General Assembly

Substitute Bill No. 5042

February Session, 2022

AN ACT CONCERNING HEALTH CARE COST GROWTH.

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

1 Section 1. Section 19a-754a of the 2022 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective from passage*):

4 (a) There is established an Office of Health Strategy, which shall be
5 within the Department of Public Health for administrative purposes
6 only. The department head of said office shall be the executive director
7 of the Office of Health Strategy, who shall be appointed by the Governor
8 in accordance with the provisions of sections 4-5 to 4-8, inclusive, with
9 the powers and duties therein prescribed.

10 (b) The Office of Health Strategy shall be responsible for the
11 following:

12 (1) Developing and implementing a comprehensive and cohesive
13 health care vision for the state, including, but not limited to, a
14 coordinated state health care cost containment strategy;

15 (2) Promoting effective health planning and the provision of quality
16 health care in the state in a manner that ensures access for all state
17 residents to cost-effective health care services, avoids the duplication of
18 such services and improves the availability and financial stability of

19 such services throughout the state;

20 (3) [Directing] (A) Developing, innovating, directing and overseeing
21 health care delivery and payment models in the state that reduce health
22 care cost growth and improve the quality of patient care, including, but
23 not limited to, the State Innovation Model Initiative and related
24 successor initiatives, (B) setting an annual health care cost growth
25 benchmark and primary care spending target pursuant to section 3 of
26 this act, (C) developing and adopting health care quality benchmarks
27 pursuant to section 3 of this act, (D) developing strategies, in
28 consultation with stakeholders, to facilitate adherence with such
29 benchmarks and targets developed pursuant to section 3 of this act, (E)
30 enhancing the transparency of provider entities, as defined in
31 subdivision (13) of section 2 of this act, (F) monitoring the development
32 of accountable care organizations and patient-centered medical homes
33 in the state, and (G) monitoring the adoption of alternative payment
34 methodologies in the state;

35 (4) (A) Coordinating the state's health information technology
36 initiatives, (B) seeking funding for and overseeing the planning,
37 implementation and development of policies and procedures for the
38 administration of the all-payer claims database program established
39 under section 19a-775a, (C) establishing and maintaining a consumer
40 health information Internet web site under section 19a-755b, and (D)
41 designating an unclassified individual from the office to perform the
42 duties of a health information technology officer as set forth in sections
43 17b-59f and 17b-59g;

44 (5) Directing and overseeing the Health Systems Planning Unit
45 established under section 19a-612 and all of its duties and
46 responsibilities as set forth in chapter 368z;

47 (6) Convening forums and meetings with state government and
48 external stakeholders, including, but not limited to, the Connecticut
49 Health Insurance Exchange, to discuss health care issues designed to
50 develop effective health care cost and quality strategies; and

51 (7) (A) Administering the Covered Connecticut program established
52 under section 19a-754c in consultation with the Commissioner of Social
53 Services, Insurance Commissioner and Connecticut Health Insurance
54 Exchange, and (B) consulting with the Commissioner of Social Services
55 and Insurance Commissioner for the purposes set forth in section 17b-
56 312.

57 (c) The Office of Health Strategy shall constitute a successor, in
58 accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the
59 functions, powers and duties of the following:

60 (1) The Connecticut Health Insurance Exchange, established
61 pursuant to section 38a-1081, relating to the administration of the all-
62 payer claims database pursuant to section 19a-755a; and

63 (2) The Office of the Lieutenant Governor, relating to the (A)
64 development of a chronic disease plan pursuant to section 19a-6q, (B)
65 housing, chairing and staffing of the Health Care Cabinet pursuant to
66 section 19a-725, and (C) (i) appointment of the health information
67 technology officer, and (ii) oversight of the duties of such health
68 information technology officer as set forth in sections 17b-59f and 17b-
69 59g.

70 (d) Any order or regulation of the entities listed in subdivisions (1)
71 and (2) of subsection (c) of this section that is in force on July 1, 2018,
72 shall continue in force and effect as an order or regulation until
73 amended, repealed or superseded pursuant to law.

