Senate

General Assembly

File No. 526

January Session, 2011

Substitute Senate Bill No. 1204

Senate, April 14, 2011

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

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

Section 1. (NEW) (*Effective from passage*) For purposes of this section and sections 2 to 13, inclusive, of this act:

(1) "Board" means the board of directors of the Connecticut Health Insurance Exchange;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 2 of this act;

(4) "Federal 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;

(5) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services.

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 of the general statutes or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate insurance policy, certificate or contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;

(iii) Other similar, limited benefits specified in regulations issued

pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time; or

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469 of the general statutes, provided under a group health plan.

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 of the general statutes or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

(6) "Health care services" has the same meaning as provided in section 38a-478 of the general statutes;

(7) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation health care center or other entity subject to the insurance laws and regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

(8) "Internal Revenue Code" means the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(9) "Navigator" means a person or entity participating in the grant program established in accordance with section 7 of this act and Section 3510 of the federal act;

(10) "Person" has the same meaning as provided in section 38a-1 of the general statutes;

(11) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 9 of this act;

(12) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the exchange, and at the option of the employer, some or all of its part-time employees, provided the employer:

(A) Has its principal place of business in the state and elects to provide coverage through the exchange to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the exchange to all of its eligible employees who are principally employed in the state;

(13) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the federal act and section 8 of this act;

(14) "Qualified individual" has the same meaning as provided in Section 1312 of the federal act;

(15) "Secretary" means the Secretary of the United States Department of Health and Human Services; and

(16) (A) "Small employer" means an employer that employed an average of not more than fifty employees during the preceding calendar year.

(B) For purposes of this subdivision:

(i) All persons treated as a single employer under Section 414(b), (c), (m) or (o) of the Internal Revenue Code shall be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer;

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year; and

(v) An employer that makes enrollment in qualified health plans available to its employees through the exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this section and sections 2 to 13, inclusive, of this act as long as it continuously makes enrollment through the exchange available to its employees.

Sec. 2. (NEW) (*Effective from passage*) (a) There is hereby created as a body politic and corporate, constituting a public instrumentality and political subdivision of the state created for the performance of an essential public and governmental function, to be known as the Connecticut Health Insurance Exchange. The purposes of the Connecticut Health Insurance Exchange shall be to reduce the number of individuals without health insurance in this state and assist small employers in the procurement and administration of health insurance by, among other services, offering easily comparable and understandable health insurance options to individuals and small employers, and enrolling individuals in medical assistance programs. The Connecticut Health Insurance Exchange shall be a solvent and self-sustaining entity on or before January 1, 2015. The Connecticut Health Insurance Exchange shall not be construed to be a department, institution or agency of the state.

(b) (1) The powers of the exchange shall be vested in and exercised by a board of directors, which shall consist of seven members who shall be appointed on or before October 1, 2011, as follows:

(A) The Governor shall appoint one director who shall serve an initial term of three years;

(B) The president pro tempore of the Senate shall appoint one director who shall serve an initial term of four years;

(C) The speaker of the House of Representatives shall appoint one director who shall serve an initial term of four years;

(D) The majority leader of the Senate shall appoint one director who shall serve an initial term of four years;

(E) The majority leader of the House of Representatives shall appoint one director who shall serve an initial term of four years;

(F) The minority leader of the Senate shall appoint one director who shall serve an initial term of three years;

(G) The minority leader of the House of Representatives shall appoint one director who shall serve an initial term of three years; and

(H) The Commissioners of Social Services and Public Health, the Insurance Commissioner, or the commissioners' designees, the Secretary of the Office of Policy and Management, or the secretary's designee and the Healthcare Advocate, or the Healthcare Advocate's designee who shall serve as ex-officio nonvoting directors.

(2) Following the expiration of such initial terms, subsequent director terms shall be for four years, commencing on October first of the year of the appointment. If an appointing authority fails to make an initial appointment to the board or an appointment to fill a board vacancy within ninety days of the date of such vacancy, the appointed directors shall, by majority vote, make such appointment to the board. Any director previously appointed to the exchange board of directors may be reappointed in accordance with this subsection.

(3) Each appointee, other than the commissioners and the secretary, shall have demonstrated expertise in at least two of the following

areas: (A) Individual health insurance coverage; (B) small employer health insurance coverage; (C) health benefits plan administration; (D) health care finance; (E) public or private health care delivery system administration; or (F) health insurance plan purchase. When making an appointment, the appointing authority shall consider the expertise of the other directors to ensure the board's composition reflects a diversity of expertise and the cultural, ethnic and geographical communities of this state.

(4) (A) No director or member of the staff of the exchange shall be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of (i) an insurer, (ii) an insurance producer or broker, (iii) a health care provider, or (iv) a health care facility or health or medical clinic while serving on the board or on the staff of the exchange. For purposes of this subdivision, "health care provider" means any person that is licensed in this state, or operates or owns a facility or institution in this state, to provide health care or health care professional services in this state, or an officer, employee or agent thereof acting in the course and scope of such officer's, employee's or agent's employment.

(B) No director or member of the staff of the exchange shall be a member, a member of the board or an employee of a trade association of (i) insurers, (ii) insurance producers or brokers, (iii) health care providers, or (iv) health care facilities or health or medical clinics while serving on the board or on the staff of the exchange.

(C) No director or member of the staff of the exchange shall be a health care provider unless such director or member of the staff receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(c) As a condition of qualifying as a member of the board of directors of the exchange, each appointee shall, before entering upon such member's duties, take and subscribe the oath or affirmation required under section 1 of article eleventh of the Constitution of the

state. A record of each such oath shall be filed in the office of the Secretary of the State. Meetings of the board of directors shall be held at such times as shall be specified in the bylaws adopted by the board and at such other time or times as the chairperson deems necessary.

(d) The board of directors shall select a chairperson every two years from among the board members. The chairperson shall schedule the first meeting of the board, which meeting shall be held not later than October 1, 2011. Any board member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the board.

(e) Board members shall receive no compensation for their services but shall receive actual and necessary expenses incurred in the performance of their official duties.

(f) Four directors of the exchange shall constitute a quorum for the transaction of any business or the exercise of any power of the exchange. For the transaction of any business or the exercise of any power of the exchange, the exchange may act by a majority of the directors present at any meeting at which a quorum is in attendance. No vacancy in the membership of the board of directors shall impair the right of such directors to exercise all the rights and perform all the duties of the board. Any action taken by the board under the provisions of sections 1 to 13, inclusive, of this act may be authorized by resolution approved by a majority of the directors present at any regular or special meeting, which resolution shall take effect immediately unless otherwise provided in the resolution.

(g) The board shall select and appoint a chief executive officer who shall be responsible for administering the exchange's programs and activities in accordance with policies and objectives established by the board. The chief executive officer shall serve at the pleasure of the board and shall receive such compensation as shall be determined by the board. The chief executive officer (1) may employ such other employees as shall be designated by the board of directors, and (2)

shall attend all meetings of the board, keep a record of all proceedings and maintain and be custodian of all records, books, documents and papers filed with or compiled by the exchange.

(h) The board may consult with such parties, public or private, as it deems desirable or necessary in exercising its duties under sections 1 to 13, inclusive, of this act.

(i) The board may create such advisory committees as it deems necessary to represent key stakeholders that may include, but need not be limited to, consumers, small employers, the insurance industry and health care providers.

Sec. 3. (NEW) (*Effective from passage*) The board of directors of the exchange shall adopt written procedures, in accordance with the provisions of section 1-121 of the general statutes, for: (1) Adopting an annual budget and plan of operations, including a requirement of board approval before the budget or plan may take effect; (2) hiring, dismissing, promoting and compensating employees of the exchange, including an affirmative action policy and a requirement of board approval before a position may be created or a vacancy filled; (3) acquiring real and personal property and personal services, including a requirement of board approval for any nonbudgeted expenditure in excess of five thousand dollars; (4) contracting for financial, legal, bond underwriting and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each such service which it uses; (5) issuing and retiring bonds, bond anticipation notes and other obligations of the exchange; (6) establishing requirements for certification of qualified health plans that include, but are not limited to, minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and quality measures for health benefit plan performance; and (7) implementing the provisions of sections 1 to 13, inclusive, of this act or other provisions of the general statutes. Any such written procedures adopted pursuant

to subdivision (7) of this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the federal act.

