General Assembly

Governor's Bill No. 983

January Session, 2023

LCO No. **4061**

Referred to Committee on INSURANCE AND REAL ESTATE

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

AN ACT LIMITING ANTICOMPETITIVE HEALTH CARE PRACTICES.

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

1 Section 1. (NEW) (*Effective January 1, 2024*) (a) As used in this section
2 and section 2 of this act:

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

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

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

10 (2) "Anti-steering clause" means a provision of a health care contract
11 that restricts the ability of a health carrier or health plan administrator
12 from encouraging an enrollee to obtain a health care service from a
13 competitor of a hospital or health system, including offering incentives

14 to encourage enrollees to utilize specific health care providers;

15 (3) "Anti-tiering clause" means a provision in a health care contract
16 that:

17 (A) Restricts the ability of a health carrier or health plan administrator
18 to introduce and modify a tiered network plan or assign health care
19 providers into tiers; or

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

23 (4) "Gag clause" means a provision of a health care contract that:

24 (A) Restricts the ability of a health care provider or health carrier or
25 health plan administrator to disclose any price or quality information,
26 including the allowed amount, negotiated rates or discounts, any fees
27 for services or any other claim-related financial obligations included in
28 the provider contract, to a governmental entity as authorized by law or
29 its contractors or agents, any enrollee, treating provider of an enrollee,
30 plan sponsor, or potential eligible enrollees and plan sponsors; or

31 (B) Restricts the ability of either a health care provider, health carrier
32 or health plan administrator to disclose out-of-pocket costs to an
33 enrollee;

34 (5) "Health benefit plan", "network", "network plan", "participating
35 provider" and "tiered network" have the same meanings as provided in
36 section 38a-472f of the general statutes;

37 (6) "Health care contract" means a contract, agreement or
38 understanding, either orally or in writing, entered into, amended,
39 restated or renewed between a health care provider and a health carrier,
40 health plan administrator, plan sponsor or its contractors or agents for
41 the delivery of health care services to an enrollee of a health benefit plan;

42 (7) "Health care provider" means a for-profit or nonprofit entity,

43 corporation, organization, parent corporation, member, affiliate,
44 subsidiary or entity under common ownership that is or whose
45 members are licensed or otherwise authorized by this state to furnish,
46 bill for or receive payment for health care service delivery in the normal
47 course of business, including, but not limited to, a health system,
48 hospital, hospital-based facility, freestanding emergency department,
49 imaging center, large physician group in a practice of eight or more
50 physicians, physician staffing organization, urgent care center and any
51 physician or physician group in a practice of fewer than eight physicians
52 that is employed by or an affiliate of any hospital, medical foundation,
53 insurance company or other similar entity;

54 (8) "Health carrier" has the same meaning as provided in section 38a-
55 591a of the general statutes; and

56 (9) "Health plan administrator" means a third-party administrator
57 that acts on behalf of a plan sponsor to administer a health benefit plan.

58 (b) No health care provider, health carrier or health plan
59 administrator, or any agent or other entity that contracts on behalf of a
60 health care provider, health carrier or health plan administrator, may
61 offer, solicit, request, amend, renew or enter into a health care contract
62 on or after January 1, 2024, that would directly or indirectly include any
63 of the following provisions:

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

65 (2) An anti-steering clause;

66 (3) An anti-tiering clause; or

67 (4) A gag clause.

68 (c) Any clause in a contract, written policy, written procedure or
69 agreement entered into, renewed or amended on or after January 1,
70 2024, that is contrary to the provisions set forth in subsection (b) of this
71 section shall be null and void. All remaining clauses of the contract,
72 written policy, written procedure or agreement shall remain in effect for

73 the duration of the contract term.

74 (d) Nothing in this section shall be construed to limit network design
75 or cost or quality initiatives by a group health plan, health carrier or an
76 administrator working on behalf of a plan sponsor, including an
77 accountable care organization, exclusive provider organization or
78 network, that tiers providers by cost or quality or that steer enrollees to
79 centers of excellence or any other pay-for-performance program.

80 Sec. 2. (NEW) (*Effective January 1, 2024*) (a) The Attorney General shall
81 have exclusive authority to enforce violations of section 1 of this act.