74 Sec. 2. (NEW) (*Effective from passage*) For the purposes of this section
75 and sections 3 to 7, inclusive, of this act:

76 (1) "Drug manufacturer" means the manufacturer of a drug that is:
77 (A) Included in the information and data submitted by a health carrier
78 pursuant to section 38a-479qqq of the general statutes, (B) studied or
79 listed pursuant to subsection (c) or (d) of section 19a-754b of the general
80 statutes, or (C) in a therapeutic class of drugs that the executive director
81 determines, through public or private reports, has had a substantial

82 impact on prescription drug expenditures, net of rebates, as a
83 percentage of total health care expenditures;

84 (2) "Executive director" means the executive director of the office;

85 (3) "Health care cost growth benchmark" means the annual
86 benchmark established pursuant to section 3 of this act;

87 (4) "Health care quality benchmark" means an annual benchmark
88 established pursuant to section 3 of this act;

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

92 (6) "Net cost of private health insurance" means the difference
93 between premiums earned and benefits incurred, and includes insurers'
94 costs of paying bills, advertising, sales commissions, and other
95 administrative costs, net additions or subtractions from reserves, rate
96 credits and dividends, premium taxes, and profits or losses;

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

99 (8) "Other entity" means a drug manufacturer, pharmacy benefits
100 manager, or other health care provider that is not considered a provider
101 entity;

102 (9) "Payer" means a payer, including Medicaid, Medicare and
103 governmental and nongovernment health plans, and includes any
104 organization acting as payer that is a subsidiary, affiliate or business
105 owned or controlled by a payer that, during a given calendar year, pays
106 health care providers for health care services or pharmacies or provider
107 entities for prescription drugs designated by the executive director;

108 (10) "Performance year" means the most recent calendar year for
109 which data were submitted for the applicable health care cost growth

110 benchmark, primary care spending target or health care quality
111 benchmark;

112 (11) "Pharmacy benefits manager" has the same meaning as provided
113 in subdivision (10) of section 38a-479ooo of the general statutes;

114 (12) "Primary care spending target" means the annual target
115 established pursuant to section 3 of this act;

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

122 (14) "Potential gross state product" means a forecasted measure of the
123 economy that equals the sum of the (A) expected growth in national
124 labor force productivity, (B) expected growth in the state's labor force,
125 and (C) expected national inflation, minus the expected state population
126 growth;

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

132 (16) "Total medical expense" means the total cost of care for the
133 patient population of a payer or provider entity for a given calendar
134 year, where cost is calculated for such year as the sum of (A) all claims-
135 based spending paid to providers by public and private payers, and net
136 of pharmacy rebates, (B) all nonclaims payments for such year,
137 including, but not limited to, incentive payments and care coordination
138 payments, and (C) all patient cost-sharing amounts expressed on a per
139 capita basis for the patient population of a payer or provider entity in
140 this state.

141 Sec. 3. (NEW) (*Effective from passage*) (a) Not later than July 1, 2022,
142 the executive director shall publish (1) the health care cost growth
143 benchmarks and annual primary care spending targets as a percentage
144 of total medical expenses for the calendar years 2021 to 2025, inclusive,
145 and (2) the annual health care quality benchmarks for the calendar years
146 2022 to 2025, inclusive, on the office's Internet web site.

147 (b) (1) (A) Not later than July 1, 2025, and every five years thereafter,
148 the executive director shall develop and adopt annual health care cost
149 growth benchmarks and annual primary care spending targets for the
150 succeeding five calendar years for provider entities and payers.

151 (B) In developing the health care cost growth benchmarks and
152 primary care spending targets pursuant to this subdivision, the
153 executive director shall consider (i) any historical and forecasted
154 changes in median income for individuals in the state and the growth
155 rate of potential gross state product, (ii) the rate of inflation, and (iii) the
156 most recent report, if any, prepared by the executive director pursuant
157 to subsection (b) of section 4 of this act.

158 (C) (i) The executive director may hold informational public hearings
159 concerning the benchmarks and targets set pursuant to subsection (a) or
160 subdivision (1) of subsection (b) of this section. Such informational
161 public hearings shall be held at a time and place designated by the
162 executive director in a notice prominently posted by the executive
163 director on the office's Internet web site and in a form and manner
164 prescribed by the executive director.

