosed at the next board meeting after the conflict is identified.

(g) Not later than December 31, 2025, and annually thereafter, the board shall report, in accordance with the provisions of section 11-4a of

the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services, insurance and public health. The report shall include, but need not be limited to: (1) Strategies for identifying and eliminating pricing or business practices that do not support or enhance innovation in drug development, (2) price trends and affordability strategies for any drug identified pursuant to subsection (b) or (c) of section 3 of this act, (3) any recommendations the board may have for legislation needed to make prescription drug products more affordable in the state while supporting and enhancing innovation in drug development, (4) purchasing strategies, cost effectiveness evaluations and the development of new technologies and drugs that increase affordability, and (5) a summary and evaluation of state prescription drug advisory board activities and recommendations.

(h) Members of the board may engage in private employment, or in a profession or business, subject to any applicable laws, rules and regulations of the state regarding official ethics or conflict of interest. As used in this subsection, (1) "conflict of interest" means (A) an association, including a financial or personal association, that has the potential to bias or appear to bias an individual's decisions in matters related to the board, and (B) any instance in which a board member, a staff member, a contractor of the division on behalf of the board or an immediate family member of a board member has received or could receive (i) a financial benefit of any amount derived from the results or findings of a study or determination that is reached by or for the board, or (ii) a financial benefit from an individual or company that owns or manufacturers a prescription drug, service or item that is being or will be studied by the board, and (2) "financial benefit" means honoraria, fees, stock or any other form of compensation, including increases to the value of existing stock holdings.

(i) In carrying out its purposes, the board may:

(1) Collect and review publicly available information regarding prescription drug pricing and business practices of health carriers,

health maintenance organizations, managed care organizations, manufacturers, wholesale distributors and pharmacy benefit managers, including, but not limited to, the annual report by pharmacy benefit managers required pursuant to section 38a-479ppp of the general statutes;

(2) Identify innovative strategies that may reduce the cost of prescription drugs to consumers;

(3) Identify states with innovative programs to lower prescription drug costs and, if relevant, enter into memoranda of understanding with such states to aid in the collection of transparency data for prescription drug products or any other information needed to establish similar programs in this state; and

(4) Receive and accept aid or contributions from any source of money, property, labor or other things of value, to be held, used and applied to carry out the purposes of the board, provided acceptance of such aid or contributions does not present a conflict of interest for any board member or any purpose of the board.

Sec. 2. (NEW) (*Effective October 1, 2024*) As used in this section and section 3 of this act:

(1) "Biologic" means a drug licensed under 42 USC 262, as amended from time to time;

(2) "Biosimilar" means a drug that is highly similar to a biologic and is produced or distributed in accordance with a biologics license application approved under 42 USC 262(k), as amended from time to time;

(3) "Board" means the Prescription Drug Affordability Board established pursuant to section 1 of this act;

(4) "Brand name drug" means a drug that is produced or distributed in accordance with an original new drug application approved under 21 USC 355, as amended from time to time, but does not include an

authorized generic drug as defined in 42 CFR 447.502, as amended from time to time;

(5) "FDA breakthrough drug" means a drug granted expedited review by the United States Food and Drug Administration under 21 USC 356, as amended from time to time.

(6) "Generic drug" means (A) a prescription drug product that is marketed or distributed in accordance with an abbreviated new drug application approved under 21 USC 355, as amended from time to time, (B) an authorized generic drug as defined in 42 CFR 447.502, as amended from time to time, or (C) a drug that entered the market before calendar year 1962 that was not originally marketed under a new prescription drug product application;

(7) "Manufacturer" means an entity that (A) engages in the manufacture of a drug product, or (B) enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name and sets or changes the wholesale acquisition cost of the prescription drug product it manufactures or markets;

(8) "Orphan drug" has the same meaning as provided in 21 CFR 316.3, as amended from time to time; and

(9) "Prescription drug product" means a brand name drug, a generic drug, a biologic or biosimilar.

