General Assembly

Raised Bill No. 328

February Session, 2020

LCO No. **1988**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING HEALTH CARE COST GROWTH BENCHMARKS, CANADIAN DRUG REIMPORTATION, STOP-LOSS INSURANCE AND REINSURANCE.

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

Section 1. Section 19a-754a of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(a) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties therein prescribed.

(b) The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a

coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

(3) **[**Directing**]** (A) Developing, innovating, directing and overseeing health care delivery and payment models in the state that reduce health care cost growth and improve the quality of patient care, including, but not limited to, the State Innovation Model Initiative and related successor initiatives, (B) setting an annual health care cost growth benchmark and primary care target pursuant to section 3 of this act, (C) developing and adopting health care quality benchmarks pursuant to section 8 of this act, (D) enhancing the transparency of health care entities, as defined in section 2 of this act, (E) monitoring the development of accountable care organizations and patient-centered medical homes in the state, and (F) monitoring the adoption of alternative payment methodologies in the state;

(4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establishing and maintaining a consumer health information Internet web site under section 19a-755b, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g;

(5) Directing and overseeing the Health Systems Planning Unit established under section 19a-612 and all of its duties and responsibilities as set forth in chapter 368z; and

(6) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut

Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies.

(c) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the functions, powers and duties of the following:

(1) The Connecticut Health Insurance Exchange, established pursuant to section 38a-1081, relating to the administration of the all-payer claims database pursuant to section 19a-755a; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725, and (C) (i) appointment of the health information technology officer, and (ii) oversight of the duties of such health information technology officer as set forth in sections 17b-59f and 17b-59g.

(d) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection (c) of this section that is in force on July 1, 2018, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 2. (NEW) (*Effective July 1, 2020*) For the purposes of this section and sections 3 to 9, inclusive, of this act:

(1) "Device manufacturer" means a manufacturer that manufactures a device for which annual sales in this state exceed ten million dollars;

(2) "Drug manufacturer" means the manufacturer of a drug that is: (A) Included in information and data submitted by a health carrier pursuant to section 38a-479qqq of the general statutes; (B) studied or listed pursuant to subsection (c) or (d) of section 19a-754b of the general statutes; or (C) in a therapeutic class of drugs that the executive director determines, through public or private reports, has had a substantial impact on prescription drug expenditures, net of rebates, as a

percentage of total health care expenditures;

(3) "Executive director" means the executive director of the office;

(4) "Health care cost growth benchmark" means the annual benchmark established pursuant to section 3 of this act;

(5) "Health care entity" means an accountable care organization, ambulatory surgical center, clinic, hospital or provider organization in this state, other than a health care provider contracting unit that, for a given calendar year: (A) Has a patient panel of not more than ten thousand patients; or (B) represents health care providers who collectively receive less than twenty million dollars in net patient service revenue from health carriers;

(6) "Health care facility" has the same meaning as provided in section 19a-630 of the general statutes;

(7) "Health care quality benchmark" means an annual benchmark established pursuant to section 8 of this act;

(8) "Health care provider" has the same meaning as provided in section 19a-17b of the general statutes;

(9) "Health status adjusted total medical expenses" means: (A) The total cost of care for the patient population of a provider organization with at least thirty-six thousand member months for a given calendar year, which cost (i) is calculated for such year on the basis of the allowed claims for all categories of medical expenses and all nonclaims payments for such year, including, but not limited to, cost-sharing payments, adjusted by health status and expressed on a per member, per month basis for all members in this state, (ii) is reported to the executive director separately for Medicaid, Medicare and nongovernment health plans for such year, and (iii) discloses the health adjustment risk score and the version of the risk adjustment tool used to calculate such score for such provider organization for such year; and (B) the total aggregate medical expenses for all health care providers and

provider organizations with fewer than thirty-six thousand member months for a given calendar year;

(10) "Hospital outpatient department" has the same meaning as such term is used in Section 413.65 of Title 42 of the Code of Federal Regulations, as amended from time to time;

(11) "Institutional provider" means any health care provider that provides skilled nursing facility services, or acute, chronic or rehabilitation hospital services, in this state;

(12) "Office" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act;

(13) "Other entity" means a device manufacturer, drug manufacturer or pharmacy benefits manager;

(14) "Payer" means a payer that, during a given calendar year, pays health care providers for health care services on behalf of, or pays pharmacies for prescription drugs dispensed to, more than ten thousand individuals in this state;

(15) "Pharmacy benefits manager" has the same meaning as provided in section 38a-479ooo of the general statutes;

(16) "Primary care target" means the annual target established pursuant to section 3 of this act;

(17) "Provider organization" means a group of persons, including, but not limited to, an accountable care organization, association, business trust, corporation, independent practice association, partnership, physician organization, physician-hospital organization or provider network, that is in the business of health care delivery or management in this state and represents a health care provider in contracting with a payer for payment for health care services; and

(18) "Total health care expenditures" means the per capita sum of all health care expenditures in this state from public and private sources

for a given calendar year, including: (A) All categories of medical expenses and all nonclaims payments to health care providers and health care facilities, as included in the health status adjusted total medical expenses reported, if any, by the executive director pursuant to subsection (c) of section 5 of this act; (B) all patient cost-sharing amounts, including, but not limited to, deductibles and copayments; (C) the net cost of nongovernment health insurance; (D) prescription drug expenditures net of rebates and discounts; (E) device manufacturer expenditures net of rebates and discounts; and (F) any other expenditures specified by the executive director.

Sec. 3. (NEW) (*Effective July 1, 2020*) (a) Not later than December 1, 2020, and annually thereafter, the executive director shall establish a health care cost growth benchmark for the calendar year next succeeding. Such health care cost growth benchmark shall address the average growth in total health care expenditures across all payers and populations in this state for such year, and the executive director shall include within such health care cost growth benchmark a primary care target to ensure primary care spending as a percentage of total health care expenditures reaches a goal of ten per cent for the calendar year beginning January 1, 2025.