Sec. 4. (NEW) (*Effective from passage*) The board of directors of the exchange shall require that the exchange be audited annually by the United States Department of Health and Human Services. The board of directors of the exchange shall submit to the joint standing committee of the General Assembly having cognizance of matters relating to insurance a copy of each audit of the exchange conducted by the United States Department of Health and Human Services and any audit conducted by an independent auditing firm, not later than seven days after the date such audit is received by the board of directors.

Sec. 5. (NEW) (*Effective from passage*) (a) For purposes of sections 1 to 13, inclusive, of this act, "purposes of the exchange" means the purposes of the exchange expressed in and pursuant to this section, which are hereby determined to be public purposes for which public funds may be expended. The powers enumerated in this section shall be interpreted broadly to effectuate the purposes of the exchange and shall not be construed as a limitation of powers.

(b) The exchange is authorized and empowered to:

(1) Have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) Adopt an official seal and alter the same at pleasure;

(3) Maintain an office in the state at such place or places as it may designate;

(4) Employ such assistants, agents and other employees as may be necessary or desirable. Nonmanagerial employees of the exchange shall be members of the classified service. Managerial employees of the exchange shall be exempt from the classified service;

(5) Engage consultants, attorneys and other experts as may be necessary or desirable to carry out the purposes of the exchange;

(6) Acquire, lease, purchase, own, manage, hold and dispose of real and personal property, and lease, convey or deal in or enter into agreements with respect to such property on any terms necessary or incidental to the carrying out of these purposes;

(7) Receive and accept, from any source, aid or contributions, including money, property, labor and other things of value;

(8) Charge assessments or user fees to health carriers or otherwise generate funding necessary to support the operations of the exchange and navigator grants under section 7 of this act;

(9) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable;

(10) Invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state and in obligations that are legal investments for savings banks in the state;

(11) Issue bonds, bond anticipation notes and other obligations of the exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes and mortgages of others;

(12) Borrow money for the purpose of obtaining working capital;

(13) Account for and audit funds of the exchange and any recipients of funds from the exchange;

(14) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers, including, but not limited to, agreements with the Departments of Revenue Services and Social Services, the Insurance Department, the

Labor Department and any other state agency, as deemed necessary by the exchange;

(15) To the extent permitted under its contract with other persons, consent to any termination, modification, forgiveness or other change of any term of any contractual right, payment, royalty, contract or agreement of any kind to which the exchange is a party;

(16) Award grants to navigators as set forth in section 7 of this act. Applications for grants from the exchange shall be made on a form prescribed by the board. The board shall review applications and decide whether to award a grant. The board may consider, as a condition for awarding a grant, any factors the board deems relevant;

(17) Sue and be sued, plead and be impleaded;

(18) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the exchange; and

(19) Do all acts and things necessary and convenient to carry out the purposes of the exchange.

(c) The exchange shall be subject to the Freedom of Information Act, as defined in section 1-200 of the general statutes, except that the following information shall not be subject to disclosure under section 1-210 of the general statutes: (1) The names and applications of individuals and employers seeking coverage through the exchange; (2) individuals' health information; and (3) information exchanged between the exchange and (A) the Departments of Social Services, Public Health and Revenue Services, (B) the Insurance Department, (C) the office of the Comptroller, and (D) any other state agency that is subject to confidentiality agreements under contracts entered into pursuant to this section.

Sec. 6. (NEW) (*Effective from passage*) The exchange shall:

(1) Implement procedures for the certification, recertification and

decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the federal act, and section 9 of this act, of health benefit plans as qualified health plans;

(2) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided consumers have an adequate number and selection of choices;

(3) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(4) Provide for enrollment periods, as provided under Section 1311(c)(6) of the federal act;

(5) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may (A) obtain standardized comparative information on such plans; (B) access quality and price rating information developed by the United States Department of Health and Human Services for qualified health plans; and (C) access transparent information concerning a qualified health plan's premiums, cost sharing requirements, including deductibles, copayments and coinsurance and coverage limitations, which information shall be contractually binding on the qualified health plan;

(6) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(7) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the federal act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the federal act;

(8) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage

established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(9) Inform individuals, in accordance with Section 1413 of the federal act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the application by the exchange, that such individual is eligible for any such program;

(10) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the federal act;

(11) Ensure that a qualified employer is permitted to make defined contributions to a health carrier on behalf of an employee enrolling in such qualified health plan;

(12) Grant a certification, subject to Section 1411 of the federal act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(13) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under

subdivision (12) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the federal act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(14) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (13) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(15) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(16) Select entities qualified to serve as navigators in accordance with Section 1311(i) of the federal act and award grants to enable navigators to carry out the provisions of section 7 of this act;

(17) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(18) Credit the amount, in accordance with Section 10108 of the federal act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(19) Consult with stakeholders relevant to carrying out the activities required under sections 1 to 13, inclusive, of this act, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Groups of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(20) Establish methods of independently evaluating consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers;

(21) Establish (A) rating systems that permit individuals and small employers to compare the value of competing qualified health plans; and (B) plan member satisfaction surveys concerning qualified health plans with particular emphasis on soliciting feedback from plan members who have serious health conditions or who have encountered financial difficulties as a result of serious health

conditions; and

(22) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the federal act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 1 to 13, inclusive, of this act, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications.

Sec. 7. (NEW) (*Effective from passage*) (a) The exchange shall establish a navigator grant program that shall award grants to certain entities to market the exchange for the purposes of: (1) Conducting public education activities to raise awareness of the availability of qualified health plans sold through the exchange; (2) distributing fair and impartial information concerning enrollment in qualified health plans; (3) distributing fair and impartial information about the availability of premium tax credits and cost-sharing reductions pursuant to the federal act; (4) facilitating enrollment in qualified health plans; (5) referring individuals with a grievance, complaint or question regarding a plan, a plan's coverage or a determination under a plan's

coverage to the Office of the Healthcare Advocate or any customer relations unit established by the exchange; and (6) providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

(b) The exchange shall award navigator grants, at the sole discretion of the board of directors, to any of the following entities to carry out navigator functions: (1) A trade, industry or professional association; (2) a community and consumer-focused nonprofit group; (3) a chamber of commerce; (4) a labor union; (5) a small business development center; or (6) an insurance producer or broker licensed in this state. A navigator shall not be an insurer or receive any consideration directly or indirectly from any insurer in connection with the enrollment of any qualified individual or employees of a qualified employer in a qualified health plan. An eligible entity shall not receive a navigator grant unless it can demonstrate to the satisfaction of the board of directors of the exchange that it has (A) existing relationships, or could readily establish such relationships, with small employers and their employees, individuals including uninsured and underinsured individuals, or self-employed individuals likely to be qualified to enroll in a qualified health plan, or (B) particular expertise or experience in meeting the health insurance needs of small employers, minority populations, elderly populations and young adults.

(c) A navigator shall comply with all applicable provisions of the federal act, regulations adopted thereunder or guidance issued pursuant to the federal act.

(d) The exchange shall collaborate with the Secretary of the United States Department of Health and Human Services to develop standards to ensure that the information distributed and provided by navigators is fair and accurate.

(e) The exchange shall establish performance standards, accountability requirements and maximum grant amounts for

navigators.

Sec. 8. (NEW) (*Effective from passage*) (a) The exchange shall make qualified health plans available to qualified individuals and qualified employers for coverage beginning on or before January 1, 2014.

(b) (1) The exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the federal act.

(c) Neither the exchange nor a health carrier offering health benefit plans through the exchange shall charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because (1) the individual has become newly eligible for that coverage, or (2) the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code.

(d) A qualified employer, participating in the exchange: (1) Shall not offer to its employees outside the exchange coverage under a competing health benefit plan offering the same, or substantially the same, benefits provided through the exchange; (2) reserves the right to determine, subject to applicable state and federal law, (A) employer criteria for eligibility, enrollment and participation in the exchange, and (B) the amount of the employer contributions, if any, to a qualified health plan for employee coverage; (3) shall participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 USC 125; and (4) shall make available, in a timely manner, for confidential review by the chief executive officer of the exchange, employer documents, records or other information that

the chief executive officer reasonably determines are necessary to verify, (A) that the employer is in compliance with applicable state and federal law relating to the offering of group health benefit plans, particularly provisions of such laws relating to nondiscrimination in coverage, and (B) the eligibility, under the terms of the health benefit plan, of those employees enrolled in such plan.