Sec. 3. (NEW) (*Effective October 1, 2024*) (a) To the extent practicable, the Prescription Drug Affordability Board established pursuant to section 1 of this act may assess pricing information for prescription drug products by: (1) Entering into a memorandum of understanding with another state to which a manufacturer reports pricing information, (2) assessing spending for the drug in the state, (3) utilizing data and findings, including consumer affordability strategies, developed by another state's board, (4) utilizing data and findings, including cost containment strategies, developed by any other state or federal entity,

(5) utilizing the maximum fair price for a prescription drug for persons eligible for Medicare established pursuant to the federal Inflation Reduction Act of 2022, P.L. No. 117-169, and (6) assessing any other available pricing information.

(b) On and after October 1, 2026, the board shall identify prescription drug products that, as adjusted annually for inflation in accordance with the consumer price index for all urban consumers published by the United States Department of Labor, Bureau of Labor Statistics, are:

(1) Brand name drugs that have a launch wholesale acquisition cost of thirty thousand dollars or more per year or course of treatment;

(2) Brand name drugs that have a wholesale acquisition cost increase of three thousand dollars or more in any twelve–month period;

(3) Biosimilars that have a launch wholesale acquisition cost that is not at least fifteen per cent lower than the referenced brand biologic at the time the biosimilars are launched; and

(4) Generic drugs that have:

(A) A wholesale acquisition cost of one hundred dollars or more for (i) a thirty-day supply lasting a patient for a period of thirty consecutive days based on the recommended dosage approved for labeling by the United States Food and Drug Administration, (ii) a supply lasting a patient for fewer than thirty days based on the recommended dosage approved for labeling by the United States Food and Drug Administration, or (iii) one unit of the drug if the labeling approved by the United States Food and Drug Administration does not recommend a finite dosage; and

(B) A wholesale acquisition cost that increased by two hundred per cent or more during the immediately preceding twelve-month period, as determined by the difference between the resulting wholesale acquisition cost and the average of the wholesale acquisition cost reported over the immediately preceding twelve months.

(c) On and after October 1, 2026, the board shall identify any other prescription drug products or pricing practices that may create affordability challenges for the health care system in the state or patients, including, but not limited to, drugs needed to address significant public health priorities.

(d) After identifying prescription drug products as required by subsections (b) and (c) of this section, the board may conduct, within available appropriations, a review for any identified prescription drug product or pricing practice if, after (1) seeking input from relevant stakeholders, and (2) considering the average patient cost share of the prescription drug product, the board determines such review is in the interest of consumers, provided the drug product is not an FDA breakthrough drug, an orphan drug, a drug with a new and unique mechanism of action for treating a medical condition or any other drug that represents a significant innovation or advance in therapy.

(e) In conducting a review of prescription drugs, the board shall examine any document and research related to the pricing of the prescription drug product, including, but not limited to, (1) net average price in the state, (2) market competition and context, (3) projected revenue to the manufacturer, (4) the estimated value or cost effectiveness, (5) whether and how the prescription drug product represents an innovative therapy or is likely to improve health or health outcomes for the target consumer, and (6) any rebates, discounts, patient access programs or other cost mitigation strategies relevant to the prescription drug product.

(f) The board shall determine whether use of the prescription drug product, consistent with the labeling approved by the United States Food and Drug Administration or standard medical practice, has led or will lead to affordability challenges for the health care system in the state or high out–of–pocket costs for patients but has not led or will not lead to significant improvements in health or health outcomes. In determining whether a prescription drug product has led or will lead to an affordability challenge, the board may consider the following factors:

(1) The wholesale acquisition cost for the prescription drug product sold in the state;

(2) The average monetary price concession, discount or rebate provided or expected to be provided to health plans in the state as reported by manufacturers and health plans, expressed as a percentage of the wholesale acquisition cost for the prescription drug product under review;

(3) The total amount of the price concession, discount or rebate the manufacturer provides to each pharmacy benefits manager operating in the state for the prescription drug product under review, as reported by manufacturers and pharmacy benefits managers, expressed as a percentage of the wholesale acquisition costs;

(4) The price at which therapeutic alternatives have been sold in the state;

(5) The average monetary concession, discount or rebate the manufacturer provides or is expected to provide to health plan payors and pharmacy benefits managers in the state for therapeutic alternatives;

(6) The costs to health plans based on patient access consistent with United States Food and Drug Administration labeled indications and recognized standard medical practice;

(7) The impact on patient access resulting from the cost of the prescription drug product relative to health plan benefit design;

(8) The current or expected dollar value of drug–specific patient access programs that are supported by the manufacturer;

(9) The relative financial impacts to health, medical or social services costs as may be quantified and compared to baseline effects of existing therapeutic alternatives;

(10) The average patient copayment or other cost sharing for the

prescription drug product in the state;

(11) Any information a manufacturer chooses to provide; and

(12) Any other factors as determined by the board.