(b) In establishing each health care cost growth benchmark pursuant to subsection (a) of this section, the executive director shall, at a minimum:

(1) Consider any change in the consumer price index for all urban consumers in the northeast region from the preceding calendar year, and the most recent publicly available information concerning the growth rate of the gross state product;

(2) Evaluate current primary care spending as a percentage of total health care expenditures; and

(3) (A) Hold an informational public hearing concerning such health care cost growth benchmark:

(i) At a time and place designated by the executive director in a notice prominently posted by the executive director on the office's Internet web site;

(ii) In a form and manner prescribed by the executive director; and

(iii) On the basis of the most recent report, if any, prepared by the executive director pursuant to subsection (c) of section 5 of this act, and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of such hearing.

(B) Notwithstanding subparagraph (A) of this subdivision, the executive director shall not be required to hold an informational public hearing concerning a health care cost growth benchmark for any calendar year beginning on or after January 1, 2022, if such health care cost growth benchmark is the same as the health care cost growth benchmark for the preceding calendar year.

(c) If the executive director determines, after any informational public hearing held pursuant to subdivision (3) of subsection (b) of this section, that a modification to the health care cost growth benchmark is, in the executive director's discretion, reasonably warranted, the executive director may modify such health care cost growth benchmark. The executive director need not hold an additional informational public hearing concerning such modified health care cost growth benchmark.

(d) The executive director shall post each health care cost growth benchmark on the office's Internet web site.

(e) The executive director may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants to assist the executive director in establishing health care cost growth benchmarks.

Sec. 4. (NEW) (*Effective July 1, 2020*) (a) (1) Not later than May 1, 2022, and annually thereafter, the executive director shall hold an

informational public hearing to compare the growth in total health care expenditures during the preceding calendar year to the health care cost growth benchmark established pursuant to section 3 of this act for such year. Such hearing shall include an examination of:

(A) The report, if any, most recently prepared by the executive director pursuant to subsection (c) of section 5 of this act;

(B) The expenditures of health care entities and payers, including, but not limited to, health care cost trends, primary care spending as a percentage of total health care expenditures, and the factors contributing to such costs and expenditures;

(C) Whether one category of expenditures may be offset by savings in another category of expenditures; and

(D) Any other matters that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director may require that any health care entity or payer that is found to be a significant contributor to health care cost growth in this state during the preceding calendar year participate in such hearing. Each such health care entity or payer that is required to participate in such hearing shall provide testimony on issues identified by the executive director, and provide additional information on actions taken to reduce such health care entity's contribution to future state-wide health care costs and expenditures.

(b) Not later than October 1, 2022, and annually thereafter, the executive director shall prepare and submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the executive director's analysis of the information submitted during the most recent informational public hearing conducted pursuant to subsection (a) of this section and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this

section, and shall:

(1) Describe health care spending trends in this state, including, but not limited to, trends in primary care spending as a percentage of total health care expenditures, and the factors underlying such trends; and

(2) Disclose the executive director's recommendations, if any, concerning strategies to increase the efficiency of this state's health care system, including, but not limited to, any recommended legislation concerning this state's health care system.

Sec. 5. (NEW) (*Effective July 1, 2020*) (a) Not later than March 1, 2022, and annually thereafter, each institutional provider, on behalf of such institutional provider and its parent organization and affiliated entities, health care provider that is not an institutional provider and provider organization in this state, shall submit to the executive director, for the preceding calendar year:

(1) Data concerning:

(A) The utilization of health care services provided by such provider or organization;

(B) The charges, prices imposed and payments received by such provider or organization for such services;

(C) The costs incurred, and revenues earned, by such provider or organization in providing such services; and

(D) Any other matter that the executive director deems relevant for the purposes of this section; and

(2) If such provider is a hospital, the data described in subdivision (1) of this subsection, and such additional data, information and documents designated by the executive director, including, but not limited to, charge masters, cost data, audited financial statements and merged billing and discharge data, provided such provider shall not be required to submit any data contained in a report that is filed pursuant to

chapters 368aa to 368*ll*, inclusive, of the general statutes and available to the executive director.

(b) The executive director shall establish standards to ensure that the data, information and documents submitted to the executive director pursuant to subsection (a) of this section are submitted to the executive director in a uniform manner. Such standards shall enable the executive director to identify, on a patient-centered and health care provider-specific basis, state-wide and regional trends in the availability, cost, price and utilization of medical, surgical, diagnostic and ancillary services and prescription drugs provided by hospital outpatient departments, acute care hospitals, chronic disease hospitals, rehabilitation hospitals and other specialty hospitals, clinics, including, but not limited to, psychiatric clinics, urgent care facilities and facilities providing ambulatory care. Such standards may require hospitals to submit such data, information and documents to the executive director in an electronic form, provided such standards shall provide for a waiver of such requirement if such waiver is reasonable in the judgment of the executive director.

(c) (1) Not later than December 1, 2021, and annually thereafter, the executive director shall prepare, to the extent practicable, and post on the office's Internet web site, a report concerning health status adjusted total medical expenses for the preceding calendar year, including, but not limited to, a breakdown of such health status adjusted total medical expenses by:

(A) Major service category;

(B) Payment methodology;

(C) Relative price;

(D) Direct hospital inpatient cost;

(E) Indirect hospital inpatient cost;

(F) Direct hospital outpatient cost;

(G) Indirect hospital outpatient cost; and

(H) Primary care spending as a percentage of total health care expenditures.

(2) Notwithstanding subdivision (1) of this subsection, the executive director shall not disclose any health care provider-specific data or information unless the executive director provides at least ten days' advance written notice of such disclosure to each health care provider that would be affected by such disclosure.

(d) The executive director shall, at least annually, submit a request to the federal Centers for Medicare and Medicaid Services for the health status adjusted total medical expenses of provider organizations that served Medicare patients during the calendar year next preceding.

(e) The executive director may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants.

Sec. 6. (NEW) (*Effective July 1, 2020*) (a) (1) For each calendar year beginning on or after January 1, 2022, if the executive director determines that the average annual percentage change in total health care expenditures for the preceding calendar year exceeded the health care cost growth benchmark for such year, the executive director shall identify, not later than May first of such calendar year, each health care entity or payer that exceeded such health care cost growth benchmark for such year.