165 (ii) If the executive director determines, after any informational
166 public hearing held pursuant to this subparagraph, that a modification
167 to any health care cost growth benchmark or annual primary care
168 spending target is, in the executive director's discretion, reasonably
169 warranted, the executive director may modify such benchmark or
170 target.

171 (iii) If the executive director determines that the rate of inflation

172 requires modification of any health care cost growth benchmark
173 adopted under this section, the executive director may modify such
174 benchmark. In such event, the executive director shall not be required
175 to hold an informational public hearing concerning such modified
176 health care cost growth benchmark.

177 (D) The executive director shall post each adopted health care cost
178 growth benchmark and annual primary care spending target on the
179 office's Internet web site.

180 (2) (A) Not later than July 1, 2025, and every five years thereafter, the
181 executive director shall develop and adopt annual health care quality
182 benchmarks for the succeeding five calendar years for provider entities
183 and payers.

184 (B) In developing annual health care quality benchmarks pursuant to
185 this subdivision, the executive director shall consider (i) quality
186 measures endorsed by nationally recognized organizations, including,
187 but not limited to, the National Quality Forum, the National Committee
188 for Quality Assurance, the Centers for Medicare and Medicaid Services,
189 the Centers for Disease Control, the Joint Commission and expert
190 organizations that develop health equity measures, and (ii) measures
191 that: (I) Concern health outcomes, overutilization, underutilization and
192 patient safety, (II) meet standards of patient-centeredness and ensure
193 consideration of differences in preferences and clinical characteristics
194 within patient subpopulations, and (III) concern community health or
195 population health.

196 (C) (i) The executive director may hold informational public hearings
197 concerning the quality measures the executive director proposes to
198 adopt as health care quality benchmarks. Such informational public
199 hearings shall be held at a time and place designated by the executive
200 director in a notice prominently posted by the executive director on the
201 office's Internet web site and in a form and manner prescribed by the
202 executive director.

203 (ii) If the executive director determines, after any informational
204 public hearing held pursuant to this subparagraph, that modifications
205 to any health care quality benchmarks are, in the executive director's
206 discretion, reasonably warranted, the executive director may modify
207 such quality benchmarks. The executive director shall not be required
208 to hold an additional informational public hearing concerning such
209 modified quality benchmarks.

210 (D) The executive director shall post each adopted health care quality
211 benchmark on the office's Internet web site.

212 (c) The executive director may enter into such contractual agreements
213 as may be necessary to carry out the purposes of this section, including,
214 but not limited to, contractual agreements with actuarial, economic and
215 other experts and consultants.

216 Sec. 4. (NEW) (*Effective from passage*) (a) Not later than August 15,
217 2022, and annually thereafter, each payer shall report to the executive
218 director, in a form and manner prescribed by the executive director, for
219 the preceding or prior years, if the executive director so requests based
220 on material changes to data previously submitted, aggregated data,
221 including aggregated self-funded data as applicable, necessary for the
222 executive director to calculate total health care expenditures, primary
223 care spending as a percentage of total medical expenses and net cost of
224 private health insurance. Each payer shall also disclose, as requested by
225 the executive director, payer data required for adjusting total medical
226 expense calculations to reflect changes in the patient population.

227 (b) Not later than March 31, 2023, and annually thereafter, the
228 executive director shall prepare and post on the office's Internet web
229 site, a report concerning the total health care expenditures utilizing the
230 total aggregate medical expenses reported by payers pursuant to
231 subsection (a) of this section, including, but not limited to, a breakdown
232 of such population-adjusted total medical expenses by payer and
233 provider entities. The report may include, but shall not be limited to,
234 information regarding the following:

235 (1) Trends in major service category spending;

236 (2) Primary care spending as a percentage of total medical expenses;
237 and

238 (3) The net cost of private health insurance by payer by market
239 segment, including individual, small group, large group, self-insured,
240 student and Medicare Advantage markets.

241 (c) The executive director shall annually submit a request to the
242 federal Centers for Medicare and Medicaid Services for the unadjusted
243 total medical expenses of Connecticut residents.

