OLR Bill Analysis

SB 842

AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

SUMMARY

This bill requires the comptroller to establish a fully insured group health insurance and pharmacy plan for multiemployer plans, nonprofit employers, and smaller employers. Under the bill, a "small employer" is an employer with 50 or fewer employees; it excludes nonstate public employers (i.e., municipalities). Coverage offered under the bill must generally comply with all existing state insurance laws and health insurance benefit mandates, except where noted below. The bill has conflicting provisions regarding the nature of the health insurance plan the comptroller must establish (see COMMENT).

The bill establishes the Connecticut Health Insurance Exchange account (CT-HIE) as a separate, nonlapsing account within the General Fund. It contains any money required to be deposited into it by law, including money generated from a fee on health insurers the bill imposes. The initial aggregate assessment for an insurer for 2022 is $50 million, which is also the maximum assessment in any subsequent year.

The Office of Health Strategy (OHS) and Access Health CT ("the exchange") must make a plan, and have it approved by the Insurance and Real Estate Committee, to use money in the account to:

1. reduce the cost of qualified health plans offered through the exchange, including by eliminating premiums for people at or below 200% of the federal poverty level (FPL);

2. provide up to $25 million annually for premium and cost-sharing subsidies for individuals ineligible for qualified health plans (QHPs) (e.g., undocumented immigrants); and

3. apply for and implement a Section 1332 waiver to (a) reduce the cost of health insurance coverage, including premiums and cost sharing, and (b) make health insurance coverage available to people who are ineligible for QHPs.

The bill also expands the minimum health benefits for silver-level QHPs and requires the plans to (1) have an actuarial value of 70% and (2) provide insureds with the broadest provider network available under QHPs offered by the carrier.

The bill also requires the Department of Labor to inform people applying for unemployment assistance of potential health care subsidies and refer them to the exchange. Under the bill, the exchange must enroll these individuals in assistance if eligible.

The bill also increases the income eligibility for Husky A Medicaid assistance for parents and caretakers from 155% of FPL to 201% of FPL. It also requires OHS to determine whether Connecticut should seek a federal Medicaid demonstration project waiver to reduce costs to moderate- and low-income families.

Lastly, the bill requires the Auditors of Public Accounts to audit the comptroller's books and accounts maintained for partnership plans, the state employee plan, and coverage offered by the comptroller under the bill, including any maintained by a third-party administrator. They must do beginning on July 1, 2021, and certify the results to the governor (§ 4).

EFFECTIVE DATE: July 1, 2021

§§ 1-3 & 5-7— FULLY INSURED HEALTH INSURANCE PLAN

The bill requires the comptroller to develop a fully insured group health insurance and pharmacy plan and offer it to plan participants and beneficiaries (including dependents, as applicable) under multiemployer plans, nonprofit employers and their employees, and small employers and their employees. Under federal law, a multiemployer plan is a collectively bargained health insurance plan covering employees of more than one employer (also called a "Taft-

Hartley Plan"). Generally, for a fully insured plan, the insurer assumes the plan's financial risk in return for premium payments. In this case, presumably, the state pays a premium to one or more insurance carriers to cover the cost of the health care plan. Several of the bill's provisions may be duplicative of, or in conflict with, procedures an insurer must carry out in servicing a fully insured plan (see COMMENT).

Premiums and Fees (§ 2)

Insurance coverage payments, which must be paid by participating multiemployer plan administrators, nonprofits, and small employers to the comptroller, must be the same as those paid by the state for state employees, including premiums paid by state employees themselves. However, the bill allows the comptroller to adjust the premiums to reflect certain risk factors and requires him to adjust them to include certain administrative and other fees.

Optional Premium Adjustments. Under the bill, premiums may be adjusted for:

1. age, in accordance with a uniform age rating curve meeting federal Affordable Care Act (ACA) requirements;

2. geography;

3. family size, so long as family premiums are not greater than the sum of premium payments for (1) all covered family members or (2) all covered family members age 21 and older and the three eldest covered dependents younger than 21;

4. actuarially justified differences in plan design, provider network, or administrative costs; and

5. the actual plan performance of the multiemployer, nonprofit, or small employer seeking coverage, so long as it does not cause the premiums to increase or decrease by more than 3% of the premiums that would otherwise be charged.

The bill also allows payments to be adjusted by a general administrative fee on a per member per month basis, which may include brokers' fees.

