OLR Bill Analysis

sHB 7115

AN ACT CONCERNING REVISIONS TO THE HEALTH CARE COST GROWTH BENCHMARK PROGRAM.

SUMMARY

This bill makes changes in laws related to payers' (e.g., private health insurers) annual reporting of aggregated data the Office of Health Strategy (OHS) uses to calculate total health care expenditures, primary care spending as a percentage of total medical expenses, and the net cost of private health insurance in the state.

Specifically, the bill requires payers to include self-funded employee health plan data in their annual data submission to OHS, if the employer of the self-funded employee health plan completes an opt-in form, which the commissioner must prescribe. Regarding the opt-in process, the bill does the following:

1. generally requires payers to give employers the form within 15 days after the claim administration services are retained and imposes a penalty for failing to do so;

2. keeps all completed opt-in forms in effect for all future data reporting periods, but allows an employer to opt out by providing written notice;

3. requires the payer to include, as part of its required data submission, the self-funded health plan data for employers that opted in; and

4. generally prohibits the payer from imposing a cost or fee on an employer whose self-funded health benefit plan data is included in the payer's submission to the commissioner.

The bill also requires each payer, starting by January 31, 2026, to

annually report to the commissioner specified information for the preceding year, such as a list of the employers that opted in and a list of those that opted out.

Existing law requires the OHS commissioner to hold annual informational hearings that certain payers, provider entities, and other entities must participate in. The bill (1) authorizes the commissioner to specify how these entities must participate and (2) specifies that the participant's required testimony can be written and oral, as the commissioner requests.

EFFECTIVE DATE: October 1, 2025

PAYER REPORTING REQUIREMENTS

Payer Defined

By law, a "payer" is an entity that, during a given calendar year, pays health care providers for health care services or pharmacies or provider entities for prescription drugs designated by the OHS commissioner. It includes Medicaid, Medicare, governmental and nongovernment health plans, and any organization acting as payer that is a subsidiary, affiliate, or business owned or controlled by a payer (CGS § 19a-754f(9)).

Payer Annual Reporting Requirement

Existing law requires each payer to annually report to the OHS commissioner certain aggregated data for the preceding year, including for self-funded plans. The commissioner uses this data to calculate total health care expenditures, primary care spending as a percentage of total medical expenses, and the net cost of private health insurance.

The bill makes the changes below to this law as it pertains to reporting self-funded health plan data.

Opt-in Form. Under the bill, each payer required to report data must give employers with self-funded employee health plans a form that an employer may complete to opt in to submitting its employee health plan data to the payer, which the payer includes in its submission to OHS.

The opt-in form must be prescribed by the OHS commissioner and

available on the office's website. The bill allows the payer to use a form developed for multistate use, if the commissioner determines that it is substantially like the form she prescribes.

Penalty for Failure to Provide the Opt-in Form. The bill authorizes the commissioner to impose a penalty on any payer that fails to give the opt-in form to an employer with a self-funded employee health plan. The penalty may be up to $10 per covered person enrolled in a self-funded employee health plan.

Delivery and Effective Date. The payer must give the employer the form within 15 days after the claim administration services are retained and the payer determines that the employer satisfies the bill's requirements. A completed opt-in form is effective for the current data reporting period and stays effective for all future data reporting periods (unless the employer opts out, see below). Also, an employer cannot opt in for a partial data reporting period.

Opting Out. An employer who opts in for a data reporting period may opt out of all subsequent data reporting periods by providing written notice at least 30 days before the next data reporting period starts.

Reporting Self-Funded Health Plan Data. The payer must include the self-funded health plan data as part of the payer's required data submission.

Payer's Report to the OHS Commissioner

Starting by January 31, 2026, each payer must annually report to the commissioner, in a form and manner she prescribes, the following for the preceding year:

1. a list of self-funded employee health plans whose employer opted in for submitting self-funded health plan data as described above;

2. a list of employers who previously opted in for submitting the data but subsequently opted out;

3. a signed certification by a payer's officer certifying that the payer has taken reasonable efforts to give each employer the opt-in form; and

4. a list identifying each employer, by name and mailing address, to whom the payer gave the form.

Other Provisions

The bill specifies that the opt-in form can only be given to employers with self-funded employee health plans. It also specifies that providing the form in compliance with the bill does not affect any other required reporting.

The bill generally prohibits any payer from imposing a cost or fee on an employer whose self-funded data is included in the payer's reporting of aggregate data to the commissioner. However, the bill allows a payor to impose the actual cost incurred for the data submission.

INFORMATIONAL PUBLIC HEARING

By law, the OHS commissioner must hold an informational public hearing annually to compare the growth in total health care expenditures in the performance year to the health care cost growth benchmark (see BACKGROUND) for that year.

The bill authorizes the commissioner to specify how payers, provider entities, and other entities (see below) participate in the informational hearing.

The bill also requires the other entities that may be required to participate in the hearing to provide written and oral testimony as the commissioner requests.

Under existing law, the commissioner may require the following persons to participate in the hearing:

1. payers and provider entities found to be significant contributors to healthcare cost growth in the state for the performance year, or that failed to meet the primary care spending target, and

2. any other entity found to be a significant contributor to health care cost growth in the state during the performance year.

By law, an "other entity" is a drug manufacturer, pharmacy benefits manager, or other health care provider that is not a provider entity (CGS § 19a-754f(8)). A "provider entity" is an organized group of clinicians that (1) come together for contracting purposes or (2) are an established billing unit that at least includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract (CGS § 19a-754f(13)).

BACKGROUND

Healthcare Cost Benchmark

By law, the OHS commissioner must publish on the office's Internet web site the (1) health care cost growth benchmarks and annual primary care spending targets as a percentage of total medical expenses for the calendar years 2021 to 2025, inclusive, and (2) annual health care quality benchmarks for the calendar years 2022 to 2025, inclusive.

By July 1, 2025, and every five years after that, the commissioner must develop and adopt annual health care cost growth benchmarks and annual primary care spending targets for the following five calendar years for provider entities and payers (CGS § 19a-754g).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 13 Nay 0 (03/13/2025)