244 (d) Not later than August 15, 2023, and annually thereafter, each
245 payer or provider entity shall report to the executive director in a form
246 and manner prescribed by the executive director, for the preceding year,
247 and for prior years if the executive director so requests based on material
248 changes to data previously submitted, on the health care quality
249 benchmarks adopted pursuant to section 3 of this act.

250 (e) Not later than March 31, 2024, and annually thereafter, the
251 executive director shall prepare and post on the office's Internet web
252 site, a report concerning health care quality benchmarks reported by
253 payers and provider entities pursuant to subsection (d) of this section.

254 (f) The executive director may enter into such contractual agreements
255 as may be necessary to carry out the purposes of this section, including,
256 but not limited to, contractual agreements with actuarial, economic and
257 other experts and consultants.

258 Sec. 5. (NEW) (*Effective from passage*) (a) (1) For each calendar year,
259 beginning on January 1, 2023, the executive director shall identify, not
260 later than May first of such calendar year, each payer or provider entity
261 that exceeded the health care cost growth benchmark or failed to meet
262 the primary care spending target for the performance year. For each
263 calendar year beginning on or after January 1, 2024, the executive
264 director shall identify, not later than May first of such calendar year,

265 each payer or provider entity that failed to meet the health care quality
266 benchmarks for the performance year.

267 (2) Not later than thirty days after the executive director identifies
268 each payer or provider entity pursuant to subsection (a) of this section,
269 the executive director shall send a notice to each such payer or provider
270 entity. Such notice shall be in a form and manner prescribed by the
271 executive director, and shall disclose to each such payer or provider
272 entity:

273 (A) That the executive director has identified such payer or provider
274 entity pursuant to subdivision (1) of this subsection; and

275 (B) The factual basis for the executive director's identification of such
276 payer or provider entity pursuant to subdivision (1) of this subsection.

277 (b) (1) For each calendar year beginning on and after January 1, 2023,
278 if the executive director determines that the annual percentage change
279 in total health care expenditures for the performance year exceeded the
280 health care cost growth benchmark for such year, the executive director
281 shall identify, not later than May first of such calendar year, any other
282 entity that significantly contributed to exceeding such benchmark. Each
283 identification shall be based on:

284 (A) The report, if any, prepared by the executive director pursuant to
285 subsection (b) of section 4 of this act for such calendar year;

286 (B) The report filed pursuant to section 38a-479ppp of the general
287 statutes for such calendar year;

288 (C) The information and data reported to the office pursuant to
289 subsection (d) of section 19a-754b of the general statutes for such
290 calendar year;

291 (D) Information obtained from the all-payer claims database
292 established under section 19a-755a of the general statutes; and

293 (E) Any other information that the executive director, in the executive
294 director's discretion, deems relevant for the purposes of this section.

295 (2) The executive director shall account for costs, net of rebates and
296 discounts, when identifying other entities pursuant to this section.

297 Sec. 6. (NEW) (*Effective from passage*) (a) (1) Not later than June 30,
298 2023, and annually thereafter, the executive director shall hold an
299 informational public hearing to compare the growth in total health care
300 expenditures in the performance year to the health care cost growth
301 benchmark established pursuant to section 3 of this act for such year.
302 Such hearing shall involve an examination of:

303 (A) The report, if any, most recently prepared by the executive
304 director pursuant to subsection (b) of section 4 of this act;

305 (B) The expenditures of provider entities and payers, including, but
306 not limited to, health care cost trends, primary care spending as a
307 percentage of total medical expenses and the factors contributing to
308 such costs and expenditures; and

309 (C) Any other matters that the executive director, in the executive
310 director's discretion, deems relevant for the purposes of this section.

311 (2) The executive director may require any payer or provider entity
312 that, for the performance year, is found to be a significant contributor to
313 health care cost growth in the state or has failed to meet the primary care
314 spending target, to participate in such hearing. Each such payer or
315 provider entity that is required to participate in such hearing shall
316 provide testimony on issues identified by the executive director and
317 provide additional information on actions taken to reduce such payer's
318 or entity's contribution to future state-wide health care costs and
319 expenditures or to increase such payer's or provider entity's primary
320 care spending as a percentage of total medical expenses.