(2) The executive director may require any health care entity or payer that is found to be a significant contributor to health care cost growth in this state during the preceding calendar year to participate in the informational public hearing held pursuant to subsection (a) of section 4 of this act. Each such entity or payer that is required to participate in such hearing shall provide testimony on issues identified by the executive director, and provide additional information on actions taken

to reduce such entity's or payer's contribution to future state-wide health care costs.

(b) Not later than thirty days after the executive director identifies each health care entity or payer pursuant to subdivision (1) of subsection (a) of this section, the executive director shall send a notice to each such entity or payer. Such notice shall be in a form and manner prescribed by the executive director, and disclose to each such entity or payer:

(1) That the executive director has identified such entity or payer pursuant to subdivision (1) of subsection (a) of this section;

(2) The factual basis for the executive director's identification of such entity or payer pursuant to subdivision (1) of subsection (a) of this section; and

(3) That such entity or payer shall file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section, provided such entity or payer may:

(A) File a request for an extension of time, or a waiver, pursuant to subdivision (1) of subsection (c) of this section; and

(B) Request a hearing pursuant to subsection (d) of this section.

(c) (1) (A) Each health care entity or payer identified by the executive director pursuant to subdivision (1) of subsection (a) of this section may, not later than thirty days after the executive director sends a notice to such entity or payer pursuant to subsection (b) of this section, file with the executive director, in a form and manner prescribed by the executive director, a request seeking:

(i) An extension of time to file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section; or

(ii) A waiver from the requirement that such entity or payer file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section.

(B) Each health care entity or payer that files a request pursuant to subparagraph (A) of this subdivision shall set forth in such request the reasons for such request.

(2) Not later than thirty days after a health care entity or payer files a request pursuant to subdivision (1) of this subsection, the executive director shall:

(A) Examine the reasons set forth in the request and decide, on the basis of such reasons, whether to approve or deny such request; and

(B) Send a notice, in a form and manner prescribed by the executive director, to the entity or payer that filed such request disclosing, at a minimum:

(i) The executive director's decision concerning such request and the reasons therefor;

(ii) If the executive director denies such entity's or payer's request, that such entity or payer may file a request for a hearing pursuant to subsection (d) of this section; and

(iii) If such entity's or payer's request is a request for an extension of time to file a proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section and the executive director approves such request, the date by which such entity or payer shall file such proposed performance improvement plan.

(d) Each health care entity or payer identified by the executive director pursuant to subsection (a) of this section may, not later than thirty days after the executive director sends a notice to such entity or payer pursuant to subsection (b) of this section or subparagraph (B) of subdivision (2) of subsection (c) of this section, as applicable, file with the executive director a request for a hearing. Each hearing conducted pursuant to this subsection shall be conducted in accordance with the procedures for hearings on contested cases established in chapter 54 of the general statutes.

(e) (1) Each health care entity or payer identified by the executive director pursuant to subdivision (1) of subsection (a) of this section, or required by the executive director pursuant to subparagraph (C)(ii)(III) of subdivision (4) of subsection (f) of this section, shall, subject to the provisions of subsections (b) to (d), inclusive, of this section, file with the executive director a proposed performance improvement plan. Such entity or payer shall file such proposed performance improvement plan, which shall include an implementation timetable, with the executive director, in a form and manner prescribed by the executive director, not later than whichever of the following dates first occurs:

(A) The date that is thirty days after the date on which the executive director sent a notice to such entity or payer pursuant to subsection (b) of this section;

(B) The date that the executive director disclosed to such entity or payer pursuant to subparagraph (B)(iii) of subdivision (2) of subsection (c) of this section; or

(C) The date that is thirty days after the date on which the notice of a final decision is issued following a hearing conducted pursuant to subsection (d) of this section.

(2) (A) The executive director shall review each health care entity's and payer's proposed performance improvement plan filed pursuant to subdivision (1) of this subsection to determine whether, in the executive director's judgment, it is reasonably likely that:

(i) Such proposed performance improvement plan will address the cause of such entity's or payer's excessive cost growth; and

(ii) Such entity or payer will successfully implement such proposed performance improvement plan.

(B) After the executive director reviews a proposed performance improvement plan pursuant to subparagraph (A) of this subdivision, the executive director shall:

(i) Approve such proposed performance improvement plan if the executive director determines, in the executive director's judgment, that such proposed plan satisfies the criteria established in subparagraph (A) of this subdivision; or

(ii) Deny such proposed performance improvement plan if the executive director determines, in the executive director's judgment, that such proposed performance improvement plan does not satisfy the criteria established in subparagraph (A) of this subdivision.

(C) (i) Not later than thirty days after the executive director approves or denies a proposed performance improvement plan pursuant to subparagraph (B) of this subdivision, the executive director shall send a notice to the health care entity or payer that filed such proposed performance improvement plan disclosing, at a minimum, that:

(I) The executive director approved such proposed performance improvement plan; or

(II) The executive director denied such proposed performance improvement plan, the reasons for such denial and that such entity or payer shall file with the executive director such amendments as are necessary for such proposed performance improvement plan to satisfy the criteria established in subparagraph (A) of this subdivision.

(ii) The executive director shall post a notice on the office's Internet web site disclosing:

(I) The name of each health care entity or payer that files, and receives approval for, a proposed performance improvement plan; and

(II) That such health care entity or payer is implementing such performance improvement plan.

(D) Each health care entity or payer that receives a notice from the executive director pursuant to subparagraph (C)(i) of this subdivision notifying such entity or payer that the executive director has denied such entity's or payer's proposed performance improvement plan shall

file with the executive director, in a form and manner prescribed by the executive director and not later than thirty days after the date that the executive director sends such notice to such entity or payer, such amendments as are necessary for such proposed performance improvement plan to satisfy the criteria established in subparagraph (A) of this subdivision.

(f) (1) Each health care entity or payer that receives a notice from the executive director pursuant to subparagraph (C)(i) of subdivision (2) of subsection (e) of this section notifying such entity or payer that the executive director has approved such entity's or payer's proposed performance improvement plan:

(A) Shall immediately make good faith efforts to implement such performance improvement plan; and

(B) May amend such plan at any time during the implementation timetable included in such performance improvement plan, provided the executive director approves such amendment.

(2) The office may provide such assistance to each health care entity or payer that the executive director, in the executive director's discretion, deems necessary and appropriate to ensure that such entity or payer successfully implements such entity's or payer's performance improvement plan.