82 (b) During the period beginning on July 1, 2024, and ending on
83 December 31, 2024, the Attorney General shall, prior to initiating any
84 action for a violation of any provision of section 1 of this act, issue a
85 notice of violation to the health care provider, health carrier, health plan
86 administrator, or any agent or other entity that contracts on behalf of a
87 health care provider, health carrier or health plan administrator if the
88 Attorney General determines that a cure is possible. If the health care
89 provider, health carrier, health plan administrator, or any agent or other
90 entity that contracts on behalf of a health care provider, health carrier or
91 health plan administrator fails to cure such violation not later than sixty
92 days after receipt of the notice of violation, the Attorney General may
93 bring an action pursuant to this section. Not later than February 1, 2024,
94 the Attorney General shall submit a report, in accordance with the
95 provisions of section 11-4a of the general statutes, to the joint standing
96 committee of the General Assembly having cognizance of matters
97 relating to general law disclosing: (1) The number of notices of violation
98 the Attorney General has issued; (2) the nature of each violation; (3) the
99 number of violations that were cured during the sixty-day cure period;
100 and (4) any other matter the Attorney General deems relevant for the
101 purposes of such report.

102 (c) Nothing in section 1 of this act shall be construed as providing the
103 basis for, or be subject to, a private right of action for violations of said
104 section or any other law.

105 (d) A violation of the requirements of section 1 of this act shall
106 constitute an unfair trade practice for purposes of section 42-110b of the
107 general statutes and shall be enforced solely by the Attorney General,
108 provided the provisions of section 42-110g of the general statutes shall
109 not apply to such violation.

110 Sec. 3. (NEW) (*Effective January 1, 2024*) (a) As used in this section:

111 (1) "Executive director" means the executive director of the Office of
112 Health Strategy;

113 (2) "Health benefit plan" means a plan, including, but not limited to,
114 a nonfederal governmental plan, as defined in 29 USC 1002(32), a policy,
115 a contract, a certificate or an agreement entered into, offered or issued
116 by a health carrier or health plan administrator acting on behalf of a plan
117 sponsor to provide, deliver, arrange for, pay for or reimburse any of the
118 costs of health care services, but does not include any coverage for
119 health care services by Medicare, Medicaid, TriCare, the United States
120 Department of Veterans Affairs, the Indian Health Services or the
121 Federal Employees Health Benefits Program;

122 (3) "Health care provider" means an individual or a for-profit or
123 nonprofit entity, corporation or organization, including, but not limited
124 to, a health system, hospital or hospital-based facility that furnishes bills
125 for or is paid for the delivery of health care services in the normal course
126 of business;

127 (4) "Health carrier" means an entity subject to the insurance laws and
128 regulations of this state or subject to the jurisdiction of the Insurance
129 Commissioner that offers health insurance, health benefits or contracts
130 for health care services, including, but not limited to, prescription drug
131 coverage, to large groups, small groups or individuals on or outside the
132 insurance marketplace;

133 (5) "Health plan administrator" means a third-party administrator
134 who acts on behalf of a plan sponsor to administer a health benefit plan;

135 (6) "Health system" means: (A) A parent corporation of one or more
136 hospitals and any entity affiliated with such parent corporation through
137 ownership, governance, membership or other means, or (B) a hospital
138 and any entity affiliated with such hospital through ownership,
139 governance, membership or other means;

140 (7) "Hospital" means a hospital licensed under section 19a-490 of the
141 general statutes;

142 (8) "Hospital-based facility" means a facility that is (A) owned or
143 operated, in whole or in part, by a hospital, and (B) where hospital or
144 professional medical services are provided;

145 (9) "Hospital price transparency laws" means Section 2718(e) of the
146 Public Health Service Act, 42 USC 256b, as amended from time to time,
147 and rules adopted by the United States Department of Health and
148 Human Services implementing said section; and

149 (10) "Transparency in coverage laws" means Section 2715A of the
150 Public Health Service Act, 42 USC 256b, as amended from time to time,
151 and Section 715 of the Employee Retirement Income Security Act of
152 1974, as amended from time to time, and Section 9815 of the Internal
153 Revenue Code, as amended from time to time, and rules adopted by the
154 United States Department of Health and Human Services, United States
155 Department of the Treasury and United States Department of Labor
156 implementing Section 2715A of the Public Health Services Act, Section
157 715 of the Employee Retirement Income Security Act, and Section 9815
158 of the Internal Revenue Code.

159 (b) (1) Total out-of-network costs assessed by any health care
160 provider for an inpatient or outpatient hospital service furnished to a
161 person covered by a health benefit plan with whom the health care
162 provider does not participate shall not exceed one hundred per cent of
163 the amount paid by Medicare for the same service in the same
164 geographic area.

165 (2) A health care provider who is reimbursed in accordance with

166 subdivision (1) of this subsection may not charge or collect from the
167 patient, or any person who is financially responsible for the patient, any
168 amount greater than cost-sharing amounts authorized by the terms of
169 the health benefit plan and allowed under applicable law. The total cost,
170 including amounts paid by the health benefit plan and individual cost-
171 sharing, shall not exceed the assessed costs described in subdivision (1)
172 of this subsection or another amount as determined by the Office of
173 Health Strategy in regulations adopted pursuant to subsection (d) of this
174 section.