Sec. 9. (NEW) (*Effective from passage*) (a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package, as described in Section 1302(a) of the federal act, and the coverage mandates required under chapter 700c of the general statutes, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection (e) of this section, if:

(A) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to subdivision (7) of section 6 of this act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the federal act, and the plan's deductibles do not exceed the limits established under Section

1302(c)(2) of the federal act;

(5) The health carrier offering the plan:

(A) Is licensed and in good standing to offer health insurance coverage in the state;

(B) Agrees to offer at least (i) one qualified health plan at a bronze, silver, gold and platinum level of coverage, as determined pursuant to subdivision (7) of section 6 of this act, and (ii) one catastrophic plan, defined in Section 1302(e) of the federal act;

(C) Agrees to offer an identical plan outside the exchange, at the same premium rate;

(D) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or directly by the health carrier or through an insurance producer;

(E) Does not charge any cancellation fees or penalties as set forth in subsection (c) of section 8 of this act;

(F) Ensures that commissions or financial incentives paid to an insurance producer or broker in connection with the sale of an insurance plan are comparable irrespective of whether the insurance plan is sold on or outside of the exchange; and

(G) Complies with the regulations developed by the Secretary under Section 1311(d) of the federal act and such other requirements as the exchange may establish;

(6) The plan meets the requirements for certification pursuant to written procedures adopted under section 3 of this act and regulations promulgated by the Secretary under Section 1311(c) of the federal act; and

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in the state.

(b) The exchange shall not refuse to certify a health benefit plan as a qualified health plan:

(1) On the basis that (A) the plan is a fee-for-service plan, or (B) the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly; or

(2) By conditioning such certification on the imposition of premium price controls by the exchange.

(c) The exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to:

(1) Agree to submit a justification for any premium increase before implementation of such increase. The health carrier shall prominently post such justification and any information related to such justification on its Internet web site. The exchange shall take such justification and information into consideration, along with any additional information and recommendations provided to the exchange by the commissioner under Section 2794(b) of the Public Health Service Act, 42 USC 300gg-94, as amended from time to time, when determining whether to allow the health carrier to continue to make such plan available through the exchange;

(2) Make available to the public in plain language, as that term is defined in Section 1311(e)(3)(B) of the federal act, and submit to the exchange, the Secretary and the commissioner, accurate and timely disclosure of the following for such plan:

(A) Claims payment policies and practices;

(B) Periodic financial disclosures;

(C) Data on enrollment;

(D) Data on disenrollment;

(E) Data on the number of claims that are denied;

(F) Data on rating practices;

(G) Information on cost-sharing and payments with respect to any out-of-network coverage;

(H) Information on enrollee and participant rights under Title I of the federal act; and

(I) Other information determined as appropriate by the Secretary; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that such individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet web site and through other means for individuals without access to the Internet.

(d) The exchange shall not exempt any health carrier seeking certification of a health benefit plan as a qualified health plan from state licensure or reserve requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

(e) (1) The provisions of sections 1 to 13, inclusive, of this act, that are applicable to qualified health plans, shall also apply to the extent applicable to qualified dental plans, except as modified in accordance with the provisions of subdivisions (2), (3) and (4) of this subsection or by written procedures adopted by the exchange.

(2) A health carrier seeking certification of a dental benefit plan as a qualified dental plan shall be licensed in the state to offer dental coverage, but need not be licensed to offer other health benefits.

(3) Qualified dental plans shall be limited to dental and oral health benefits, without substantial duplication of the benefits typically

offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange may specify or the Secretary may specify by regulation.

(4) Health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by a health carrier through a qualified dental plan and health benefits are provided by another health carrier through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same such prices.

Sec. 10. (NEW) (*Effective from passage*) The state of Connecticut does hereby pledge to, and agree with, any person with whom the exchange may enter into contracts pursuant to the provisions of sections 1 to 13, inclusive, of this act, that the state will not limit or alter the rights hereby vested in the exchange until such contracts and the obligations thereunder are fully met and performed on the part of the exchange, except that nothing in this section shall preclude such limitation or alteration if adequate provision shall be made by law for the protection of such persons entering into contracts with the exchange.

Sec. 11. (NEW) (*Effective from passage*) The exchange shall be exempt from all franchise, corporate business, property and income taxes levied by the state or any municipality, except that nothing in this section shall be construed to exempt from any such taxes, or from any taxes levied in connection with, (1) the manufacture or sale of any products that are the subject of any agreement made by the exchange, or (2) any person entering into any contract with the exchange.

Sec. 12. (NEW) (*Effective from passage*) (a) Not later than January 1, 2013, the board of directors of the exchange shall report, in accordance with section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to finance, revenue and bonding, insurance and public health on the following:

(1) The potential effect of adverse selection on the operations of the exchange and recommendations to reduce the potential negative impact from any such adverse selection, including, but not limited to:

(A) Recommendations to ensure that rules governing health benefit plans are similar for plans offered through the exchange and outside the exchange; and

(B) Recommendations on whether the exchange should, as a condition of participating in the exchange:

(i) Require health carriers to offer health benefit plans such carriers offer outside the exchange at silver and gold levels of coverage, as determined pursuant to subdivision (7) of section 6 of this act, and

(ii) Prohibit such carriers from only offering health benefit plans at a bronze level of coverage, as determined pursuant to subdivision (7) of section 6 of this act, and catastrophic plans, as defined in Section 1302(e) of the federal act, outside the exchange; or

(iii) Prohibit health carriers from offering through or outside the exchange, through affiliates, the same health benefit plans at different premium rates;

(2) Recommendations to promote transparency in the exchange including, but not limited to, whether any contract between a health carrier and the exchange should be subject to disclosure pursuant to section 1-210 of the general statutes;

(3) (A) An initial methodology for imposing assessments or user fees on health carriers that demonstrates a reasonable likelihood of (i) collecting sufficient funds for the exchange including start-up costs, operating and administrative costs and moneys for navigator awards under section 7 of this act, and (ii) achieving financial sustainability of the exchange on or before January 1, 2015; and

(B) Any other funds the exchange has procured or is attempting to procure;

(4) Recommendations to ensure maximum participation by individuals and small employers in the exchange in order to optimally pool risks;

(5) Recommendations to ensure that the exchange is a viable and competitive alternative in the procurement of a health benefit plan for individuals and small employers;

(6) Recommendations to ensure that the administrative costs relating to the procurement of a health benefit plan for small employers participating in the exchange are reduced;

(7) Recommendations to ensure that defined contributions from a qualified employer for an employee's procurement of a health benefit plan are in fact used by the employee for the procurement of a health benefit plan;

(8) Whether to revise the definition of "small employer" from not more than fifty employees to not more than one hundred employees;

(9) Whether to allow employers with more than one hundred employees to participate in the exchange beginning in 2017;

(10) Whether to continue to require qualified health plans to provide benefits beyond those that are to be included in the essential health benefits package, as described in Section 1302(a) of the federal act;

(11) The administrative role, if any, the exchange should have in the collection and payment of premiums due to health carriers from individuals and small employers purchasing health benefit plans on the exchange;

(12) The relationship of the exchange to insurance producers and agents;

(13) Recommendations to ensure that transitions between state health care programs, including, Medicaid, HUSKY Plan, Part A or Part B, and the Charter Oak Health Plan, other federally subsidized

health care coverage and fully private pay health coverage are centralized, seamless and preserve continuity of coverage and care; and

(14) The capacity of the exchange to award navigator grants pursuant to section 7 of this act.

(b) (1) The board of directors shall file the initial assessment methodology required under subparagraph (A) of subdivision (3) of subsection (a) of this section with the clerks of the House of Representatives and the Senate not later than ten days after the date on which the report required under subsection (a) of this section has been provided to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to finance, revenue and bonding, insurance and public health. Such methodology shall be deemed approved if the General Assembly fails to vote to approve or reject such methodology not later than thirty days after the date of filing. If the General Assembly votes to reject such methodology not later than thirty days after the date of filing, the board of directors shall, not later than fifteen days after such rejection, refile a revised methodology. Such refiling shall be subject to the provisions of this subdivision.