(3) Each health care entity or payer shall be subject to such additional reporting requirements that the executive director, in the executive director's discretion, deems necessary to ensure that such entity or payer successfully implements such entity's or payer's performance improvement plan.

(4) (A) Each health care entity or payer that files, and receives approval for, a performance improvement plan pursuant to this section shall, not later than thirty days after the last date specified in the implementation timetable included in such performance improvement plan, submit to the executive director, in a form and manner prescribed

by the executive director, a report regarding the outcome of such entity's or payer's implementation of such performance improvement plan.

(B) If the executive director determines, on the basis of the report submitted by a health care entity or payer pursuant to subparagraph (A) of this subdivision, that such entity or payer successfully implemented such entity's or payer's performance improvement plan, the executive director shall:

(i) Send a notice to such entity or payer, in a form and manner prescribed by the executive director, disclosing such determination; and

(ii) Remove from the office's Internet web site the notice concerning such entity or payer that the executive director posted on such Internet web site pursuant to subparagraph (C)(ii) of subdivision (2) of subsection (e) of this section.

(C) If the executive director determines, on the basis of the report submitted by a health care entity or payer pursuant to subparagraph (A) of this subdivision, that such entity or payer failed to successfully implement such entity's or payer's performance improvement plan, the executive director shall:

(i) Send a notice to such entity or payer, in a form and manner prescribed by the executive director, disclosing such determination and any action taken by the executive director pursuant to clause (ii) of this subparagraph; and

(ii) In the executive director's discretion:

(I) Extend the implementation timetable included in such performance improvement plan;

(II) Require such entity or payer to file with the executive director, in a form and manner prescribed by the executive director, such amendments to such performance improvement plan as are, in the executive director's judgment, necessary to ensure that such entity or payer successfully implements such performance improvement plan;

(III) Require such entity or payer to file a new proposed performance improvement plan pursuant to subdivision (1) of subsection (e) of this section; or

(IV) Waive or delay the requirement that such entity or payer file any future proposed performance improvement plan until the executive director determines, in the executive director's discretion, that such entity or payer has successfully implemented its current performance improvement plan.

(g) The executive director shall keep confidential all nonpublic clinical, financial, operational or strategic documents and information filed with, or submitted to, the executive director pursuant to this section. The executive director shall not disclose any such document or information to any person without the consent of the health care entity or payer that filed such document or information with, or submitted such document or information to, the executive director pursuant to this section, except in summary form as part of an evaluative report if the executive director determines that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Notwithstanding any provision of the general statutes, no document or information filed with, or submitted to, the executive director pursuant to this section shall be deemed to be a public record or subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes.

Sec. 7. (NEW) (*Effective July 1, 2020*) (a) (1) For each calendar year beginning on or after January 1, 2022, if the executive director determines that the average annual percentage change in total health care expenditures for the preceding calendar year exceeded the health care cost growth benchmark for such year, the executive director shall identify each other entity that significantly contributed to exceeding such benchmark. Each identification shall be based on:

(A) The report, if any, prepared by the executive director pursuant to subsection (c) of section 5 of this act for such calendar year;

(B) The report filed pursuant to section 38a-479ppp of the general statutes for such calendar year;

(C) The information and data reported to the office pursuant to section 19a-754b of the general statutes for such calendar year;

(D) Information obtained from the all-payer claims database established under section 19a-755a of the general statutes; and

(E) Any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director shall account for costs, net of rebates and discounts, when identifying other entities pursuant to this section.

(b) The executive director may require that any other entity that is found to be a significant contributor to health care cost growth in this state during the preceding calendar year participate in the informational public hearing held pursuant to subsection (a) of section 4 of this act. Each such other entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director, and provide additional information on actions taken to reduce such other entity's contribution to future state-wide health care costs. If such other entity is a drug manufacturer, and the executive director requires that such drug manufacturer participate in such hearing with respect to a specific drug or class of drugs, such hearing may, to the extent possible, include representatives from at least one brand-name manufacturer, one generic manufacturer and one innovator company that is less than ten years old.

Sec. 8. (NEW) (*Effective July 1, 2020*) (a) (1) For each calendar year beginning on or after January 1, 2022, the executive director shall develop and adopt annual health care quality benchmarks for health care entities and payers that:

(A) Enable health care entities and payers to report to the executive director a standard set of information concerning health care quality for

such year; and

(B) Include measures concerning clinical health outcomes, overutilization, underutilization and safety measures.

(2) In developing annual health care quality benchmarks pursuant to subdivision (1) of this subsection, the executive director shall:

(A) Consider:

(i) Nationally recognized quality measures that are recommended by medical groups or provider organizations concerning appropriate quality measures for such groups' or organizations' specialties; and

(ii) Measures, including, but not limited to, newly developed measures, that:

(I) Concern health outcomes, overutilization, underutilization and patient safety; and

(II) Meet standards of patient-centeredness and ensure consideration of important differences in preferences and clinical characteristics within patient subpopulations;

(B) Provide stakeholders with an opportunity to engage with the executive director in developing such benchmarks; and

(C) Ensure that the processes the executive director uses to develop, and any research that the executive director relies upon in developing, such benchmarks is transparent.

(b) Not later than October 1, 2021, and annually thereafter, the executive director shall, prior to adopting health care quality benchmarks pursuant to subdivision (1) of subsection (a) of this section for the calendar year next succeeding, hold an informational public hearing concerning the quality measures the executive director proposes to adopt as health care quality benchmarks for the calendar year next succeeding.

(c) Not later than November 1, 2021, and annually thereafter, the executive director shall send a notice to each health care entity, payer and other entity disclosing the health care quality benchmarks that the executive director has adopted for the calendar year next succeeding.

Sec. 9. (NEW) (*Effective July 1, 2020*) The executive director may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 2 to 8, inclusive, of this act.