321 (3) The executive director may require that any other entity that is
322 found to be a significant contributor to health care cost growth in this

323 state during the performance year participate in such hearing. Any other
324 entity that is required to participate in such hearing shall provide
325 testimony on issues identified by the executive director and provide
326 additional information on actions taken to reduce such other entity's
327 contribution to future state-wide health care costs. If such other entity is
328 a drug manufacturer, and the executive director requires that such drug
329 manufacturer participate in such hearing with respect to a specific drug
330 or class of drugs, such hearing may, to the extent possible, include
331 representatives from at least one brand-name manufacturer, one generic
332 manufacturer and one innovator company that is less than ten years old.

333 (4) Not later than October 15, 2023, and annually thereafter, the
334 executive director shall prepare and submit a report, in accordance with
335 section 11-4a of the general statutes, to the joint standing committees of
336 the General Assembly having cognizance of matters relating to
337 insurance and public health. Such report shall be based on the executive
338 director's analysis of the information submitted during the most recent
339 informational public hearing conducted pursuant to this subsection and
340 any other information that the executive director, in the executive
341 director's discretion, deems relevant for the purposes of this section, and
342 shall:

343 (A) Describe health care spending trends in this state, including, but
344 not limited to, trends in primary care spending as a percentage of total
345 medical expense, and the factors underlying such trends; and

346 (B) Disclose the executive director's recommendations, if any,
347 concerning strategies to increase the efficiency of the state's health care
348 system, including, but not limited to, any recommended legislation
349 concerning the state's health care system.

350 (b) (1) Not later than June 30, 2024, and annually thereafter, the
351 executive director shall hold an informational public hearing to
352 compare the performance of payers and provider entities in the
353 performance year to the quality benchmarks established for such year
354 pursuant to section 3 of this act. Such hearing shall include an

355 examination of:

356 (A) The report, if any, most recently prepared by the executive
357 director pursuant to subsection (e) of section 4 of this act; and

358 (B) Any other matters that the executive director, in the executive
359 director's discretion, deems relevant for the purposes of this section.

360 (2) The executive director may require any payer or provider entity
361 that failed to meet any health care quality benchmarks in this state
362 during the performance year to participate in such hearing. Each such
363 payer or provider entity that is required to participate in such hearing
364 shall provide testimony on issues identified by the executive director
365 and provide additional information on actions taken to improve such
366 payer's or provider entity's quality benchmark performance.

367 (3) Not later than October 15, 2024, and annually thereafter, the
368 executive director shall prepare and submit a report, in accordance with
369 section 11-4a of the general statutes, to the joint standing committees of
370 the General Assembly having cognizance of matters relating to
371 insurance and public health. Such report shall be based on the executive
372 director's analysis of the information submitted during the most recent
373 informational public hearing conducted pursuant to this subsection and
374 any other information that the executive director, in the executive
375 director's discretion, deems relevant for the purposes of this section, and
376 shall:

377 (A) Describe health care quality trends in this state and the factors
378 underlying such trends; and

379 (B) Disclose the executive director's recommendations, if any,
380 concerning strategies to improve the quality of the state's health care
381 system, including, but not limited to, any recommended legislation
382 concerning the state's health care system.

383 Sec. 7. (NEW) (*Effective from passage*) The executive director may
384 adopt regulations, in accordance with chapter 54 of the general statutes,

385 to implement the provisions of section 19a-754a of the general statutes,
386 as amended by this act, and sections 2 to 6, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-754a
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section

Statement of Legislative Commissioners:

In Section 1(b)(3), "primary care target" was changed to "primary care spending target" for consistency; in Section 2(10), "cost growth benchmark" was changed to "health care cost growth benchmark", "primary care spend target" was changed to "primary care spending target", and "quality benchmark" was changed to "health care quality benchmark" for consistency; in Section 2(12), "Primary care target" was changed to "Primary care spending target" for consistency; and in Section 3(b)(2)(C)(ii), "quality benchmarks" was changed to "health care quality benchmarks" for consistency.

INS *Joint Favorable Subst. -LCO*