04 OHS Legislative Proposals

4.1 Cost Growth Benchmark

Employer Opt-In

Background:

- Each year OHS collects data from CT Health Insurers to measure the state's performance again the Cost Growth and Primary Care benchmarks.
- Insurers are required to submit this data, known as "Benchmark Data" to OHS. To date, all insurers have included ALL of their covered lives, both self-funded and fully insured without issues or concerns.

Issue:

- Anthem has recently decided to withhold data on the self-insured lives from its Benchmark Data:
- Self-insured plans make up 30% of all Anthem members—approximately 210,000 individuals
- Anthem concluded that self-insured data is precluded from automatic submission to state cost growth benchmark programs and concludes that they only need to report on fully-insured lives. As of 2025, Anthem reports it will ask employers if they would like to be included in data submissions
- Unnecessary partial data submissions to the Benchmark program could become a threat to the integrity of the program

Solution:

- Require a payer to ask an employer of a self-funded employee health plan to opt-in to providing data required for the benchmark.
- Allow OHS to impose a civil penalty for failure of an insurer to seek approval from an employer to submit to OHS.

Participation in the Cost Growth Benchmark Hearing

Background:

- Statute requires OHS to hold an Annual Public Hearing on the Benchmark results.
- OHS identifies "significant contributors" to the benchmark results and calls them to appear at the hearing. Statute states that significant contributors "shall participate" in the hearing if called by OHS.

Issue:

- For two consecutive years, Pharmaceutical manufacturers refused to both attend and participate in the cost growth benchmark hearing as required by statute.

Solution:

- Clarify the meaning of “participate” in the benchmark hearing and
- Allow OHS to subpoena testimony and/or documents from those who refuse to participate

Performance Improvement Plan Study

Issue:

Many stakeholders have encouraged OHS to strengthen the benchmark program.

Solution:

- Require OHS to conduct a one-time study to assess performance improvement plans as a tool to slow cost growth.
- Demonstrates that the state is committed to curbing health care cost growth evaluating the effectiveness of means to achieve such goal.

Policies and Procedures

Issue:

Some statutory provisions necessitate implementing regulations, and clarity of policies and procedures are needed in the interim.

Some parts of OHS statute have ability to use policies and procedures, while others do not.

Solution:

Allow OHS to establish policies and procedures throughout the CGB statute while regulations are being promulgated.

4.2 Certificate of Need

Update Definition of “Termination of Services”

Background:

- CON statute requires OHS to approve certain "terminations" of services, such as Labor and Delivery or ICU.
- Many terminations of service lines are occurring in CT and around the country.

Issue:

- Current definition of “termination of services” is not precise
- Some providers argue that a termination only occurs if they are closed for 180 consecutive days, so they can cycle services on and off indefinitely leading to confusion and loss of staff

Solution:

Clarify that a termination of services is “a combined total of greater than 180 days within any two-year period” or “at least 30 consecutive days”

Add Proton Beam Therapy to CON Review

Background:

Current statute requires a CON for technologies not in use in the state

Issue:

In 2025, OHS anticipates the opening of CT's first Proton Beam Therapy facility, meaning that this will no longer be a "technology not in use in the state."

Solution:

Add proton beam therapy to list of services that require a CON, unless replacing an existing machine previously acquired through a CON determination.

Expedited Review Process

Issue:

There are instances when an expedited review process is warranted but currently no process exists.

Solution:

- Authorize an expedited review process for applicants that address a significant unmet need in the service area
- An expedited review application would be resolved as follows: 1) approved with or without conditions; 2) with an agreed settlement; or 3) requiring the applicant to submit a full CON application.
- There would be no public hearing for an expedited application

Cost and Market Review (CMIR) Allotment

Background:

Certain hospital transfers of ownership require a detailed study (CMIR) of the impact of transfer on healthcare markets and prices

Issue:

The cost of conducting a Cost and Market Impact Review has not kept up with changing vendor requirements and has limited OHS's ability to find appropriate resources for the CMIR.

Solution:

Increase amount that a vendor can receive for a CMIR to $300K from $200K. (This is paid by the applicant)

Clarify Cost and Market Impact Review (CMIR) use in CON Determination

Issue:

- OHS is required to conduct a CMIR for certain hospital transfer of ownerships, which then goes to the Attorney General for consideration of anti-trust violations.
- The statute is unclear on whether OHS can use the CMIR in its CON application deliberations.

Solution:

- Clarify that OHS shall be permitted to use the CMIR preliminary report, applicant responses to such report, and the final report in the CON determination.

Policies and Procedures

Issue:

Some statutory provisions necessitate implementing regulations, and clarity of policies and procedures are needed in the interim.

Some parts of OHS statute have ability to use policies and procedures, while others do not.

Solution:

Allow OHS to establish policies and procedures throughout the CON statute while regulations are being promulgated.

4.3 Health Care Cabinet

Update Health Care Cabinet Membership

Issue:

Current Health Care Cabinet membership is outdated

Solution:

Update membership by 1) removing the “Nonprofit Liaison to the Governor” position which no longer exists;

2) Adding the Behavioral Health Advocate;

3) Adding a representative of the nonprofit community;

4) Cleaning up the SustiNet language; and,

5) Removing references to the ACA

Discussion