(2) The provisions of subdivision (1) of this subsection shall apply only to the initial assessment methodology. Any subsequent revision of the initially approved assessment methodology shall not be subject to the provisions of subdivision (1) of this subsection, provided the board of directors shall provide reasonable notice to carriers of any such revision.

(c) Not later than one year following the date of implementation of the exchange, and annually thereafter, the board shall evaluate and report to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to finance, revenue and bonding, insurance and public health whether adverse selection is occurring in the exchange with respect to self-insured plans and health benefit plans offered outside the exchange.

Sec. 13. (NEW) (*Effective from passage*) Nothing in sections 1 to 12, inclusive, of this act, and no action taken by the exchange pursuant to said sections of this act shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance in the state. Except as expressly provided to the contrary in sections 1 to 12, inclusive, of this act, all health carriers offering qualified health plans in the state shall comply with all applicable health insurance laws of the state and regulations adopted and orders issued by the commissioner.

Sec. 14. Subsection (l) of section 1-79 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(l) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Education Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Lower Fairfield County Convention Center Authority, Capital City Economic Development Authority, Connecticut Lottery Corporation, **[**and**]** Health Information Technology Exchange of Connecticut and Connecticut Health Insurance Exchange.

Sec. 15. Subdivision (1) of section 1-120 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Educational Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Capital City Economic Development Authority, Connecticut Lottery Corporation, **[**and**]** Health Information Technology Exchange of Connecticut and Connecticut Health

Insurance Exchange.

Sec. 16. Section 1-124 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Connecticut Development Authority, the Connecticut Health and Educational Facilities Authority, the Connecticut Higher Education Supplemental Loan Authority, the Connecticut Housing Finance Authority, the Connecticut Housing Authority, the Connecticut Resources Recovery Authority, the Health Information Technology Exchange of Connecticut, **[**and**]** the Capital City Economic Development Authority and the Connecticut Health Insurance Exchange shall not borrow any money or issue any bonds or notes which are guaranteed by the state of Connecticut or for which there is a capital reserve fund of any kind which is in any way contributed to or guaranteed by the state of Connecticut until and unless such borrowing or issuance is approved by the State Treasurer or the Deputy State Treasurer appointed pursuant to section 3-12. The approval of the State Treasurer or said deputy shall be based on documentation provided by the authority that it has sufficient revenues to (1) pay the principal of and interest on the bonds and notes issued, (2) establish, increase and maintain any reserves deemed by the authority to be advisable to secure the payment of the principal of and interest on such bonds and notes, (3) pay the cost of maintaining, servicing and properly insuring the purpose for which the proceeds of the bonds and notes have been issued, if applicable, and (4) pay such other costs as may be required.

(b) To the extent the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Connecticut Health and Educational Facilities Authority, the Health Information Technology Exchange of Connecticut, **[**or**]** the Capital City Economic Development Authority or the Connecticut Health Insurance Exchange is permitted by statute and

determines to exercise any power to moderate interest rate fluctuations or enter into any investment or program of investment or contract respecting interest rates, currency, cash flow or other similar agreement, including, but not limited to, interest rate or currency swap agreements, the effect of which is to subject a capital reserve fund which is in any way contributed to or guaranteed by the state of Connecticut, to potential liability, such determination shall not be effective until and unless the State Treasurer or his or her deputy appointed pursuant to section 3-12 has approved such agreement or agreements. The approval of the State Treasurer or his or her deputy shall be based on documentation provided by the authority that it has sufficient revenues to meet the financial obligations associated with the agreement or agreements.

Sec. 17. Section 1-125 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The directors, officers and employees of the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, including ad hoc members of the Connecticut Resources Recovery Authority, Connecticut Health and Educational Facilities Authority, Capital City Economic Development Authority, the Health Information Technology Exchange of Connecticut, **[**and**]** Connecticut Lottery Corporation and Connecticut Health Insurance Exchange and any person executing the bonds or notes of the agency shall not be liable personally on such bonds or notes or be subject to any personal liability or accountability by reason of the issuance thereof, nor shall any director or employee of the agency, including ad hoc members of the Connecticut Resources Recovery Authority, be personally liable for damage or injury, not wanton, reckless, wilful or malicious, caused in the performance of his or her duties and within the scope of his or her employment or appointment as such director, officer or employee, including ad hoc members of the Connecticut Resources Recovery Authority. The

agency shall protect, save harmless and indemnify its directors, officers or employees, including ad hoc members of the Connecticut Resources Recovery Authority, from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand, suit or judgment by reason of alleged negligence or alleged deprivation of any person's civil rights or any other act or omission resulting in damage or injury, if the director, officer or employee, including ad hoc members of the Connecticut Resources Recovery Authority, is found to have been acting in the discharge of his or her duties or within the scope of his or her employment and such act or omission is found not to have been wanton, reckless, wilful or malicious.

Sec. 18. Subsection (a) of section 17b-261 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a

court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence. Except as provided in section 17b-277, the medical assistance program shall provide coverage to persons under the age of nineteen with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit and to persons under the age of nineteen and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by **[**said**]** federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of the availability of HUSKY Plan, Part B health insurance benefits. On and after January 1, 2014, medical assistance shall be provided to childless adults and parents and needy caretaker relatives who qualify for coverage under Section 1902(a)(10)(A)(i)(viii) of the Social Security Act, with family income up to one hundred thirty-three per cent of the federal poverty

level, without an asset test. On and after January 1, 2014, the Commissioner of Social Services shall implement the basic health program option in accordance with the provisions of Section 1331 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time. On and after January 1, 2014, all individuals under sixty-five years of age with family income up to two hundred per cent of the federal poverty level, as determined in accordance with Section 1331 of the Patient Protection and Affordable Care Act, and who are ineligible for medical assistance pursuant to Title XIX of the Social Security Act, shall be eligible for medical assistance under the basic health program. Medical assistance provided through the basic health program shall include all benefits, limits on cost-sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act. Individuals enrolled in the basic health program shall include, but not be limited to, parents and other caretaker relatives with incomes above one hundred thirty-three per cent of the federal poverty level, as determined under said Section 1331 of the Patient Protection and Affordable Care Act, who would otherwise qualify for HUSKY Plan, Part A and individuals described in section 17b-257b. To the extent that federal funds received pursuant to the basic health program exceed the cost of medical assistance that would otherwise be provided to such enrollees pursuant to Title XIX of the Social Security Act, the excess of such federal funds shall be used to increase reimbursement rates for providers serving individuals receiving benefits pursuant to this section. The Commissioner of Social Services shall take all necessary actions to maximize federal funding received in connection with the establishment of a basic health program.

Sec. 19. (NEW) (*Effective from passage*) There is established an account to be known as the "basic health program account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Commissioner of Social Services for the purposes of operating the basic health program in conformance with Section 1331 of the Patient

Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section
Sec. 8	*from passage*	New section
Sec. 9	*from passage*	New section
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	1-79(l)
Sec. 15	*from passage*	1-120(1)
Sec. 16	*from passage*	1-124
Sec. 17	*from passage*	1-125
Sec. 18	*from passage*	17b-261(a)
Sec. 19	*from passage*	New section

Statement of Legislative Commissioners:

In section 2(b)(4)(A), "No appointee" was changed to "No director or member of the staff of the exchange" for clarity and consistency with the other provisions of the subdivision. In section 2(i), "but not be limited to" was changed to "but need not be limited to" for accuracy. In section 3(5) "authority" was changed to "exchange" for accuracy. In section 12(a)(3)(A), "subdivision (16) of section 6" was changed to "section 7" for accuracy. In section 12(a)(3)(B), the word "and" which appeared at the end of the subparagraph was deleted for accuracy.

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact: See below

Municipal Impact: See below

Explanation

Insurance Exchange

This bill creates the Connecticut Health Insurance Exchange (the Exchange). The Exchange is a quasi-public agency tasked with implementing the insurance exchange requirements of the federal Patient Protection and Affordable Care Act (PPACA).

The Exchange will have ongoing operational costs that will depend upon the administrative structures that are developed by the board. For purposes of comparison, the Commonwealth of Massachusetts (with roughly twice the population of Connecticut), established a health insurance exchange in 2007. Initial operating costs were $19.5 million in the first year and $29.9 million in the second year. However, the Massachusetts Exchange is tasked with administering a publically subsidized health insurance program, which is outside the scope of this bill. Therefore, the cost of the Connecticut Exchange is likely to be proportionately less.