(g) If the board finds that the spending on a prescription drug product reviewed under this section has led or will lead to an affordability challenge but has not provided or will not provide significant benefits to health or health outcomes, the board shall recommend potential cost containment strategies and tools to the executive director of the Office of Health Strategy considering: (1) The cost of administering the drug, (2) the cost of delivering the drug to patients, and (3) other administrative costs related to the drug. In making such recommendations, the board may utilize (A) cost containment strategies set by similar boards in other states, (B) cost containment strategies set by any other state or federal entity, and (C) the maximum fair price for a prescription drug for persons eligible for Medicare established pursuant to the federal Inflation Reduction Act of 2022. The board's recommendations shall not apply to Medicare Part D prescription drug plans.

Sec. 4. (NEW) (*Effective July 1, 2024*) (a) There is established, within the Office of Health Strategy, the Cost Growth Benchmark Oversight Commission for the purpose of advising the executive director of the Office of Health Strategy regarding implementation of the provisions of sections 19a-754f to 19a-754j, inclusive, of the general statutes, as amended by this act.

(b) (1) The commission shall consist of thirteen voting members who shall be appointed by the Governor not later than August 31, 2024. The Governor shall endeavor to appoint members representing the following interests and specialties across the health care continuum, including, but not limited to, (A) academic institutions, (B) employers, (C) philanthropic, medical research and nonprofit organizations with experience addressing health equity, health care costs, health care advocacy and access to health care for underserved communities, (D)

health care economists or actuarial experts, (E) health care-related employer coalitions and labor unions, (F) consumers of health care services, and (G) health care advocates. At a minimum, the commission shall include the following voting members: (i) Two representatives of one or more consumer organizations with expertise in cost and quality management; (ii) two health economists; (iii) two experts in health care quality measurement and reporting; (iv) one expert in payment and delivery system reform; and (v) one expert in primary care. Members shall not include representatives of organizations that directly contribute to health care costs in the state, including, but not limited to, hospital systems, health carriers and provider organizations. The executive director of the Office of Health Strategy, or the executive director's designee, the Insurance Commissioner, or the commissioner's designee, the Commissioners of Public Health, Social Services and Mental Health and Addiction Services, or the commissioners' designees, and the chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee, shall serve as ex-officio nonvoting members of the commission.

(2) The membership terms for voting members initially appointed to the commission shall be divided such that seven of the voting members are appointed for an initial two-year term and six of the voting members are appointed for an initial three-year term. Following the expiration of such voting members' initial terms, the membership terms for voting members shall be for two years, commencing on August first of the year of the member's appointment.

(3) The Governor shall designate one member of the commission to serve as the chairperson of the commission.

(c) The commission shall advise the executive director of the Office of Health Strategy regarding all aspects of the initiatives concerning the health care cost growth and health care quality benchmarks set forth in sections 19a-754f to 19a-754j, inclusive, of the general statutes, as amended by this act, and shall:

(1) Provide guidance, direction and oversight with respect to such initiatives;

(2) Review and make recommendations to the executive director on the methodology for (A) setting such benchmarks, (B) determining compliance with such benchmarks, (C) analyzing the data regarding drivers of health care cost growth, (D) conducting annual inflation reviews, and (E) establishing additional quality benchmarks and measure sets;

(3) Review and make policy recommendations and advise on implementation strategies; and

(4) Develop recommendations that advance health equity in the implementation of the health care cost growth benchmark to support equitable access to affordable and high-quality health care for underserved populations.

(d) The commission shall vote on each recommendation and submit recommendations approved by the majority of voting members to the executive director. The executive director shall:

(1) Review each recommendation;

(2) Determine whether to accept each recommendation; and

(3) If the executive director does not accept a recommendation from the commission, the executive director shall provide a written response to the commission that outlines the facts concerning such recommendation and explains the factors considered in and rationale for not accepting the recommendation. The executive director shall submit such response to the commission not later than thirty days after the receipt of the commission's recommendation. The commission may allow the executive director additional time to respond.