Required Premium Adjustments. The bill requires these premium payments to be adjusted to include:

1. the CT-HIE account fee (see § 3 below);

2. the health and welfare and public health fees (see §§ 5 & 6 below), which the bill requires the comptroller to annually collect from multiemployer plan administrators, small employers, and nonprofit employers;

3. the administrative fee the comptroller assesses on a per member per month basis to retain an independent actuarial firm required by the bill and ensure federal Employee Retirement Income Security Act (ERISA) compliance; and

4. a risk fund fee the comptroller assesses to pay claims that exceed premiums (see COMMENT).

An independent actuary must establish the premiums that satisfy these requirements.

Coverage Requirements (§ 2)

Under the bill, coverage provided by the comptroller (presumably under a new plan he establishes) must:

1. be available regardless of age, gender, health status, or any other predictive health care factor;

2. include the same health enhancement program (HEP) as is available under the state employee health insurance plan;

3. be consistent with value-based insurance design (i.e., a plan design that lowers or removes financial barriers to essential, high-value clinical services);

4. be approved by the Insurance Department and Health Care Cost Containment Committee in public meetings; and

5. cover all essential health benefits and state mandated health benefits (see BACKGROUND).

The plan must also enable participants and beneficiaries to access any assistance offered by the Office of the Healthcare Advocate (OHA) (see § 8 below).

Adverse Determination Reviews. The plan must also include a process for independent external reviews of adverse or final adverse determination reviews that is equivalent to the review process existing law requires for other health insurers.

Plan Administration (§ 2)

The comptroller must provide coverage for intervals of at least (1) three years for multiemployer plans and nonprofits with more than 50 employees and (2) one year for small employers. Plan administrators may apply to the comptroller for renewals any time before expiration.

Under the bill, the comptroller must develop procedures for multiemployer plan administrators, nonprofits, and small employers to apply for, renew, and withdraw from coverage, as well as any participation rules he deems necessary.

However, the bill cannot be construed to require the comptroller to offer coverage under the state plan or prevent the comptroller from:

1. procuring coverage for nonstate public employees from different vendors than those that service state employees or

2. offering a plan design or benefit coverage levels that differ from those offered to state employees, except that he is prohibited from offering a high deductible health plan.

Exclusivity. The bill requires plan administrators, if they choose to offer the comptroller's plan to their employees, to offer it to all their employees and to offer it exclusively (i.e., an administrator cannot

offer both the comptroller's plan and competing plan). However, the bill allows participants to offer separate plans to active employees and retirees.

Claim Tracking. The comptroller must establish accounting procedures to track claims and premium payments from participating multiemployer plans, nonprofit employers, and small employers.

Auditing and Compliance. Under the bill, the comptroller must retain an independent actuarial firm to set premium payments that conform to the bill's requirements and actuarial best practices.

Beginning November 1, 2022, the actuary must annually (1) examine the comptroller's books and records, including those of anyone providing services for the comptroller related to providing coverage under the bill, and (2) prepare a report based on the examination. The report must include:

1. the number of multiemployer plans, nonprofit employers, and small employers receiving coverage during the prior fiscal year;

2. the number of plan participants and beneficiaries covered for the prior fiscal year;

3. the aggregate premiums collected, claims paid, and administrative costs incurred for the prior fiscal year;

4. the most recent available medical loss ratio (MLR);

5. the balance of the accounts collecting premiums and paying claims at the beginning and end of the prior fiscal year;

6. a comparison of these amounts to what the actuary recommends as a reserve; and

7. the description and cost of each strategy the comptroller employed to mitigate the risk of the plan to state finances, along with any recommendations to improve or update the strategies (see COMMENT).

The actuarial firm must annually submit the report to the comptroller, the Office of Policy and Management, and the Appropriations and Insurance and Real Estate committees.

The bill requires the comptroller to also procure other necessary services, including services to ensure ERISA compliance.

Risk Mitigation and Stop-Loss. The bill requires the comptroller to make reasonable efforts to minimize any risk the plan poses to state finances (see COMMENT). In doing so, the bill requires him to at least (1) purchase aggregate stop-loss insurance on behalf of all plan participants (i.e., multiemployer plans, nonprofits, and small employers) or individual stop loss on each participant and (2) establish a risk fund to pay claims that exceed premiums, fund it through an assessment on plan participants, and adopt operating procedures.

Multiple Employer Welfare Arrangement. The bill deems that any coverage offered by the comptroller is not a multiple employer welfare arrangement (MEWA). (It appears that the federal, not state law, determines whether a plan fulfills the criteria to be defined as a MEWA.)