The bill specifies that the Exchange can charge assessments or user fees to health carriers to generate necessary funding to support operations. Connecticut has already received an exchange planning grant from the federal government of $996,848. Under PPACA, additional federal funds are available to assist states in the implementation of the health insurance exchanges. A consortium of the six New England states has already been granted $35.6 million to

develop an on-line gateway to health insurance options.

It is anticipated that the federal grants available will fund the implementation of the Exchange. Once established, it is assumed that the Exchange will charge any fees necessary to fund its operations.

Agencies will incur minimal costs, estimated to be less than $5,000, associated with mileage reimbursement of 51 cents per mile for agency staff (who seek such reimbursement) participating on the Exchange Board.

Medicaid for Low Income Adults

Section 18 of the bill expands the Medicaid LIA coverage group, effective January 1, 2014. Currently, childless adults are covered under this group with incomes up to approximately 68% of the federal poverty level (FPL). This bill raises this income limit to 133% FPL, as required by PPACA. PPACA requires states to submit an amendment to the state Medicaid plan to implement this expansion. As the bill is codifying an existing federal mandate, there is no direct fiscal impact from this language. [1]

Basic Health Plan

Section 18 of the bill also requires the Department of Social Services (DSS) to implement, on or after January 1, 2014, the Basic Health Plan (BHP) option in accordance with PPACA. This requirement will result in a net additional annual state cost of between $184.4 million and

1 It is estimated that by 2014, there will be approximately 81,000 enrollees in the existing LIA coverage group, at a cost of $728 million annually. Based on this enrollment pattern, the expansion to 133% FPL would add an additional 32,000 clients, with annual costs of $288 million.

Under PPACA, the cost of the expansion of coverage to childless adults is fully covered by the federal government until January 1, 2017. Therefore, there is no cost to the state for this expansion until that date. After January 1, 2017, the federal government's share gradually declines from 100% to 90% by 2020. Therefore, the state's cost for this expansion grows from $8.9 million in FY 17 to $32.8 million in FY 20.

$425.2 million, and will cover an estimated 80,250 new individuals. Details on the various parts involved in this estimate appear below.

This proposal will create a new state program, outside the federally mandated insurance exchanges, for adults with incomes between 133% FPL and 200% FPL. This section specifically moves parents within this income band who are current enrollees in the HUSKY A program to the new BHP. The section specifies that all benefits, cost sharing requirements and consumer safeguards in place for the Medicaid program shall apply to the BHP.

The fiscal impact to the state from these provisions is twofold. First, the state will realize a savings under the HUSKY program as parents with incomes in excess of 133% FPL are disenrolled. It is estimated that there will be 31,000 parents in this category by 2014, with an annual cost per case of $4,700.[2] Therefore, the state will realize net annualized savings of $72.9 million (after 50% federal reimbursement).

The new BHP program is expected to serve 111,250 clients when fully annualized.[3] The BHP is required to have the same benefits and cost sharing as the Medicaid program. Although the costs for the clients transferred from HUSKY are anticipated to be consistent, it is not known what the cost profile of the new, non-HUSKY enrollees will be. This new population is likely to include individuals with significantly higher cost profiles.[4] It is assumed that the cost per case for the non-HUSKY enrollees in this new program will be $6,000 by 2014. Therefore, the gross annualized program cost is anticipated to be $627.2 million. Should the cost profile of the non-HUSKY BHP

[2] Based on DSS cost and caseload data for the adult 133% - 185% population. Costs inflated at 5% annually.

[3] This assumes 31,000 former HUSKY A parents and 80,250 non-HUSKY adults. According to Connecticut Department of Revenue Services data, there were 225,000 tax filers with incomes between $14,000 and $22,000 in 2009. The U.S. Census Bureau estimates that 29% of individuals with incomes under $25,000 are uninsured. This would yield approximately 65,250 individuals. It is further assumed that 15,000 of those in this income bracket who currently have insurance would transition to BHP, for a total of 80,250 non-HUSKY BHP enrollees.

[4] A portion of high cost Medicaid clients who currently spend down to Medicaid eligibility are likely to instead spend down to the BHP.

enrollees be similar to that of the LIA population discussed above ($9,000 annually), the gross annualized program cost would be $868.0 million.

Under PPACA, the state will receive a federal subsidy for those residents enrolled in the BHP. This subsidy is equal to 95% of what the federal government would have spent on premium tax credits and cost sharing reductions that BHP enrolled individuals would have been eligible for had they purchased private insurance through the State Insurance Exchange. The tax credits and cost sharing reductions are based on the "Silver Plan" on the insurance exchange. At this time, the federal government has not stated what the essential benefit package will be, which will dictate both the cost of the Silver Plan and the value of the associated federal subsidy.

For the purposes of this analysis, the cost of the Silver Plan is estimated to be $4,500 annually.[5] Based on maximum client contributions included in PPACA, it is estimated that the federal subsidy available for the BHP will be $3,325 annually.[6] Compared to the $6,000 to $9,000 estimated cost for the non-HUSKY BHP, there exists $2,675 to $5,675 annual cost per person that is not covered by the federal subsidy. Given the bill's requirement that the BHP have the same cost sharing as the state Medicaid program (which is currently $0), it is assumed that the state must pay the unsubsidized costs for all BHP enrollees. Based on the enrollment and cost assumptions above,

[5] Although the cost of the Silver Plan has not been established, the Congressional Research Service and Congressional Budget Office have used $4,500 as a general estimate. The final average cost of the Silver plan will be dependent upon the benefit plan as well as the cost profile of the individuals enrolled.

[6] PPACA includes maximum client premium and cost sharing for Exchange products, which vary by income limit. Based on these requirements, this analysis assumes that a client's share of the premium would average $1,000 (derived from Kaiser Family Foundation estimates). The federal subsidy available for the BHP would be 95% of the federal share of the cost of the Silver Plan. Therefore, the federal subsidy would be $3,325, which equates to ($4,500 - $1,000)*95%. It should be noted that the federal subsidy will not consider any state health mandate costs that are in excess of the essential benefit package. Also, PPACA indexes the federal subsidy to the Consumer Price Index (CPI). If the average cost of the Silver plan increases at a higher rate than the CPI, the real value of the subsidy will decrease over time.

the new BHP benefit for all clients would result in a net state cost of between $257.3 million and $498.0 million annually.

The total state impact from implementing the BHP is summarized in the following tables:

Basic Health Plan – HUSKY A Impact

	Clients	State Cost per year	Impact
Remove clients from HUSKY A	-31,000	$2,350	-$72,850,000
HUSKY A BHP Cost	31,000	$1,375[7]	$42,630,000
Net Savings			**-$30,220,000**

Basic Health Plan - Non-HUSKY Impact

	State Cost – HUSKY Level	State Cost – LIA Level
Clients	80,250	80,250
Per Person Cost	$6,000	$9,000
Non-HUSKY BHP Cost	**$481,500,000**	**$722,250,000**
Per Person Federal Subsidy	($3,325)	($3,325)
Non-HUSKY BHP Federal Subsidy	**($266,831,250)**	**($266,831,250)**
Net State Cost Non-HUSKY BHP	**$214,668,750**	**$455,418,750**
Cost Less HUSKY A Savings	**$184,443,750**	**$425,193,750**

Basic Health Plan Account

Section 19 creates a non-lapsing basic health program account from which the costs to operate the BHP are to be paid by DSS. It is

[7] State HUSKY BHP cost is the cost of care ($4,700) less available federal subsidy ($3,325)

assumed that the federal BHP subsidy would be deposited in this account. However, it is not clear what the source of funds is for the state cost for the unsubsidized portion of the BHP benefit identified above. Presumably, a General Fund appropriation would have to be made.

The Out Years

The relevant out year impacts from this bill are included in the analysis above. The proposals in the bill are closely tied to federal reform efforts, and are likely to be affected by regulations and changes that are still forthcoming from the federal government.

