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Connecticut Health Care Bill Revises Provider-Payor Contracting Requirements to Address Competitive Concerns

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On June 7, 2023, the Connecticut Legislature passed HB6669, "An Act Protecting Patients and Prohibiting Unnecessary Health Care Costs" ("the Act"), which includes a prohibition on certain contractual clauses in agreements between health care providers and insurance companies. The Act implements previously-announced legislative initiatives that are the product of collaboration between Connecticut Governor Ned Lamont and the Connecticut Hospital Association, as well as other health care stakeholders. Governor Lamont is expected to sign the Act but has not done so as of this publication.

Among other things, the Act: (i) prohibits so-called all-or-nothing, anti-steering, anti-tiering, and gag clauses in network agreements between health insurance payors and providers; (ii) establishes new required contract provisions related to tiered networks; and (iii) clarifies notice requirements related to provider-payor contract terminations. Each of these changes is outlined in more detail below.

Prohibitions on Certain Contract Clauses (Effective July 1, 2024)

The Act newly prohibits and renders null and void the following contract clauses in agreements between health care providers and (i) health carriers, (ii) plan administrators, or (iii) plan sponsors (i.e., health insurers and other payors) or any of their respective agents: "all-or-nothing clauses," "anti-steering clauses," "anti-tiering clauses," and "gag clauses." This prohibition applies to payor contracts that are offered, solicited, entered into, renewed, or amended on or after July 1, 2024. Importantly, the Act also prohibits such clauses in "written policies" and "written procedures" of payors, but does not define either such term. The inclusion of these terms suggests that the Act prohibits payors from unilaterally modifying their policies in a manner that would have a similar effect as inclusion of one of the prohibited clauses in a payor contract.

The Act defines each of the prohibited clauses. We summarize the definition of each term below but note that interpretation of specific clauses will require analysis of the exact statutory definitions in the Act:

- An “all-or-nothing clause” generally means any provision in a payor agreement that requires the payor to either (a) include all members of a health care provider (e.g., an entire physician practice) in a certain insurance network plan; or (b) enter into an additional contract with the health care provider’s affiliate as a condition to entering into a contract with such health care provider.

- An “anti-steering clause” generally means any provision in a payor agreement that restricts the ability of the payor to encourage 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 providers;

- An “anti-tiering clause” generally means any provision in a payor agreement that either: (a) restricts the payor from modifying a tiered network plan or assigning providers into tiers, including tiering providers by cost or quality; or (b) requires the payor to place all members of a provider in the same tier of a tiered network plan;

- A “gag clause” generally means any provision in a payor agreement that restricts the ability of a provider or payor to: (a) disclose price or quality information (including the allowed amount, negotiated rates or discounts, fees for services, or any other claim-related financial obligations) to any governmental entity or such government entity’s contractors or agents, enrollee, treating provider of an enrollee, plan sponsor, or potential eligible enrollees and plan sponsors; or (b) disclose out-of-pocket costs to any enrollee.

Tiered Network Contract Requirements (Effective July 1, 2024)

Existing Connecticut law permits tiered networks, by which payors may identify and group certain health care providers and facilities into specific tiers to which different reimbursement, cost-sharing, or participating provider access requirements apply for the same health care services.

The Act requires all contracts between health care providers and health insurers involving a tiered network entered into, renewed, or amended on or after July 1, 2024, to include a provision requiring the health insurer, upon request, to provide the provider’s calculated score, related data, and a description of the standards used for tiering. Additionally, the Act requires health insurers to establish a grievance process for providers to appeal tiering decisions and performance measurements. Health insurers are required to provide at least the following information related to their tiering standards:

- Definitions of measures related to quality, cost, efficiency, satisfaction, and any other factors used to measure performance;

- A defined time period of not less than one year to measure performance;

- A summary of the grievance process to appeal tiering decisions and performance measurements, which process must also be posted on the insurer’s website.

The Act requires that the tiering standards remain in place for at least one year and that health insurers provide at least 90 days’ written notice to providers before changes are made to such tiering standards.

Updated Network Termination Notice Requirements (Effective Upon Passage)

Finally, the Act makes various clarifications to existing Connecticut law regarding termination or nonrenewal of network participation agreements between health insurers and health care providers. These issues have historically been the source of disputes between health insurers and health care providers, and confusion for enrollees affected by such disputes. The Act revises the notice requirements to provide that:

- Health insurers and health care providers must each provide the other with at least 90 days' written notice of intent to terminate or not renew an agreement (measured from the proposed date of termination or nonrenewal, as applicable).

- In the case of termination of a participating provider's network agreement with a health insurer and health care provider, the Act revises the patient notice requirement, providing that health insurers are required to make a good faith effort to give at least 30 days' written notice of termination or nonrenewal to all covered patients being treated on a regular basis by or at the participating provider prior to the contract end or termination date. However, the Act adds a new provision indicating that this notice requirement is not applicable where the health insurer and the participating provider agree in writing on an extension of the agreement for up to one year.

- The Act clarifies that the current continuity of care requirement that obligates health insurers and participating providers that are hospitals (or parent corporations of hospitals) to continue to abide by the terms of a participation agreement, including its reimbursement terms, for a period of 60 days post-termination or nonrenewal, applies to (i) intermediaries of hospitals as well as hospitals and their parents, and (ii) to the reimbursement terms for all health services and provisions under the applicable contract.

In addition to changes affecting the certificate of need process and the above changes affecting payor-provider contracting, the Act includes other changes to Connecticut health care laws. Those changes will be discussed in future *Health Law Diagnosis* posts.

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