Health Insurance Report Card (§ 2)

Starting by October 15, 2021, the comptroller must annually prepare a report card in consultation with the Department of Public Health and Insurance Department commissioners. The report card must enable plan participants and administrators to compare the coverage offered by the comptroller to coverage offered on the private market to the same extent that the Consumer Report Card on Health Insurance Carriers in Connecticut permits similar comparisons. (By law, the consumer report card is an annual report issued by the insurance commissioner that contains certain comparative information on HMOs and the 15 largest health insurers that use provider networks in the state.)

The report card must be prominently displayed on the comptroller's website and disclose (1) the MLR for any fully insured coverage

provided under the bill, (2) the MLR for private group health coverage available to plan participants, and (3) any other information the comptroller deems relevant.

Provider Disruption Report (§ 2)

The bill allows a plan participant that applies for coverage to request a "provider disruption report" from the comptroller in a form and manner he prescribes. The comptroller must provide the report within 30 days. Neither the bill nor existing law define "provider disruption report."

Coverage Fee (§ 3)

By law, domestic insurers annually pay an insurance fund fee proportionate to their total net direct premiums sufficient to fund the insurance department, the OHA, and certain other programs (CGS § 38a-47 & -48). Starting with FY 22, the bill requires the comptroller to annually assess a fee on plan participants and administrators equivalent to the insurance fund fee the comptroller would pay for plan coverage if he were a domestic insurer offering fully insured group health coverage. (Because the comptroller's coverage under the bill is fully insured already, it appears that plan participants are assessed the fee twice (see COMMENT).)

Revenue from the fee must be deposited into the CT-HIE account, which the bill establishes (§ 13). (The bill requires funds in the CT-HIE account to be spent for specified purposes (§ 13) but establishes a separate fee to fully fund the amount needed for those purposes (§ 9(c)). It is therefore unclear how the money generated by this coverage fee may be spent under the bill.)

Similar to existing law's mechanisms for establishing the insurance fund fee, the bill requires the comptroller to annually provide each administrator or plan participant the proposed assessment amount and allow time for them to object. Beginning by July 15, 2021, he must annually consult with the insurance commissioner to determine the fee. He must provide the proposed amount to plan participants annually beginning by July 31 and assess it (after incorporating any

objections he feels appropriate) by September 1, and it must be paid in two equal installments by the following December 31 and March 31. The assessment may be appealed to the New Britain Superior Court in the same manner as the insurance fund fee may be appealed under existing law (CGS § 38a-52). If the fee is not paid on time, the comptroller must impose a $25 per day late fee and 6% annual interest.

Regulations (§§ 2 & 3)

The bill authorizes the commissioner to adopt implementing regulations for fully insured health insurance plans and the coverage fee.

Health and Welfare and Public Health Fees (§§ 5-7)

By law, the insurance department assesses domestic insurers for specific programs, including programs related to (1) childhood vaccinations and other treatments through the Health and Welfare Fee (CGS § 19a-7j) and (2) breast and cervical cancer detection and treatment, AIDS services, and syringe services through the Public Health Fee (CGS § 19a-7p). The bill requires the comptroller to pay these fees to the insurance commissioner on behalf of plan participants. It makes corresponding changes (1) requiring the comptroller to report to the insurance commissioner, in a form and manner he prescribes, the number of plan participants and beneficiaries as of the prior May 1 (data that is used to calculate the fee) and (2) incorporating the comptroller into certain existing statutes governing these fees. Among other things, this allows plan administrators and employers covered under the plan to appeal the fee to the New Britain Superior Court (CGS § 38a-52) and be eligible for a refund if they overpaid it.

In a fully insured plan, as required under the bill, these fees are already assessed on health insurers providing the plan. Thus, these fees appear to be in addition to fees assessed under existing law (see COMMENT).

Assistance from the Office of the Healthcare Advocate (§ 8)

The bill requires OHA to assist plan participants and beneficiaries to

the same extent it would assist health insurance consumers.

§§ 9-13, 15 & 16 — OHS PLAN AND CT-HIE ACCOUNT SPENDING

OHS Plan for the Exchange (§ 16)

The bill requires OHS, in consultation with the exchange, to develop a plan for the exchange to:

1. establish a subsidiary to create a marketplace for health carriers to offer affordable health insurance coverage to people who are ineligible for QHPs;

2. seek, and, if granted, implement a state innovation waiver under Section 1332 of the federal Affordable Care Act to (a) reduce health insurance costs, including premiums and cost-sharing, and (b) make health insurance coverage available to those who are ineligible for QHPs; and

3. beginning with the 2022 plan year, use money deposited in the CT-HIE account for specified purposes described below.

