OLR Bill Analysis
sHB 6871

AN ACT LIMITING OUT-OF-NETWORK HEALTH CARE COSTS.

SUMMARY

For health benefit plans entered into, renewed, or amended on or after January 1, 2027, this bill prohibits a health care provider's out-of-network charges for inpatient or outpatient hospital services provided to a health benefit plan enrollee from exceeding 240% of the Medicare reimbursement rate charged for the same service in the same geographic area. It also prohibits a health care provider from charging or collecting any amount greater than the cost sharing amounts under the patient's health benefit plan and allowed by law. The bill specifies that the total cost paid by the plan and the patient combined cannot exceed the 240% of Medicare limit or an amount the Office of Health Strategy (OHS) determines in regulations. Under the bill, any plan that does not reimburse claims on a fee-for-service basis but that uses an alternative payment method (e.g., value based, capitation, or bundled payments) still must account for the limit. (The bill exempts from its requirements a (1) hospital in a rural town as determined by the state's Office of Rural Health and (2) federally qualified health center.)

The bill requires health care providers to give OHS certain information necessary for the office to calculate in- and out-of-network hospital service costs and monitor compliance with the out-of-network cost limit. It requires OHS to report twice a year, beginning by January 1, 2028, to the Insurance and Real Estate Committee on health care provider cost trends, compliance with the out-of-network cost limit, and recommendations to make health care more affordable and accessible.

Under the bill, a health care provider who violates the bill's provisions may be required to issue a refund to the patient, the person financially responsible for the patient, or the health benefit plan in the amount that the provider received in excess of the out-of-network cost

limit. The provider may also be liable for a civil penalty of up to $1,000.

The bill allows the OHS commissioner to issue a notice of violation and civil penalty, under certain conditions, to any person, health care provider, or health carrier that may be violating the bill's requirements or any associated regulation. (However, the bill only specifies the allowed civil penalty amount for health care providers, not for other persons or carriers.) The bill also outlines a process for holding hearings requested to contest a notice of violation.

Lastly, the bill allows OHS to adopt implementing regulations. It also lets the OHS commissioner adopt policies and procedures needed to administer the bill's provisions while in the process of adopting regulations, so long as she posts notice of the intent to adopt regulations within 20 days after adopting the policies and procedures. Any such policies and procedures will be valid until regulations are adopted.

EFFECTIVE DATE: January 1, 2026

OUT-OF-NETWORK COST LIMIT FOR HOSPITAL SERVICES

Health Benefit Plan

Under the bill, a "health benefit plan" generally includes any agreement issued by a health carrier or a health plan administrator on a plan sponsor's behalf to cover costs for health care services. It excludes agreements that provide coverage under federal governmental plans, Medicare, Medicaid, TriCare, the U.S. Department of Veterans Affairs, the Indian Health Services, or the Federal Employees Health Benefits Program.

Savings Passed to Consumers

The bill requires a health benefit plan to pass on to consumers any savings achieved through implementing the out-of-network cost limit. A health carrier must reflect in its annual rate filing for the plan the amount of any savings achieved from reduced health care provider payments.

Provider Reporting to OHS and Confidentiality

The bill requires health care providers to give OHS information covered under federal hospital price transparency laws and other data the office determines is necessary for it to calculate in- and out-of-network hospital service costs and monitor compliance with the out-of-network cost cap. Providers must report in the way the OHS commissioner prescribes. (Federal law requires each hospital operating within the United States to maintain and publish annually a list of the hospital's standard charges for items and services the hospital provides.)

Under the bill, OHS (1) must generally keep nonpublic reported information confidential and (2) is prohibited from sharing that information without the provider's consent. However, the bill lets OHS share information with consultants who are bound by the same confidentiality requirements. Under the bill, information provided to OHS is not a public record and is exempt from disclosure under the Freedom of Information Act.

Enforcement and Penalties

If the OHS commissioner receives information or has a reasonable belief that a person, health care provider, or health carrier is violating the bill's provisions or associated regulations, the bill allows her to issue a notice of violation and civil penalty. (However, the bill only specifies the allowed civil penalty amount for health care providers (i.e. up to $1,000).) The notice, which must be sent by first class mail or personal service, must contain the following information:

1. the statute, rule, or regulation that was allegedly violated;
2. a short, plain language statement of the matters asserted or charged;
3. a description of the activity to cease;
4. the amount of any civil penalties imposed; and
5. a statement of their right to a hearing, and that they may request

one no later than 10 business days after receiving the notice.

Under the bill, if a hearing is not timely requested, OHS must issue a cease and desist order or a civil penalty. If a hearing is held and OHS finds by a preponderance of the evidence that the person, provider, or carrier violated the bill's provisions or any associated regulations or OHS orders, the bill requires OHS to issue a final cease and desist order and any civil penalty that the office may impose. The bill requires that any hearing held must be in accordance with the Uniform Administrative Procedure Act.

Audits and Record Retention

The bill allows the OHS commissioner, or her designee, to audit any person, provider, or carrier for compliance with the bill's requirements. A person, provider, or carrier under audit must make available to the OHS commissioner or her designee, upon written request, any records needed for the audit for four years following the date of a provided service for which an out-of-network cost was charged, billed, or collected.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 7 Nay 6 (03/11/2025)