General Assembly

Substitute Bill No. 983

January Session, 2023

* SB00983APP 050223 *

AN ACT LIMITING ANTICOMPETITIVE HEALTH CARE PRACTICES.

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

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

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

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

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

(2) "Anti-steering clause" means any provision of a health care contract that restricts the ability of the health carrier or health plan administrator from encouraging an enrollee to obtain a health care service from a competitor of a hospital or health system, including offering incentives to encourage enrollees to utilize specific health care providers;

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

that:

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

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

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

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

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

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

(6) "Health care contract" means any contract, agreement or 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, 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, any health system, hospital, hospital-based facility, freestanding emergency department, imaging center, physician group in a practice of eight or more physicians, urgent care center as defined in section 19a-493d of the general statutes 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 of the general statutes; and

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

(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 January 1, 2024, that directly or indirectly includes any of the following provisions:

(1) An all-or-nothing clause;

(2) An anti-steering clause;

(3) An anti-tiering clause; or

(4) A gag clause.

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

shall remain in effect for the duration of the contract term.

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

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

(b) For the period beginning July 1, 2024, and ending December 31, 2024, inclusive, the Attorney General shall, prior to initiating any action for a violation of any provision of section 1 of this act, issue a notice of violation to the 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 if the Attorney General determines that a resolution is possible. If the 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 fails to resolve such violation not later than sixty days after receipt of such notice of violation, the Attorney General may bring an action pursuant to this section. Not later than February 1, 2024, the Attorney General shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to general law disclosing: (1) The number of notices of violation the Attorney General has issued; (2) the nature of each violation; (3) the number of violations that were resolved during such sixty-day resolution period; and (4) any other matter the Attorney General deems relevant for the purposes of such report.

(c) Nothing in section 1 of this act shall be construed to provide the basis for, or be subject to, a private right of action for any violation of said section or any other law.

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

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

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

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

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

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

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

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

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

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

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

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

(b) (1) The total out-of-network costs assessed by any health care provider for an inpatient or outpatient hospital service furnished to any person covered by a health benefit plan entered into, renewed or amended on or after January 1, 2024, with whom the health care provider does not participate shall not exceed one hundred fifty per cent of the reimbursement rate payable under Medicare for the same service provided in the same geographic area.

(2) No health care provider who is reimbursed in accordance with subdivision (1) of this subsection shall charge or collect from the patient, or any person who is financially responsible for the patient, any amount greater than cost-sharing amounts authorized by the terms of the health benefit plan and allowed under applicable law. The total cost, including amounts paid by such health benefit plan and individual cost-sharing, shall not exceed the assessed costs described in subdivision (1) of this subsection or a separate amount as determined by the Office of Health Strategy in regulations adopted pursuant to subsection (d) of this section.

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

(4) A health benefit plan shall pass on any savings from any reduction in provider payments pursuant to this subsection to consumers. Any savings by a health carrier from any reduction in provider payments shall be reflected in such health carrier's annual rate filing for such health benefit plan.

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

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

(2) The Office of Health Strategy shall keep confidential all nonpublic information and documents obtained under this subdivision and shall not disclose such information or documents to any person without the consent of the party that produced such information or documents, except such information or documents may be disclosed to an expert or consultant under contract with said office, provided such expert or consultant is bound by the same confidentiality requirements as said office. Such information and documents shall not be public records and shall be exempt from disclosure pursuant to the provisions of chapter 14 of the general statutes.

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

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

(e) (1) (A) If the executive director receives information or has a reasonable belief that any person, health care provider or health carrier violated or is violating any provision of this section, or rule or regulation adopted thereunder, the executive director may issue a notice of violation and civil penalty pursuant to this section by first-class mail or personal service. Such notice shall include: (i) A reference to the section of the general statutes, rule or section of the regulations of Connecticut

state agencies believed or alleged to have been violated; (ii) a short and plain language statement of the matters asserted or charged; (iii) a description of the activity to cease; (iv) a statement of the amount of the civil penalty or penalties that may be imposed; (v) a statement concerning the right to a hearing; and (vi) a statement that such person, health care provider or health carrier may, not later than ten business days after receipt of such notice, make a request for a hearing on the matters asserted.

(B) The person, health care provider or health carrier to whom such notice is provided pursuant to subparagraph (A) of this subdivision may, not later than ten business days after receipt of such notice, make written application to the Office of Health Strategy to request a hearing to demonstrate that such violation did not occur. The failure to make a timely request for a hearing shall result in the issuance of a cease and desist order or civil penalty. All hearings held under this subsection shall be conducted in accordance with the provisions of chapter 54 of the general statutes.

(C) Following any hearing before the Office of Health Strategy pursuant to this subsection, if the Office of Health Strategy finds by a preponderance of the evidence that such person, health care provider or health carrier violated or is violating any provision of this section, any rule or regulation adopted thereunder or any order issued by the Office of Health Strategy, the Office of Health Strategy shall issue a final cease and desist order in addition to any civil penalty the Office of Health Strategy imposes.

(2) The executive director, or the executive director's designee, may audit any person, health care provider or health carrier subject to the provisions of this section for compliance with the requirements of this section. Until the expiration of four years after the furnishing of any services for which an out-of-network cost was charged, billed or collected, each person, health care provider or health carrier subject to any such audit shall make available, upon written request of the executive director of the Office of Health Strategy, or the executive

director's designee, copies of any books, documents, records or data that are necessary for completing such 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

INS *Joint Favorable Subst.*

APP *Joint Favorable*