175 (3) If a health benefit plan does not reimburse claims on a fee-for-
176 service basis, the payment method used shall take into account the limit
177 on the assessed costs specified in subdivision (1) of this subsection. Such
178 payment methods include, but are not limited to, value-based
179 payments, capitation payments and bundled payments.

180 (4) This section shall not apply to (A) a hospital located in a rural
181 town, as designated by the State Office of Rural Health, or (B) a federally
182 qualified health center, as described in section 17b-245b of the general
183 statutes.

184 (c) (1) Health care providers shall provide the Office of Health
185 Strategy, in a form and manner prescribed by the executive director, any
186 information and data as said office determines is necessary for hospital
187 price transparency, to calculate the costs of in-network and out-of-
188 network hospital services and to monitor compliance with the limit on
189 out-of-network costs established in subsection (b) of this section.

190 (2) The Office of Health Strategy shall keep confidential all nonpublic
191 information and documents obtained under this subdivision and shall
192 not disclose such information or documents to any person without the
193 consent of the party that produced such information or documents,
194 except such information or documents may be disclosed to an expert or
195 consultant under contract with said office, provided such expert or
196 consultant is bound by the same confidentiality requirements as said
197 office. Such information and documents shall not be public records and

198 shall be exempt from the provisions of chapter 14 of the general statutes.

199 (3) Not later than January 1, 2025, and annually thereafter, the Office
200 of Health Strategy shall report, in accordance with the provisions of
201 section 11-4a of the general statutes, to the joint standing committee of
202 the General Assembly having cognizance of matters related to insurance
203 and real estate on trends of provider in-network and out-of-network
204 costs and compliance with the provisions of this section. The Office of
205 Health Strategy may include in such report recommendations for
206 further action to make health care more affordable and accessible to
207 residents of the state.

208 (d) The Office of Health Strategy may adopt regulations, in
209 accordance with the provisions of chapter 54 of the general statutes, to
210 implement the provisions of this section, alter or reduce the limit on
211 assessed costs established under subsection (b) of this section and
212 impose civil penalties for noncompliance with the provisions of this
213 section in accordance with the provisions of section 19a-653 of the
214 general statutes.

215 (e) (1) (A) If the executive director has received information or has a
216 reasonable belief that any person, health care facility or institution has
217 violated or is violating any provision of this section, or rule or regulation
218 adopted thereunder, the executive director may issue a notice of
219 violation and civil penalty pursuant to this section by first-class mail or
220 personal service. The notice shall include: (i) A reference to the section
221 of the general statutes, rule or section of the regulations of Connecticut
222 state agencies believed or alleged to have been violated; (ii) a short and
223 plain language statement of the matters asserted or charged; (iii) a
224 description of the activity to cease; (iv) a statement of the amount of the
225 civil penalty or penalties that may be imposed; (v) a statement
226 concerning the right to a hearing; and (vi) a statement that such person,
227 health care facility or institution may, not later than ten business days
228 after receipt of such notice, make a request for a hearing on the matters
229 asserted.

230 (B) The person, health care facility or institution to whom such notice
231 is provided pursuant to subdivision (1) of this subsection may, not later
232 than ten business days after receipt of such notice, make written
233 application to the Office of Health Strategy to request a hearing to
234 demonstrate that such violation has not occurred. A failure to make a
235 timely request for a hearing shall result in the issuance of a cease and
236 desist order or civil penalty. All hearings held under this subsection
237 shall be conducted pursuant to chapter 54 of the general statutes.

238 (C) Following a hearing before the Office of Health Strategy pursuant
239 to this subsection if the office finds by a preponderance of the evidence
240 that such person, health care facility or institution has violated or is
241 violating any provision of this section, any rule or regulation adopted
242 thereunder or any order of the office, the office shall issue a final cease
243 and desist order in addition to any civil penalty the office imposes.

244 (2) The executive director, or the executive director's designee, may
245 audit any person, health care facility or institution governed by the
246 provision of this section for compliance with the requirements of this
247 section. Until the expiration of four years after the furnishing of any
248 services for which an out-of-network cost was charged, billed or
249 collected, each person, health care facility or institution subject to the
250 audit shall make available, upon written request of the executive
251 director of the Office of Health Strategy, or the executive director's
252 designee, copies of any books, documents, records or data that are
253 necessary for completing the audit.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2024*	New section
Sec. 2	*January 1, 2024*	New section
Sec. 3	*January 1, 2024*	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.]