Sec. 10. (NEW) (*Effective July 1, 2020*) For the purposes of this section and sections 11 to 15, inclusive, of this act unless the context otherwise requires:

(1) "Drug" means an article that is (A) recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement thereto, (B) intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, (C) not food and intended to affect the structure or any function of the human body, and (D) not a device and intended for use as a component of any other article specified in subparagraphs (A) to (C), inclusive, of this subdivision;

(2) "Drug Quality and Security Act" means the federal Drug Quality and Security Act, 21 USC 351, et seq., as amended from time to time;

(3) "Food, Drug and Cosmetic Act" means the Federal Food, Drug and Cosmetic Act, 21 USC 301, et seq., as amended by the Drug Quality and Security Act, as both may be amended from time to time;

(4) "Laboratory testing" means a quantitative and qualitative analysis of a prescription drug consistent with the official United States Pharmacopoeia;

(5) "Legend drug" means a drug that (A) any applicable federal or state law requires to be (i) dispensed pursuant to a prescription, or (ii) used by a prescribing practitioner, or (B) applicable federal law requires to bear the following legend: "RX ONLY" IN ACCORDANCE WITH

GUIDELINES ESTABLISHED IN THE FEDERAL FOOD, DRUG AND COSMETIC ACT;

(6) "Participating Canadian supplier" means a manufacturer or wholesale drug distributor that is (A) licensed or permitted under applicable Canadian law to manufacture or distribute prescription drugs, (B) exporting legend drugs, in the manufacturer's original container, to a participating wholesaler for distribution in this state under the program, and (C) properly registered, if such Canadian supplier is required to be registered, with the United States Food and Drug Administration, or any successor agency;

(7) "Participating wholesaler" means a wholesaler, as defined in section 21a-70 of the general statutes, that (A) has received a certificate of registration from the Commissioner of Consumer Protection pursuant to said section, and (B) is designated by the commissioner to participate in the program;

(8) "Prescription" means a lawful verbal, written or electronic order by a prescribing practitioner for a drug for a specific patient;

(9) "Program" means the Canadian legend drug importation program established by the Commissioner of Consumer Protection pursuant to section 11 of this act;

(10) "Qualified laboratory" means a laboratory that is (A) adequately equipped and staffed to properly perform laboratory testing on legend drugs, and (B) accredited to International Organization for Standardization (ISO) 17025; and

(11) "Track-and-trace" means the product tracing process for the components of the pharmaceutical distribution supply chain, as described in Title II of the Drug Quality and Security Act.

Sec. 11. (NEW) (*Effective July 1, 2020*) (a) The Commissioner of Consumer Protection shall establish a program to be known as the "Canadian legend drug importation program". Under such program,

the commissioner shall, notwithstanding any contrary provision of the general statutes:

(1) Provide for the importation of safe and effective legend drugs from Canada that have the highest potential for cost savings in this state; and

(2) Designate one or more participating wholesalers to distribute legend drugs in this state:

(A) In the manufacturer's original container;

(B) From a participating Canadian supplier; and

(C) To a pharmacy or institutional pharmacy, as both terms are defined in section 20-571 of the general statutes, or a qualified laboratory.

(b) (1) Not later than July 1, 2021, the Commissioner of Consumer Protection shall submit a request to the federal Secretary of Health and Human Services seeking approval for the program under 21 USC 384, as amended from time to time. Such request shall, at a minimum:

(A) Describe the commissioner's plans for operating the program;

(B) Demonstrate that the legend drugs that will be imported and distributed in this state under the program shall:

(i) Meet all applicable federal and state standards for safety and effectiveness; and

(ii) Comply with all federal tracing procedures; and

(C) Disclose the costs of implementing the program.

(2) (A) If the federal Secretary of Health and Human Services approves the commissioner's request, the commissioner shall:

(i) Submit to the Commissioner of Public Health a notice disclosing

that the federal Secretary of Health and Human Services has approved such request;

(ii) Submit to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, general law, human services and public health a notice disclosing that the federal Secretary of Health and Human Services has approved such request; and

(iii) Begin operating the program not later than one hundred eighty days after the date of such approval.

(B) Except as otherwise provided in this subsection, the Commissioner of Consumer Protection shall not operate the program unless the federal Secretary of Health and Human Services approves the commissioner's request.

Sec. 12. (NEW) (*Effective July 1, 2020*) (a) Each participating wholesaler may, subject to the provisions of this section and sections 11 and 14 of this act, import into this state a legend drug from a participating Canadian supplier, and distribute such legend drug to a pharmacy or institutional pharmacy, as both terms are defined in section 20-571 of the general statutes, or a qualified laboratory in this state, under the program if:

(1) Such participating wholesaler:

(A) Is registered with the federal Secretary of Health and Human Services pursuant to Section 510(b) of the Food, Drug and Cosmetic Act, 21 USC 360(b), as amended from time to time; and

(B) Holds a valid labeler code that has been issued to such participating wholesaler by the United States Food and Drug Administration, or any successor agency; and

(2) Such legend drug:

(A) May be imported into this state in accordance with applicable

federal patent laws;

(B) Meets the United States Food and Drug Administration's, or any successor agency's, standards concerning drug safety, effectiveness, misbranding and adulteration; and

(C) Is not:

(i) A controlled substance, as defined in 21 USC 802, as amended from time to time;

(ii) A biological product, as defined in 42 USC 262, as amended from time to time;

(iii) An infused drug;

(iv) An intravenously injected drug;

(v) A drug that is inhaled during surgery; or

(vi) A drug that is a parenteral drug, the importation of which is determined by the federal Secretary of Health and Human Services to pose a threat to the public health.

(b) Each participating wholesaler shall:

(1) Comply with all applicable track-and-trace requirements, and make available to the Commissioner of Consumer Protection all track-and-trace records not later than forty-eight hours after the commissioner requests such records;

(2) Not import, distribute, dispense or sell in this state any legend drugs under the program except in accordance with the provisions of this section and sections 11 and 14 of this act;

(3) Not distribute, dispense or sell outside of this state any legend drugs that are imported into this state under the program;

(4) Ensure the safety and quality of the legend drugs that are

imported and distributed in this state under the program;

(5) For each initial shipment of a legend drug that is imported into this state by such participating wholesaler, ensure that a qualified laboratory engaged by such participating wholesaler tests a statistically valid sample size for each batch of such legend drug in such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act;

(6) For each shipment of a legend drug that is imported into this state by such participating wholesaler, and sampled and tested pursuant to subdivision (5) of this subsection, ensure that a qualified laboratory engaged by such participating wholesaler tests a statistically valid sample of such legend drug in such shipment for authenticity and degradation in a manner that is consistent with the Food, Drug and Cosmetic Act;