OLR Bill Analysis

sSB 1204

AN ACT ESTABLISHING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

SUMMARY:

This bill establishes the Connecticut Health Insurance Exchange, a quasi-public agency, to satisfy requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). Under the bill, a 12-member board manages the exchange, including operating an online marketplace where individuals and small employers (i.e., an employer with up to 50 employees) will be able to compare and purchase insurance plans beginning in 2014.

The bill also requires the Department of Social Services (DSS) commissioner, starting January 1, 2014, to implement the "basic health program" option provided for in the PPACA. Adults under age 65 with incomes between 134% and 200% of the federal poverty level (FPL) who are ineligible for Medicaid qualify for this program, which would receive federal funding.

EFFECTIVE DATE: Upon passage

§§ 2, 14-17 – EXCHANGE CREATION

The bill creates the Connecticut Health Insurance Exchange (exchange) as a quasi-public agency and adds it to the statutes governing quasi-public agencies. It must be a solvent and self-sustaining entity by January 1, 2015. The exchange is not a state department, institution, or agency.

The purpose of the exchange is to reduce the number of people without health insurance in the state, assist small employers with purchasing and administering health insurance by offering easily comparable and understandable health insurance options to

individuals and small employers, and enroll individuals in medical assistance programs (See Section 5 below).

Board Membership

The bill vests the exchange's powers in a 12-member board of directors, which includes the public health, insurance, and social services commissioners; the Office of Policy and Management secretary; and the healthcare advocate, or their designees, as ex-officio, non-voting members. The seven voting members must be appointed by the governor and the legislative leaders by October 1, 2011. Board members are not compensated but can be reimbursed for the expenses they incur.

Board Members' Terms and Meetings

Appointed board members serve staggered four-year terms. Four are initially appointed for four years, while the governor's and Senate and House minority leaders' appointees initially serve for three years. Subsequent terms begin on October 1st of the year appointed. Directors may be reappointed. Vacancies must be filled by the appointing authority for the rest of the term. If an appointing authority does not make an appointment initially or within 90 days of a vacancy, the board must appoint a member by majority vote. Any director who fails to attend three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned.

Meetings must be held as specified in the bylaws the board adopts and at other times as the chairperson deems necessary.

The board must elect a chairperson every two years from among its members. The chairperson must schedule the board's first meeting by October 1, 2011.

Board Members' Qualifications

Each appointee must have demonstrated expertise in at least two of the following areas:

1. individual or small employer health insurance coverage,

2. health benefits plan administration,

3. health care finance,

4. public or private health care delivery system administration, or

5. health insurance plan purchase.

Each appointing authority must consider the other appointees' expertise when making an appointment to ensure the board reflects a diversity of expertise and the state's cultural, ethnic, and geographical communities.

Exchange directors and staff members cannot be employed by or affiliated with (1) an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic while serving as an exchange director or staff member or (2) a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. Nor can they be health care providers, unless they receive no compensation as a provider and do not have an ownership interest in a professional health care practice.

As a condition of qualifying for the board of directors, an appointee must take and subscribe the state Constitutional oath or affirmation. A record of the oath must be filed in the secretary of state's office.

Quorum; Transacting Business

Four of the 12 directors constitute a quorum for the board to transact business. The board may act by a majority vote at any meeting where there is a quorum. The bill specifies that a board vacancy does not impair the board's authority to exercise its rights and perform its duties. Any actions it takes may be authorized by resolution, which takes effect immediately unless it provides otherwise.

Chief Executive Officer

The bill requires the board to select and appoint a chief executive officer (CEO) who serves at its pleasure and receives compensation the board sets. The CEO administers the exchange's programs and

activities in accordance with the board's established policies and objectives. He or she may hire other employees as designated by the board.

Consultation

The bill allows the board to consult with public or private parties it deems necessary or desirable in performing its duties.

Advisory Committees

The bill authorizes the board to create advisory committees it deems necessary to represent key stakeholders, including consumers, small employers, the insurance industry, and health care providers.

§ 3 – WRITTEN PROCEDURES

The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before either may take effect;

2. hiring, dismissing, promoting, and compensating exchange employees, including an affirmative action policy and a requirement for board approval before a position may be created or a vacancy filled;

3. acquiring real and personal property and personal services, including a requirement for board approval for any nonbudgeted expenditure over $5,000;

4. contracting for financial, legal, bond, underwriting, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses;

5. issuing and retiring bonds, bond anticipation notes, and other obligations of the exchange;

6. establishing requirements for certifying qualified health plans

including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and coverage descriptions, and quality measures for health benefit plan performance; and

7. implementing the bill or other provisions of state law, provided they do not conflict with U.S. Health and Human Services (HHS) regulations.

§ 4 – AUDIT

The bill requires the board to require that the exchange be annually audited by HHS. It must submit to the Insurance and Real Estate Committee a copy of each audit conducted by HHS or any independent auditing firm within seven days of receiving the audit.

§ 5 – PURPOSES OF THE EXCHANGE

The bill specifies the purposes of the exchange and permits public funds to be spent to carry them out. Under the bill, the exchange can:

1. employ assistants, agents, and other employees as necessary who are exempt from classified service unless they are not managers;

2. engage consultants, attorneys, and other experts as necessary;

3. acquire, own, manage, hold, or dispose of real and personal property and lease, convey, deal, or enter into agreements concerning its property on any terms necessary to carry out these purposes;

4. receive and accept aid or contributions of any type from any source;

5. charge assessments or user fees to health carriers or otherwise generate funds to support exchange operations and navigator grants (see below);

6. obtain insurance against loss of property and other assets;

7. invest funds not needed for immediate use or disbursement in U.S.- or state-issued or –guaranteed obligations and in obligations that are legal investments for savings banks in Connecticut;

8. issue, fund, or refund bonds, notes, and other obligations of the exchange for any of its corporate purposes and provide for and secure bondholders' rights;

9. borrow money to obtain working capital;

10. account for and audit its funds and those of any entity that receives funds from the exchange;

11. enter into contracts or agreements necessary to perform its duties, including agreements with the departments of Revenue Services, Social Services, Insurance, Labor, and any other state agency;

12. if permitted under its contracts, agree to any termination, modification, forgiveness, or other change of any term of any contractual right, payment, royalty, contract, or agreement; and

13. award grants to navigators (see below).

§ 5 – FREEDOM OF INFORMATION

The exchange is subject to the Freedom of Information Act, except the following information is not subject to disclosure:

1. the names and applications of individuals and employers seeking coverage through the exchange;

2. individuals' health information; and

3. information exchanged between the exchange and the departments of Social Services, Public Health, Revenue Services, and Insurance, the Comptroller's Office, or any other state

agency that is subject to confidentiality agreements under contracts with the exchange.

§ 6 – DUTIES OF THE EXCHANGE

Under the bill, the exchange must:

1. implement procedures for certifying, recertifying, and decertifying health benefit plans as qualified health plans, consistent with HHS guidelines;

2. use selective criteria to limit the number of plans offered through the exchange, provided consumers have an adequate selection of plans;

3. operate a toll-free consumer assistance hotline;

4. provide for enrollment periods as provided in the PPACA;

5. maintain an Internet website through which people may obtain (a) standardized comparative information on qualified health plans, (b) quality and price rating information developed by HHS for qualified health plans, and (c) transparent, contractually binding information about a qualified health plan's premiums and cost-sharing requirements, including deductibles, copayments, and coinsurance and coverage limitations;

6. publish on its website the average costs of licensing, regulatory fees, and any other payments the exchange requires and the exchange's administrative costs, including information on amounts lost to waste, fraud, and abuse;

7. rate each qualified health plan offered through the exchange and determine each plan's level of coverage, in accordance with criteria and regulations developed by HHS;

8. use a standardized format for presenting health benefit options in the exchange;

9. determine if an applicant is eligible for Medicaid, the State Children's Health Insurance Program, or other state public programs and enroll an eligible applicant in the program;

10. establish and make available electronically a calculator that allows individuals to determine the actual cost of coverage, taking into consideration any applicable premium tax credit and cost-sharing reduction;

11. ensure a qualified employer is allowed to make defined contributions to a health carrier on behalf of an employee enrolling in a qualified health plan;

12. certify if an individual is exempt from the PPACA requirement to carry health insurance or from the penalty for not doing so;

13. provide to the U.S. treasury secretary the name and taxpayer identification number of each individual (a) granted an exemption from PPACA requirements, (b) who was an employee eligible for the premium tax credit because his or her employer did not provide minimum essential health benefits coverage or provided coverage that was unaffordable or did not meet the required actuarial value, (c) who notifies the exchange he or she has changed employers, and (d) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

14. give each employer the name of each employee who was eligible for a premium tax credit and ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

15. determine eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions as required by HHS or the Treasury department;

16. select entities qualified to serve as navigators under the PPACA and award grants to them (see below);

17. review the rate of premium growth within and outside the exchange and consider that information when developing recommendations on whether to continue limiting qualified employer status to small employers;

18. develop ways to independently evaluate consumers' experiences with the exchange, including hiring consultants to act as secret shoppers;

19. establish (a) rating systems that allow individuals and small employers to compare the value of competing qualified health plans and (b) plan member satisfaction surveys that emphasize soliciting comment from members with serious health conditions or financial difficulties resulting from serious health conditions; and

20. credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer. (A free choice voucher is an option that allows employees with incomes up to 400% of the FPL to apply the amount their employer contributes for insurance to buy a plan on the exchange if the amount they must pay for employer-sponsored insurance is unaffordable.)