(e) The commission may convene working groups that include volunteer health care experts to advise the commission on any matters related to the provisions of sections 19a-754f to 19a-754j, inclusive, of the

general statutes, as amended by this act.

(f) The Office of Health Strategy shall provide administrative support to the commission.

Sec. 5. Section 19a-754i of the general statutes is amended by adding subsections (c) and (d) as follows (*Effective October 1, 2025*):

(NEW) (c) (1) Not later than January 1, 2026, if the executive director finds, based on the office's annual cost growth benchmark report required pursuant to subsection (b) of section 19a-754h, the office's annual cost trend hearings or any other pertinent information, that the average percentage change in cumulative total health care expenditures from calendar years 2022 to 2023 exceeded the average health care cost growth benchmark for calendar years 2022 to 2023, the executive director shall establish procedures to (A) assist health care entities in improving efficiency and reducing cost growth by requiring certain health care entities to file and implement a performance improvement plan, and (B) support the state's efforts to meet future health care cost growth benchmarks, as established pursuant to section 19a-754g.

(2) On and after January 1, 2026, and annually thereafter, if the executive director finds, based on the office's annual cost growth benchmark report required pursuant to subsection (b) of section 19a-754h, the office's annual cost trend hearings or any other pertinent information, that the percentage change in cumulative total health care expenditures from one calendar year to the next, beginning with calendar years 2023 to 2024, exceeded the health care cost growth benchmark for such calendar years, the executive director shall establish procedures to (A) assist health care entities in improving efficiency and reducing cost growth by requiring certain health care entities to file and implement a performance improvement plan, and (B) support the state's efforts to meet future health care cost growth benchmarks developed pursuant to section 19a-754g.

(3) In addition to the notice provided under subdivision (3) of subsection (a) of this section, the executive director may require any

health care entity that is identified by the office under subsection (a) of this section as exceeding the health care cost growth benchmark developed pursuant to section 19a-754g to file a performance improvement plan with the office. The executive director shall provide written notice to such health care entity that the entity is required to file a performance improvement plan. Not later than forty-five days after receipt of such written notice, the health care entity shall either file (A) a performance improvement plan with the office, or (B) an application with the office to waive or extend the requirement to file a performance improvement plan.

(4) The health care entity identified under subsection (a) of this section may file any documentation or supporting evidence with the office to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The executive director shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application, provided such information shall be made public at the discretion of the office.

(5) The executive director may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under subdivision (3) of this subsection and in consideration of any information received from the health care entity pursuant to subdivision (4) of this subsection, based on a consideration of the following factors: (A) The costs, price and utilization trends of the health care entity over time and any demonstrated reduction in total medical expenses related to the health status of patients; (B) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth; (C) whether the factors that led to increased costs for the health care entity may reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but need not be limited to, the age of patients, other factors related to the health status of patients and other cost inputs such as pharmaceutical expenses and medical device expenses; (D) the overall

financial condition of the health care entity; (E) a significant difference between the growth rate of the potential gross state product, as defined in section 19a-754f, and the growth rate of the actual gross state product; and (F) any other factors the executive director considers relevant.

(6) If the executive director declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the executive director shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan pursuant to subdivision (7) of this subsection.

(7) A health care entity shall file a performance improvement plan: (A) Not later than forty-five days after receipt of a notice under subdivision (6) of this subsection; (B) if the health care entity has requested a waiver or extension, not later than forty-five days after receipt of a notice that such waiver or extension has been denied; or (C) if the health care entity is granted an extension, on the date for filing provided on the notice of such extension. The performance improvement plan shall identify the causes of the entity's cost growth and shall include, but need not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance. The performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed eighteen months.

(8) The executive director shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation.

(9) If the executive director determines that the performance improvement plan is unacceptable or incomplete, the executive director may provide consultation on the criteria that have not been met and may allow an additional time period, up to thirty calendar days, for

resubmission of the performance improvement plan, provided all aspects of the performance improvement plan shall be proposed by the health care entity and the office shall not require specific elements for approval.