(7) Certify to the Commissioner of Consumer Protection that each legend drug imported into this state under the program:

(A) Is approved for marketing in the United States and not adulterated or misbranded; and

(B) Meets all labeling requirements under 21 USC 352, as amended from time to time;

(8) Maintain laboratory records, including, but not limited to, complete data derived from all tests necessary to ensure that each legend drug imported into this state under the program satisfies the requirements of subdivisions (5) and (6) of this subsection;

(9) Maintain documentation demonstrating that the testing required by subdivisions (5) and (6) of this subsection was conducted at a qualified laboratory in accordance with the Food, Drug and Cosmetic Act and all other applicable federal and state laws and regulations concerning laboratory qualifications;

(10) Maintain the following information for each legend drug that

such participating wholesaler imports and distributes in this state under the program, and submit such information to the Commissioner of Consumer Protection upon request by the commissioner:

(A) The name and quantity of the active ingredient of such legend drug;

(B) A description of the dosage form of such legend drug;

(C) The date on which such participating wholesaler received such legend drug;

(D) The quantity of such legend drug that such participating wholesaler received;

(E) The point of origin and destination of such legend drug;

(F) The price paid by such participating wholesaler for such legend drug;

(G) A report for any legend drug that fails laboratory testing under subdivision (5) or (6) of this subsection; and

(H) Such additional information and documentation that the commissioner deems necessary to ensure the protection of the public health; and

(11) Maintain all information and documentation that is submitted to the Commissioner of Consumer Protection pursuant to this subsection for a period of not less than three years.

Sec. 13. (NEW) (*Effective July 1, 2020*) Each participating Canadian supplier shall:

(1) Comply with all applicable track-and-trace requirements;

(2) Not distribute, dispense or sell outside of this state any legend drugs that are imported into this state under the program; and

(3) Maintain the following information and documentation and, upon request by the Commissioner of Consumer Protection, submit such information and documentation to the commissioner for each legend drug that such participating Canadian supplier exports into this state under the program:

(A) The original source of such legend drug, including, but not limited to:

(i) The name of the manufacturer of such legend drug;

(ii) The date on which such legend drug was manufactured; and

(iii) The location where such legend drug was manufactured;

(B) The date on which such legend drug was shipped to a participating wholesaler;

(C) The quantity of such legend drug that was shipped to a participating wholesaler;

(D) The quantity of each lot of such legend drug that such participating Canadian supplier originally received and the source of such lot;

(E) The lot or control number and the batch number assigned to such legend drug by the manufacturer; and

(F) Such additional information and documentation that the commissioner deems necessary to ensure the protection of the public health.

Sec. 14. (NEW) (*Effective July 1, 2020*) (a) The Commissioner of Consumer Protection shall issue a written order:

(1) Suspending importation and distribution of a legend drug under the program if the commissioner discovers that such distribution or importation violates any provision of sections 11 to 13, inclusive, of this act or any other applicable state or federal law or regulation;

(2) Suspending all importation and distribution of legend drugs by a participating wholesaler under the program if the commissioner discovers that the participating wholesaler has violated any provision of section 11 or 12 of this act or any other applicable state or federal law or regulation;

(3) Suspending all importation and distribution of legend drugs by a participating Canadian supplier under the program if the commissioner discovers that the participating Canadian supplier has violated any provision of section 11 or 13 of this act or any other applicable state or federal law or regulation; or

(4) Requiring the recall or seizure of any legend drug that was imported and distributed under the program and has been identified as adulterated, within the meaning of section 21a-105 of the general statutes, or misbranded.

(b) The Commissioner of Consumer Protection shall send a notice to each participating Canadian supplier and participating wholesaler affected by an order issued pursuant to subsection (a) of this section notifying such participating Canadian supplier or participating wholesaler that:

(1) The commissioner has issued such order, and providing the legal and factual basis for such order; and

(2) Such participating Canadian supplier or participating wholesaler may request, in writing, a hearing before the commissioner, provided such request is received by the commissioner not later than thirty days after the date of such notice.

(c) If a participating Canadian supplier or participating wholesaler timely requests a hearing pursuant to subsection (b) of this section, the Commissioner of Consumer Protection shall, not later than thirty days after the receipt of the request, convene the hearing as a contested case in accordance with the provisions of chapter 54 of the general statutes. Not later than sixty days after the receipt of such request, the

commissioner shall issue a final decision vacating, modifying or affirming the commissioner's order. A participating Canadian supplier or participating wholesaler aggrieved by a final decision may appeal such decision in accordance with the provisions of section 4-183 of the general statutes.

Sec. 15. (NEW) (*Effective July 1, 2020*) The Commissioner of Consumer Protection may, in consultation with the Commissioner of Public Health, adopt regulations in accordance with the provisions of chapter 54 of the general statutes to implement the provisions of sections 10 to 14, inclusive, of this act.

Sec. 16. Section 38a-8b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(a) For the purposes of this section:

(1) "Attachment point" means the dollar value of claims incurred by a policyholder at which the insurer that issues or delivers a medical stop-loss insurance policy to the policyholder incurs liability to such policyholder for payment under such medical stop-loss insurance policy;

(2) "Employee" has the same meaning as provided in section 38a-564;

(3) "Expected claims" means the dollar value of claims that, in the absence of a medical stop-loss insurance policy, the policyholder of a medical stop-loss insurance policy is projected to incur under such policyholder's health benefit plan;

(4) "Lasering" means assigning a different attachment point or deductible, or denying coverage altogether, under a medical stop-loss insurance policy for an enrollee or a dependent because the enrollee or dependent has a high-cost preexisting condition or another identified risk;

(5) "Medical stop-loss insurance" means stop-loss insurance purchased by a person, other than a health carrier or health care

provider, and providing coverage for catastrophic, excess or unexpected losses incurred by the policyholder, and due and owing to a third party, under a health benefit plan not providing coverage for retirees;

(6) "Medical stop-loss insurer" means an insurer that is licensed pursuant to section 38a-41 to sell, issue and deliver medical stop-loss insurance in this state;

(7) "Retiree stop-loss insurance" means stop-loss insurance purchased by a person, other than a health carrier or health care provider, and providing coverage for catastrophic, excess or unexpected losses incurred by the policyholder, and due and owing to a third party, under a health benefit plan providing coverage for retirees; and

(8) "Stop-loss insurance" means insurance, other than reinsurance, providing coverage for catastrophic, excess or unexpected losses incurred by the policyholder, and due and owing to a third party, under another insurance policy or a health benefit plan.

