General Assembly

Raised Bill No. 7116

January Session, 2025

LCO No. **5482**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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 Section 38a-477i of the general statutes is repealed and the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,

restated or renewed between a health care provider and a health carrier, health plan administrator, plan sponsor or its contractors or agents for delivery of health care services to an enrollee of a health benefit plan;

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

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

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

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

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

(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-479ooo;

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 Heath 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	*July 1, 2025*	38a-477i
Sec. 2	*from passage*	19a-754f
Sec. 3	*from passage*	New section

Statement of Purpose:

To: (1) Prohibit any health care contract from including a revenue neutrality clause in such contract; and (2) allow the Insurance Commissioner to engage the services of a third party to conduct an audit of the payer reporting data provided to the Commissioner of Health Strategy for the purpose of reporting on the health care cost growth benchmark and primary care spending target.

[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.]