(10) Upon approval of a proposed performance improvement plan, the executive director shall notify the health care entity to begin immediate implementation of such plan. The executive director shall provide public notice on the office's Internet web site that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the office.

(11) All health care entities shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan, the health care entity may file amendments to the performance improvement plan, subject to the approval of the executive director.

(12) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the office regarding the outcome of the performance improvement plan. If the performance improvement plan is found to be unsuccessful, the executive director shall: (A) Extend the implementation timetable of the existing performance improvement plan; (B) approve amendments to the performance improvement plan as proposed by the health care entity; (C) require the health care entity to submit a new performance improvement plan; or (D) waive or delay the requirement to file any additional performance improvement plans.

(13) Upon the successful completion of the performance improvement plan, the executive director shall remove the identity of the health care entity from the office's Internet web site.

(14) If the executive director determines that further legislative authority is needed to (A) achieve the health care cost growth

benchmarks, primary care spending targets or health care quality benchmarks developed pursuant to section 19a-754g, (B) assist health care entities with the implementation of performance improvement plans, or (C) otherwise ensure compliance with the provisions of this section, the executive director may submit, in accordance with the provisions of section 11-4a, a recommendation for proposed legislation to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(15) If the executive director determines that a health care entity has (A) negligently failed to file a performance improvement plan with the office not later than forty-five days after receipt of notice from the office pursuant to subsection (d) of this section, (B) failed to file an acceptable performance improvement plan in good faith with the office, (C) failed to implement the performance improvement plan in good faith, or (D) knowingly failed to provide required information to the office or knowingly falsified such information, the executive director may assess a civil penalty to the health care entity of not more than five hundred thousand dollars. The executive director shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(NEW) (d) (1) If the executive director finds, based on the office's annual report and in addition to the grounds for a cost and market impact review set forth in section 19a-639f, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the executive director may conduct, within available appropriations, a cost and market impact review of any health care entity identified by the office under this section.

(2) The executive director shall initiate a cost and market impact review by sending the identified health care entity a written notice containing a description of the basis for the cost and market impact review and a request for information and documents. Not later than thirty days after receipt of such notice, the identified entity shall submit

to the office a written response.

(3) A cost and market impact review may examine factors relating to the health care entity's business and its relative market position, including, but not limited to: (A) The health care entity's size and market share within its primary service areas by major service category and within its dispersed service areas; (B) the health care entity's prices for services, including its relative price compared to other health care entities for the same services in the same market; (C) the health care entity's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar providers; (D) the quality of the services the health care entity provides, including patient experience; (E) the health care entity's provider cost and cost trends in comparison to total health care expenditures state-wide; (F) the availability and accessibility of services similar to those provided, or proposed to be provided, through the health care entity within its primary service areas and dispersed service areas; (G) the health care entity's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a health care entity's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (H) the methods used by the health care entity to attract patient volume and to recruit or acquire health care professionals or facilities; (I) the role of the health care entity in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (J) the role of the health care entity in providing low margin or negative margin services within its primary service areas and dispersed service areas; (K) consumer concerns, including, but not limited to, complaints or other allegations that the health care entity has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (L) any other factors that the executive director determines to be in the public interest.

(4) The executive director shall make factual findings and issue a

preliminary report on the cost and market impact review. In the report, the executive director shall identify any health care entity that meets all of the following criteria: (A) The health care entity has a dominant market share for the services it provides; (B) the health care entity charges prices for services that are materially higher than the median prices charged by all other providers for the same services in the same market; and (C) the health care entity has a health status adjusted total medical expense that is materially higher than the median total medical expense for all other providers for the same service in the same market.

(5) Not later than thirty days after issuance of a preliminary report, the health care entity may respond in writing to the findings of the executive director in the report. After receipt of such written response, or if no response is received by the office on or before thirty days after issuance of its preliminary report, the executive director shall issue the office's final report on the cost and market impact review.

Sec. 6. Subsection (a) of section 19a-754j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(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 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;

(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 executive director, in the executive

director's discretion, deems relevant for the purposes of this section.