(b) No **[**stop loss**]** stop-loss insurance policy **[**may**]** shall be issued or delivered in this state unless a copy of the **[**stop loss**]** stop-loss insurance policy form has been submitted to, and approved by, the Insurance Commissioner. **[**pursuant to regulations that the commissioner may adopt in accordance with chapter 54. Such regulations, if adopted, shall include, but need not be limited to, a definition of a stop loss policy and the standards for filing and review of stop loss policies.**]**

(c) (1) Except as provided in subdivision (4) of subsection (d) of this section, no medical stop-loss insurer shall issue or deliver, and the Insurance Commissioner shall not approve, a medical stop-loss insurance policy in this state on or after January 1, 2021, if the medical stop-loss insurance policy:

(A) Imposes an annual attachment point that is less than twenty thousand dollars for claims incurred per enrolled employee or dependent;

(B) Imposes an annual aggregate attachment point:

(i) That is less than the greatest of the following amounts for an insured group consisting of not more than fifty employees, as calculated in the manner set forth in subdivision (2) of this subsection:

(I) Four thousand dollars multiplied by the number of employees in such insured group;

(II) One hundred twenty per cent of the expected claims for such insured group; or

(III) Twenty thousand dollars; or

(ii) That is less than one hundred ten per cent of the expected claims for an insured group consisting of more than fifty employees, as calculated in the manner set forth in subdivision (2) of this subsection;

(C) Provides direct coverage for an enrollee's or dependent's health care expenses;

(D) Provides for a determination regarding whether a benefit is:

(i) Medically necessary;

(ii) Usual or customary; or

(iii) Experimental or investigational;

(E) Imposes a case management requirement or an annual dollar limitation for an enrolled employee, dependent or benefit;

(F) Requires an enrolled employee or dependent to use a provider network or provides a benefit incentive for an enrolled employee or dependent to use a provider participating in a provider network;

(G) Provides the medical stop-loss insurer with a right to examine an enrolled employee or dependent;

(H) Permits the medical stop-loss insurer to:

(i) Deny a claim if the policyholder is legally obligated to pay the claim under such policyholder's health benefit plan;

(ii) Rescind such medical stop-loss insurance policy for any reason other than fraud or intentional misrepresentation;

(iii) Terminate such medical stop-loss insurance policy, in the sole discretion of such medical stop-loss insurer, in any manner that is inconsistent with applicable laws concerning cancellation or nonrenewal of medical stop-loss insurance policies; or

(iv) Increase the rates imposed under such medical stop-loss insurance policy, in the sole discretion of such medical stop-loss insurer, during the term of such medical stop-loss insurance policy;

(I) Requires an enrolled employee to be actively at work; or

(J) Contains any provision that is misleading, deceptive or contrary to any provision of the general statutes or the public interest.

(2) (A) For the purposes of subparagraph (B) of subdivision (1) of this subsection, the number of employees in an insured group shall be determined by adding:

(i) The number of the policyholder's full-time employees for each month who work a normal work week of thirty hours or more; and

(ii) The number of the policyholder's full-time equivalent employees, calculated for each month by dividing by one hundred twenty the aggregate number of hours worked for such month by employees who work a normal work week of less than thirty hours, and averaging such total for the calendar year.

(B) If a policyholder was not in existence throughout the preceding calendar year, the number of employees shall be based on the average number of employees that such policyholder reasonably expects to employ in the current calendar year.

(d) Each insurer that underwrites a medical stop-loss insurance policy issued or delivered in this state on or after January 1, 2021, may use lasering in underwriting such medical stop-loss insurance policy, provided:

(1) If such insurer uses lasering in underwriting such medical stop-loss insurance policy, such insurer and any insurance producer who sells, solicits or negotiates such medical stop-loss insurance policy on behalf of such insurer includes in each application for coverage under such medical stop-loss insurance policy:

(A) A statement disclosing the increased financial risk that each prospective policyholder under such medical stop-loss insurance policy will bear because such insurer intends to use lasering in underwriting such medical stop-loss insurance policy, and any alternatives available to each such prospective policyholder with respect to such insurer's intended use of lasering in underwriting such medical stop-loss insurance policy;

(B) A statement by such insurer or insurance producer, as applicable, affirming that such insurer or insurance producer fully explained to each prospective policyholder under such medical stop-loss insurance policy the increased financial risk described in subparagraph (A) of this subdivision and that each such prospective policyholder understands such increased financial risk; and

(C) The signature of such insurer, insurance producer and each prospective policyholder below the statement required under subparagraph (B) of this subdivision;

(2) If such insurer uses lasering on the effective date of such medical stop-loss insurance policy, such insurer shall not change such lasering during the term of such medical stop-loss insurance policy;

(3) If such insurer does not use lasering on the effective date of such medical stop-loss insurance policy, such insurer shall not use lasering during the term of such medical stop-loss insurance policy; and

(4) The attachment point for an enrolled employee under such medical stop-loss insurance policy shall not exceed an amount that is equal to three hundred per cent of the attachment point for such medical stop-loss insurance policy.

(e) No retiree stop-loss insurance policy issued or delivered in this state on or after January 1, 2021, shall be subject to the provisions of subsection (c) or (d) of this section, and the Insurance Commissioner shall review and approve, on a case-by case basis, such retiree stop-loss insurance policies for issuance and delivery in this state on or after said date.

(f) The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to carry out the purposes of this section.

Sec. 17. Subparagraph (C) of subdivision (3) of subsection (m) of section 5-259 of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(C) The Comptroller may offer to nonstate public employers that choose to purchase prescription drugs pursuant to subparagraph (A) of this subdivision the option to purchase **[**stop loss**]** stop-loss coverage from an insurer at a rate negotiated by the Comptroller.