Stakeholders

The exchange must consult with stakeholders relevant to implementing the bill, including:

1. people who are knowledgeable about the health care system, have experience in making informed decisions regarding health, medical, and scientific matters, and are enrolled in qualified health plans;

2. people and entities with experience in facilitating enrollment in qualified health plans;

3. representatives of small employers and self-employed individuals;

4. the DSS; and

5. advocates for enrolling hard-to-reach populations.

Financial Integrity

The exchange must meet the following financial integrity requirements:

1. keep an accurate accounting of all activities, receipts, and expenditures and annually report about these to HHS and the governor, insurance commissioner, and legislature;

2. fully cooperate with any HHS investigation and allow HHS to (a) investigate its affairs, (b) examine its properties and records, and (c) require periodic reports of its activities; and

3. ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or lobbying state or federal governments.

§ 7 – NAVIGATOR GRANT PROGRAM

The bill requires the exchange to establish a "navigator" grant program to award grants to certain entities to market the exchange. The exchange must establish performance standards, accountability requirements, and maximum grant amounts.

Purpose

Under the bill, a navigator must:

1. conduct public education activities to raise awareness of the availability of qualified health plans sold through the exchange;

2. distribute fair and impartial information about enrollment in qualified health plans and the availability of federal premium tax credits and cost-sharing reductions under the PPACA;

3. facilitate enrollment in qualified health plans;

4. refer individuals with a grievance, complaint, or question about a plan, a plan's coverage, or a determination under a plan's coverage to the healthcare advocate or any customer relations unit the exchange establishes; and

5. provide information in a manner that is culturally and linguistically appropriate.

Entities Allowed as Navigators

The bill requires the exchange to award navigator grants at the board's sole discretion to any of the following entities:

1. a trade, industry, or professional association;

2. a community and consumer-focused nonprofit group;

3. a chamber of commerce;

4. a labor union;

5. a small business development center; or

6. a Connecticut-licensed insurance producer or broker.

Under the bill, a navigator cannot (1) be an insurer or (2) receive any direct or indirect consideration from an insurer for enrolling people in a qualified health plan.

To receive a navigator award, an entity must demonstrate to the board's satisfaction that it has (1) relationships, or could develop relationships, with small employers, their employees, and individuals, including those who are underinsured, uninsured, or self-insured, who are likely to qualify to enroll in a qualified health plan or (2) particular expertise or experience in meeting the health insurance needs of small employers, minorities, seniors, and young adults.

Miscellaneous

The bill requires a navigator to comply with the PPACA and related federal regulations and guidance. It also requires the exchange to collaborate with HHS to develop standards that ensure the information navigators provide is fair and accurate.

§§ 8, 9 – QUALIFIED HEALTH PLANS

The bill requires the exchange to make qualified health plans available to qualified individuals and employers by January 1, 2014. The exchange cannot make plans available unless they are qualified health plans.

The bill defines a "qualified health plan" as a health benefit plan that is certified as meeting criteria outlined in the PPACA and this bill. A "qualified individual" is a state resident seeking to enroll in a qualified health plan offered to individuals through the exchange. A "qualified employer" is a small employer that elects to make its full-time employees eligible for at least one qualified health plan offered through the exchange, and if it chooses, make some or all part-time employees eligible. The employer must either (1) have its principal place of business in Connecticut and provide coverage through the exchange to all its eligible employees wherever located or (2) provide coverage through the exchange to all its eligible employees employed in Connecticut.

The exchange must allow a health carrier to offer a limited scope dental plan, either separately or as part of a plan that covers pediatric dental benefits.

Under the bill, the exchange or a health carrier offering plans through the exchange cannot charge an individual a coverage termination fee or penalty if the individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards.

Employer Requirements

To participate in the exchange, a qualified employer must:

1. not offer to its employees coverage outside the exchange under a competing health benefit plan that offers the same, or substantially the same, benefits provided through the exchange;

2. participate in a "cafeteria plan" that allows employees to get federal tax benefits for their health insurance premium payments; and

3. make available in a timely manner, for confidential review by the exchange's CEO, employer documents, records, or other information the CEO determines are necessary to verify that (a) the employer is in compliance with state and federal law relating to providing group health plans, especially nondiscrimination in coverage, and (b) enrollees' eligibility under the health benefit plan's terms.

The bill also requires the employer to reserve the right to determine, subject to state and federal law, employer eligibility, enrollment, and participation criteria and the amount of any employer contributions to a qualified health plan to cover its employees. (It appears to give the employer the responsibility to determine its own eligibility to participate in the exchange but requires the exchange to determine whether the employer is allowed to make defined contributions to a health carrier on behalf of an employee enrolling in a qualified health plan.)

Certifying Qualified Health Plans

The bill authorizes the exchange to certify a health benefit plan as a qualified health plan if:

1. the plan covers the state's insurance benefit mandates and the federally designated essential health benefits (but a plan does not have to contain all essential health benefits if it is a qualified dental plan and the health carrier prominently discloses that (1) the plan does not provide all essential pediatric benefits and (2) qualified dental plans with those and other dental benefits are offered through the exchange);

2. the insurance commissioner has approved the premium rates and contract language;

3. the plan provides at least a bronze level of coverage (covering 60% of the cost of essential health benefits) unless it is certified as meeting federal catastrophic plan requirements and is offered only to people eligible for such plans (e.g., under age 30 or exempt from the PPACA's requirement to carry health insurance);

4. the plan complies with federal limits on out-of-pocket costs;

5. the plan meets the requirements for certification in accordance with the exchange's adopted written procedures and HHS regulations; and

6. the exchange determines that making the plan available is in the interests of qualified individuals and employers in the state.

Under the bill, the exchange cannot refuse to certify a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it provides treatments to prevent patients' deaths in circumstances the exchange believes are too costly or inappropriate.

The exchange cannot exempt any health carrier from state licensure or reserve requirements and must apply the certification criteria in a way that assures a level playing field among health carriers participating in the exchange.

Health Carrier Requirements

To be eligible to offer qualified health plans through the exchange, a health carrier must:

1. be licensed and in good standing to offer health insurance in Connecticut;

2. offer through the exchange one catastrophic plan and at least

one plan each at the (a) bronze coverage level (covering 60% of the cost of essential health benefits), (b) silver coverage level (covering 70% of the cost of essential health benefits), (c) gold coverage level (covering 80% of the cost of essential health benefits), and (d) platinum coverage level (covering 90% of the cost of essential health benefits);

3. offer an identical plan outside the exchange at the same premium rate (presumably for each of the five plans above);

4. charge the same premium rate for each qualified health plan whether offered (a) through the exchange or outside the exchange or (b) directly by the carrier or through an insurance producer;

5. not charge a coverage termination fee or penalty to an individual who enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards;

6. ensure that commissions or financial incentives paid to an insurance producer or broker in connection with an insurance plan's sale are comparable whether the plan is sold within or outside the exchange; and

7. comply with HHS regulations and any other requirements the exchange may establish.

A health carrier seeking exchange certification for a qualified health plan must agree to submit (presumably to the exchange) and prominently post on the carrier's website, justification for any premium increase (and any related information) before it is implemented (the bill does not give a specific timeframe). The exchange must consider this justification, along with any additional information and recommendations from the insurance commissioner, when determining whether to allow the carrier to continue making the

plan available through the exchange.

