General Assembly **Amendment**

February Session, 2012 LCO No. **4661**

HB0501304661SD0

Offered by:
SEN. CRISCO, 17th Dist.

To: Subst. House Bill No. **5013** File No. 594 Cal. No. 431

"AN ACT CONCERNING THE BOARD MEMBERS AND EMPLOYEES OF THE CONNECTICUT HEALTH INSURANCE EXCHANGE."

After the last section, add the following and renumber sections and internal references accordingly:

"Sec. 501. (*Effective from passage*) Not later than August 1, 2012, the Connecticut Health Insurance Exchange board of directors, established under section 38a-1081 of the general statutes, shall submit to the joint standing committee of the General Assembly having cognizance of matters relating to insurance the board's recommendation for a benchmark plan, as outlined in the Essential Health Benefits Informational Bulletin issued by the United States Department of Health and Human Services on December 16, 2011, to be selected as the standard for qualified health plans, as defined in section 38a-1080 of the general statutes, and plans sold outside the exchange.

Sec. 502. Section 38a-1085 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof

(*Effective from passage*):

(a) (1) Not later than August 31, 2012, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall convene a meeting to select a benchmark plan, as outlined in the Essential Health Benefits Informational Bulletin issued by the United States Department of Health and Human Services on December 16, 2011, by a majority vote as the standard for qualified health plans and plans sold outside the exchange.

(2) Such selection shall be reduced to writing and the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall file such selection with the clerks of the House of Representatives and the Senate not later than five calendar days after the date on which such selection is made.

(3) (A) The General Assembly may approve such selection by a majority vote of each house or may reject such selection by a majority vote of either house. If rejected, the matter shall be returned to the joint standing committee of the General Assembly having cognizance of matters relating to insurance for further discussion. Not later than five calendar days after such rejection, such committee shall make another selection and file such selection as prescribed under subdivision (2) of this subsection. Such committee shall not select again a benchmark plan that has been rejected by the General Assembly.

(B) Such selection shall be deemed approved if the General Assembly fails to vote to approve or reject such selection within thirty days after such filing.

[(a)**]** (b) The exchange shall make qualified health plans available to qualified individuals and qualified employers for coverage beginning on or before January 1, 2014.

[(b)**]** (c) (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 Affordable Care Act.

[(c)**]** (d) 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.

Sec. 503. Subsection (a) of section 38a-1086 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan includes, at a minimum, essential benefits as determined under the Affordable Care Act and the coverage requirements under **[**chapter 700c**]** the benchmark plan, as outlined by the United States Department of Health and Human Services, and approved by the General Assembly pursuant to subsection (a) of section 38a-1085, as amended by this act, 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 (8) of section 38a-1084, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Affordable Care 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 Affordable Care Act, and if the plan is offered through the program for small employers, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the Affordable Care 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 silver level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, and (ii) one qualified health plan at a gold level of coverage, as determined pursuant to subdivision (8) of section 38a-1084, through each component of the exchange in which the health carrier participates, where "component" refers to the program for small employers and the program for individual coverage;

(C) 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;

(D) Does not charge any cancellation fees or penalties as set forth in subsection **[**(c)**]** (d) of section 38a-1085, as amended by this act; and

(E) Complies with the regulations developed by the Secretary under Section 1311(d) of the Affordable Care Act and such other requirements as the exchange may establish;

(6) The plan meets the requirements for certification pursuant to written procedures adopted under subsection (a) of section 38a-1082 and regulations promulgated by the Secretary under Section 1311(c) of the Affordable Care 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.

Sec. 504. Subsection (a) of section 38a-1089 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Not later than January 1, 2012, and annually thereafter until January 1, 2014, the chief executive officer of the exchange shall report, in accordance with section 11-4a, to the Governor and the General Assembly on a plan, and any revisions or amendments to such plan, to establish a health insurance exchange in the state. Such report shall address:

(1) Whether to establish two separate exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single exchange;

(2) Whether to merge the individual and small employer health insurance markets;

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

(4) Whether to allow large employers to participate in the exchange beginning in 2017;

[(5) Whether to require qualified health plans to provide the

essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or include additional state mandated benefits;**]**

[(6)**]** (5) Whether to list dental benefits separately on the exchange's Internet web site where a qualified health plan includes dental benefits;

[(7)**]** (6) The relationship of the exchange to insurance producers;

[(8)**]** (7) The capacity of the exchange to award Navigator grants pursuant to section 38a-1087;

[(9)**]** (8) Ways to ensure that the exchange is financially sustainable by 2015, as required by the Affordable Care Act including, but not limited to, assessments or user fees charged to carriers; and

[(10)**]** (9) Methods to independently evaluate consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	*from passage*	New section
Sec. 502	*from passage*	38a-1085
Sec. 503	*from passage*	38a-1086(a)
Sec. 504	*from passage*	38a-1089(a)