(2) The executive director 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. Each such payer 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 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 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) For any hearing to be held pursuant to this subsection, the executive director or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to such person by the executive director or such executive director's authorized agent or to produce any records and papers pursuant thereto, the executive director or such executive director's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person

resides or wherein the business has been conducted, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

[(4)**]** (5) 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;

(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 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.

Sec. 7. Section 19a-754k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

The executive director may adopt regulations, in accordance with

chapter 54, to implement the provisions of section 19a-754a and sections 19a-754f to 19a-754j, inclusive, as amended by this act. The executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the executive director holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes notice of intention to adopt the regulations on the Office of Health Strategy's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this section shall be valid until the time such regulations are effective.

Sec. 8. (NEW) (*Effective January 1, 2025*) (a) As used in this section:

(1) "Alternative payment model" means a health care payment method that uses financial incentives to promote or leverage greater value, including higher quality care at lower costs for patients, purchasers, payers and providers.

(2) "Health care cost growth benchmark" means the annual benchmark established pursuant to section 19a-754g of the general statutes.

(3) "Total medical expenditure" 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.

(4) "Carrier" has the same meaning as provided in section 38a-175 of the general statutes.

(b) The executive director of the Office of Health Strategy shall establish an affordability standard for coverage of persons by an individual health insurance policy or a group health insurance policy providing coverage of the type specified in section 38a-469 of the general statutes that is delivered, issued for delivery or renewed in the state. Such standard shall consider a carrier's efforts to keep year over year increases in premiums at or below the health care cost growth benchmark developed pursuant to section 19a-754g of the general statutes, including, but not limited to, the following:

(1) Efforts to reach primary care spending targets as established under such benchmark;

(2) The number and type of alternative payment models in operation and the dates on which such models were established, including details on models that tie payments to health care quality, health outcomes and decreases in health disparities;

(3) The proportion of total medical expenditure and the percentage of covered lives in each market that are associated with alternative payment models;

(4) Efforts to tie increases in contracted provider rates to the health care cost growth benchmark;

(5) Efforts to reduce unnecessary utilization by addressing health-related social needs; and

(6) Efforts to incorporate standards of the health care organizations designated by the Comptroller as "Centers for Excellence" into provider contracts.

(c) Beginning on April 1, 2025, each carrier shall annually submit, not later than sixty days prior to filing premium rates pursuant to sections 38a-481 and 38a-513 of the general statutes, a report to the Office of Health Strategy demonstrating its compliance with the affordability standard established pursuant to subsection (b) of this section. Upon

request by the executive director, a carrier shall provide additional information to the office, not later than thirty days after the date of such request, that the executive director of the office determines is necessary to evaluate whether the carrier has met the affordability standard. The office may hold a public hearing on the carrier's report.

(d) The executive director shall determine, based on the information provided in the carrier's report and any additional information provided by the carrier, if the carrier is in compliance with the affordability standard established pursuant to subsection (b) of this section. The executive director shall not unreasonably withhold a determination of compliance. For any carrier that has not established compliance with the affordability standard, the executive director may request further explanation from the carrier as to the carrier's inability to comply with the standard and may request that the carrier provide information regarding how the carrier intends to come into compliance with the standard in the following year.

(e) Not later than July 1, 2025, and annually thereafter, the executive director shall submit determinations of compliance made pursuant to subsection (d) of this section to the Insurance Commissioner.

(f) The executive director may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to carry out the provisions of this section. If the executive director decides to adopt regulations, the executive director shall propose such regulations not later than January 1, 2025. The executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 9. (NEW) (*Effective January 1, 2025*) On and after July 1, 2025, the Insurance Commissioner may consider a carrier's compliance with the

affordability standard established by the executive director of the Office of Health Strategy pursuant to section 8 of this act when evaluating a request for a rate increase pursuant to section 38a-481 or 38a-513 of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	New section
Sec. 2	*October 1, 2024*	New section
Sec. 3	*October 1, 2024*	New section
Sec. 4	*July 1, 2024*	New section
Sec. 5	*October 1, 2025*	19a-754i(c) and (d)
Sec. 6	*July 1, 2024*	19a-754j(a)
Sec. 7	*October 1, 2024*	19a-754k
Sec. 8	*January 1, 2025*	New section
Sec. 9	*January 1, 2025*	New section

Statement of Purpose:

To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]