A health carrier must disclose information in plain language to the public regarding claims, finances, enrollment and disenrollment, rating practices, out-of-network payments and cost sharing, enrollee rights under the PPACA, and other information HHS requires. It must also submit this information to the exchange, insurance commissioner and HHS.

A health carrier must also inform individuals, upon request, of the amount of cost sharing (e.g., deductibles, copayments, and coinsurance) they are responsible for under their plans for specific services. The information must be provided through an Internet website and through other means (which the bill does not specify) for individuals without Internet access.

Qualified Dental Plans

The bill applies, to the extent applicable, to qualified dental plans, except as modified by written procedures adopted by the exchange and the following:

1. a health carrier seeking certification of a dental plan as a qualified dental plan must be licensed in Connecticut to offer dental coverage but does not need to be licensed to offer other health benefits;

2. qualified dental plans are limited to dental and oral health benefits, cannot duplicate benefits typically offered by non-dental plans, and must include, at a minimum, the essential pediatric dental benefits defined by HHS and other dental benefits as the exchange or HHS may specify; and

3. health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by one carrier and health benefits by another carrier, as long as the plans are priced and made available for purchase separately.

§ 10 – STATE PLEDGE REGARDING CONTRACTUAL OBLIGATIONS

Under the bill, the state pledges and agrees with any person the exchange contracts with that the state will not limit or alter the rights vested in the exchange until the exchange's contractual obligations are fully met and performed. But the bill does not preclude limitation or alteration if the law makes adequate provision to protect those with contracts with the exchange.

§ 11 – EXCHANGE TAX EXEMPTIONS

The bill exempts the exchange from all state and local franchise, corporate business, property, and income taxes except for those levied for or in connection with (1) the manufacture or sale of products subject to an agreement made by the exchange or (2) any person contracting with the exchange.

§ 12 – REPORTING REQUIREMENTS

The bill requires the exchange's board to report to the governor and Insurance, Public Health and Finance Committees by January 1, 2013 on the following:

1. the potential effect of adverse selection on the exchange (see below);

2. recommendations to promote transparency in the exchange, including whether contracts between health carriers and the exchange should be subject to disclosure under the Freedom of Information Act;

3. an initial methodology for imposing assessments or user fees on health carriers that are reasonably likely to (a) collect sufficient funds for the exchange, including start-up, operating, and administrative costs, and money for navigator grants and (b) achieve financial sustainability for the exchange by January 1, 2015;

4. any funds the exchange has or is attempting to procure;

5. recommendations to ensure (a) maximum participation in the exchange by individuals and small employers to optimally pool risks, (b) the exchange is a viable and competitive alternative for individuals and small employers to procure health benefit plans, (c) that administrative costs relating to procuring health benefit plans are reduced for small employers participating in the exchange, and (d) that an employee uses a qualified employer's defined contributions to purchase a health benefit plan;

6. whether the expand the definition of "small employer" to include employers with up to 100 employees;

7. whether to allow employers with more than 100 employees to participate in the exchange starting in 2017;

8. whether to continue to require qualified health plans to provide benefits beyond those included in the federal essential health benefits package;

9. any administrative role the exchange should have in collecting and paying premiums due to health carriers from individuals and small employers purchasing health benefit plans on the exchange;

10. the relationship of the exchange to insurance producers and agents;

11. recommendations to ensure that transitions between state health care programs (including Medicaid, HUSKY A and B, and the Charter Oak Plan) and federally subsidized and private pay health care coverage are centralized, seamless, and preserve continuity of coverage and care; and

12. the exchange's capacity to award navigator grants.

Report on Adverse Selection

The above report must include (1) the effect of adverse selection on the exchange's operation and (2) any recommendations to reduce the

potential negative effect of any such adverse selection. The report must include recommendations to ensure that regulation of health benefit plans is similar for qualified health plans offered through the exchange and health benefit plans offered outside it. It must also include recommendations on whether the exchange should require health carriers, as a condition of participating in the exchange, to (1) offer health benefit plans outside the exchange at silver and gold coverage levels, (2) not offer only catastrophic or bronze coverage level plans outside the exchange, or (3) not offer within or outside the exchange through affiliates, the same health benefit plans at different premium rates.

Within one year of the exchange's implementation, the board must also annually evaluate and report to the governor and Insurance, Public Health, and Finance committees on whether adverse selection is occurring with respect to self-insured plans and plans sold outside the exchange.

Initial Assessment Methodology

The bill requires the exchange's board of directors to file the initial assessment methodology for imposing user fees or assessments required above with the clerks of the House of Representatives and Senate within 10 days after the date it submits its initial report to the governor and legislative committees. The methodology is deemed approved if the legislature does not vote to approve or reject it within 30 days of its filing. If the legislature rejects the methodology, the board of directors must refile a revised methodology within 15 days of the vote. It specifies that these requirements apply only to the board's initial assessment methodology as long as the board provides reasonable notice to carriers of any subsequent changes to the approved initial methodology.

§ 13 – INSURANCE COMMISSIONER'S AUTHORITY

The bill and the exchange's actions do not preempt or supersede the insurance commissioner's authority to regulate insurance in Connecticut. Unless the bill expressly provides to the contrary, all

health carriers offering qualified health plans in Connecticut must comply with all applicable state health insurance laws and regulations and insurance commissioner's orders.

§§ 18 & 19 – MEDICAID INCOME LIMITS; NEW BASIC HEALTH PROGRAM FOR ADULTS UNDER AGE 65

Changes in Medicaid Income Limits

The bill requires that, starting January 1, 2014, Medicaid must be provided to all adults ages 18 to 64, including childless adults, parents, and needy caretaker relatives, (1) who qualify for coverage under PPACA's provisions extending Medicaid to low-income adults (Section 1902 (a)(10)(A)(i)(VIII) of the Social Security Act) and (2) whose family income is up to 133% of the FPL, regardless of assets. Currently, 133% of the FPL for one person is $14,483 annually.

Under current law, these adults are eligible for Medicaid but at different income levels, and they do not have to meet an asset test. Parents and caretaker relatives receive HUSKY A coverage under a different provision of the Social Security Act (Section 1931) if their income is up to 185% of the FPL (currently $20,146 annually for one person). The state also offers Medicaid coverage to childless adults if their income is up to 60% of the FPL. This latter coverage is authorized under the above PPACA provision.

Under the bill, starting January 1, 2014, children are still covered if their family income is up to 185% of the FPL. But parents and caretaker relatives of these children, and childless adults are covered only up to 133% of the FPL.

New Basic Health Program for Adults under Age 65

Starting January 1, 2014, the bill requires the DSS commissioner to implement a "basic health program" (BHP) option provided for in the PPACA. The BHP must provide medical benefits to Medicaid ineligible adults under age 65 with family income between 134% and 200% of the FPL. The bill explicitly includes in the program (1) parents and other caretaker relatives of HUSKY A children whose family

income exceeds 133% of the FPL and (2) certain legal immigrants.

The program must include the same benefits, cost-sharing limits, and other consumer safeguards that apply to Medicaid beneficiaries. If federal funds the state receives for the basic health program exceed its costs, the excess funds must be used to increase reimbursement rates of participating Medicaid or BHP providers. The commissioner must take all necessary actions to maximize available federal funds to establish the program.

Under the BHP, the federal government pays 95% of the amount it would pay in subsidies and tax credits if BHP enrollees were in the health insurance exchange.

The bill establishes a separate, non-lapsing "Basic Health Plan Program Account" in the General Fund to hold any money required by law to be deposited into it. The DSS commissioner must spend the funds to operate the BHP in conformance with federal law.

BACKGROUND

Related Bills

The Insurance and Real Estate Committee favorably reported SB 921 and HB 6323, both of which similarly create an exchange as a quasi-public agency.

The Public Health Committee favorably reported HB 6305 which also requires the DSS commissioner to establish a Basic Health Program for certain Medicaid-ineligible adults starting January 1, 2014.

HB 6587, favorably reported by the Human Services Committee to the Appropriations Committee on March 22, also requires DSS to establish a Basic Health Program starting January 1, 2014.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 18 Nay 10 (03/30/2011)