Sec. 18. Subdivision (1) of subsection (c) of section 7-464 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(1) In no event shall any commercial insurance company which provides health insurance benefits to the employees of a town, city or borough and their covered dependents and family members, including, but not limited to, **[**stop loss**]** stop-loss insurance beyond a municipal self-funded medical expense amount, be entitled to any reimbursement from a tortfeasor recovery. The provisions of this subsection shall be construed to only permit a self-insured town, city or borough to recover medical expenses paid from its own revenues. The provisions of this subsection shall not be construed to permit a self-insured town, city or

borough to recover medical expenses paid from an insured plan, whether insured in whole or in part.

Sec. 19. Subparagraph (F) of subdivision (18) of section 38a-465 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(F) An authorized or eligible insurer that provides **[**stop loss**]** stop-loss coverage to a provider, purchaser, financing entity, special purpose entity or related provider trust;

Sec. 20. Subsection (c) of section 38a-465d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(c) Except as otherwise required or permitted by law, no person, including, but not limited to, a provider, broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall disclose such identity or information where there is a reasonable basis to conclude such information could be used to identify the insured or the insured's financial or medical information to any other person unless such disclosure: (1) Is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to such disclosure; (2) is provided in response to an investigation or examination by the commissioner or any other governmental office or agency or pursuant to the requirements of section 38a-465i; (3) is necessary to effectuate the sale of life settlement contracts or interests therein as investments, provided the sale is conducted in accordance with applicable state and federal securities laws, and provided further the owner and the insured have both provided prior written consent to the disclosure; (4) is a term of or condition to the transfer of a policy by one provider to another provider, in which case the provider receiving such information shall comply with the confidentiality requirements specified in this subsection; (5) is necessary to allow the provider or broker or their authorized

representatives to make contacts for the purpose of determining health status. For the purpose of this section, "authorized representative" does not include any person who has or may have a financial interest in the settlement contract other than a provider, licensed broker, financing entity, related provider trust or special purpose entity. Each provider or broker shall require its authorized representative to agree in writing to comply with the privacy provisions of this part; or (6) is required to purchase **[**stop loss**]** stop-loss coverage.

Sec. 21. Subparagraph (A) of subdivision (2) of subsection (b) of section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(A) "State medical loss ratio" means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for **[**stop loss**]** stop-loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features;

Sec. 22. Subsection (c) of section 38a-720h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(c) The third-party administrator shall disclose to the insurer or other person utilizing the services of the third-party administrator all charges, fees and commissions that the third-party administrator receives arising from services it provides for the insurer or other person utilizing the services of the third-party administrator, including any fees or commissions paid by insurers providing reinsurance or **[**stop loss**]** stop-loss coverage.

Sec. 23. (NEW) (*Effective from passage*) (a) For the purposes of this section:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and

Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted thereunder;

(2) "Exchange" means the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes; and

(3) "Office" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act.

(b) The office shall, in conjunction with the Office of Policy and Management, the Insurance Department and the Health Reinsurance Association created under section 38a-556 of the general statutes, seek a state innovation waiver from the United States Department of the Treasury or the United States Department of Health and Human Services, as applicable, pursuant to Section 1332 of the Affordable Care Act to establish a reinsurance program pursuant to subsection (d) of this section.

(c) Subject to the approval of a waiver described in subsection (b) of this section, the office, not later than September 1, 2020, for plan year 2021 and annually thereafter for the subsequent plan year, shall:

(1) Determine the amount needed, not to exceed twenty-one million two hundred ten thousand dollars, annually, to fund the reinsurance program established pursuant to subsection (d) of this section; and

(2) Inform the Office of Policy and Management of the amount determined pursuant to subdivision (1) of this subsection.

(d) The amount described in subsection (c) of this section shall be utilized to establish a reinsurance program for the individual health insurance market designed to lower premiums on health benefit plans sold in such market, on and off the exchange, provided the United States Department of the Treasury or the United States Department of Health and Human Services, as applicable, approves the waiver described in subsection (b) of this section. Any such reinsurance program shall be administered by the Health Reinsurance Association. The Treasurer

shall annually transmit the amount as described in subsection (c) of this section for the purpose of administering such reinsurance program.

(e) If the waiver described in subsection (b) of this section terminates and the office does not obtain another waiver pursuant to subsection (a) of this section, the Treasurer shall cease transmitting the amount described in subsection (c) of this section for the purpose of administering the reinsurance program established pursuant to subsection (d) of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2020*	19a-754a
Sec. 2	*July 1, 2020*	New section
Sec. 3	*July 1, 2020*	New section
Sec. 4	*July 1, 2020*	New section
Sec. 5	*July 1, 2020*	New section
Sec. 6	*July 1, 2020*	New section
Sec. 7	*July 1, 2020*	New section
Sec. 8	*July 1, 2020*	New section
Sec. 9	*July 1, 2020*	New section
Sec. 10	*July 1, 2020*	New section
Sec. 11	*July 1, 2020*	New section
Sec. 12	*July 1, 2020*	New section
Sec. 13	*July 1, 2020*	New section
Sec. 14	*July 1, 2020*	New section
Sec. 15	*July 1, 2020*	New section
Sec. 16	*January 1, 2021*	38a-8b
Sec. 17	*January 1, 2021*	5-259(m)(3)(C)
Sec. 18	*January 1, 2021*	7-464(c)(1)
Sec. 19	*January 1, 2021*	38a-465(18)(F)
Sec. 20	*January 1, 2021*	38a-465d(c)
Sec. 21	*January 1, 2021*	38a-478l(b)(2)(A)
Sec. 22	*January 1, 2021*	38a-720h(c)
Sec. 23	*from passage*	New section

Statement of Purpose:

To: (1) Require the Office of Health Strategy to establish and implement health care cost growth benchmarks in this state; (2) require the Commissioner of Consumer Protection to submit a request to the federal Secretary of Health and Human Services to implement a Canadian prescription drug reimportation program in this state and, if the secretary approves such request, implement such program in this state; (3) implement the Insurance Commissioner's recommendations regarding stop-loss insurance; and (4) require the Office of Health Strategy to seek a state innovation waiver from the federal government to establish a reinsurance program in this state and, if the federal government approves such request, implement such program in this state.

[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.]