Legislative Approval (§ 16(d))

OHS must report the plan to the Insurance and Real Estate Committee by August 1, 2021. By October 1, 2021, the committee must approve or reject the plan and advise OHS and the exchange of its decision. If the committee does not act by October 1, 2021, the plan is deemed rejected.

Exchange Subsidiary (§ 11)

Subject to the Insurance and Real Estate Committee's approval of OHS's plan, the bill requires the exchange to establish a subsidiary by November 1, 2021, to create a health insurance marketplace for individuals who are not eligible for QHPs through the exchange (e.g., people who are undocumented).

Existing law allows the exchange to create subsidiaries, which, once established, are quasi-public agencies for tax purposes and generally have the exchange's powers and privileges (CGS § 38a-1093).

CT-HIE Account Purposes (§§ 13 & 16(b))

The bill requires the exchange to administer the CT-HIE account and consult with OHS to reduce insurance premiums and establish a reinsurance program. The bill requires OHS's plan to provide for the exchange to use money in the CT-HIE account to do the following, beginning in the 2022 plan year:

1. make coverage affordable for people ineligible for QHPs by, among other things, providing up to $25 million annually for premium and cost-sharing subsidies;

2. implement, if federally approved, the state innovation waiver; and

3. reduce the cost of QHPs.

Specifically, account funds must be used to reduce the cost of QHPs by, among other things, (1) reducing premiums and cost-sharing for households at or above 201% of FPL, (2) eliminating premiums for households with income below that level, and (3) establishing a reinsurance program using up to $20 million in the account annually.

CT-HIE Account Funding Determination (§ 9(b))

Starting July 1, 2022, and subject to legislative approval of OHS's plan, the bill requires OHS to annually determine an amount, up to $50 million, that the exchange requires to complete its duties described above and report it to the insurance commissioner. The bill requires OHS by July 1, 2021, to report the amount for 2022 as $50 million (making the initial aggregate assessment $50 million).

CT-HIE Account Fee Amount (§ 9(c))

Under the bill, the amount that OHS determines above is funded through a fee on health insurers. The bill requires the insurance commissioner to assess insurers and HMOs doing business in Connecticut, including exempt insurers, a fee proportionate to their covered lives sufficient to fully meet the exchange's budgetary needs described above (up to the aggregate $50 million cap). (Under the bill and existing law, an "exempt insurer" is an insurer acting in its

capacity as a third-party administrator.) This money is deposited into the CT-HIE account. (Presumably, if the Insurance and Real Estate Committee rejects OHS's plan for the exchange to spend money in the account for the purposes described above, the commissioner will not assess the fee.)

Beginning July 1, 2021, each insurer, HMO, and exempt insurer must annually report to the commissioner the number of enrolled or insured lives in the state covered by certain health insurance plans as of the preceding May 1. The number must not include any individuals covered by insurance sold in the small group market, Medicare, any DSS medical assistance program, Medicare Part C plans, or workers' compensation insurance. The reporting must be in a form and manner the commissioner prescribes and applies to health insurance policies (including self-insured plans) delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

The commissioner must determine the fee annually, beginning by August 1, 2021, based on the amount of covered lives reported to him in July and the amount that OHS determines the exchange needs. Annually, also by August 1, the commissioner must inform insurers, health care centers (i.e., HMOs), and exempt insurers of the proposed fee. These entities must pay the fee by November 1 of that year.

Insurers failing to file the report or pay the fee must pay a late filing fee of $100 per day to be deposited into the CT-HIE account.

The bill authorizes the commissioner to require insurers to produce any supporting documents used to prepare the report. If he determines there exists anything other than a good faith discrepancy between the actual and reported numbers of covered lives, he must impose a civil penalty of up to $15,000 per report.

Grievances and Overpayments. Any aggrieved insurer may appeal the assessment in the same manner that existing law allows them to do

so for other insurance assessments. This includes appealing the assessment to the New Britain Superior Court (CGS § 38a-52).

The bill requires the commissioner to apply an overpayment of the fee as a credit against the next year's fee, so long as (1) the overpayment is more than $5,000 and (2) by April 1 of that year, the insurer, HMO, or exempt insurer notifies the commissioner of the overpayment amount and provides supporting evidence.

Within 90 days of receiving the notice and evidence, the commissioner must determine whether an overpayment occurred and notify the payor.

If an insurer fails to notify the commissioner within this timeframe, they waive their right to an overpayment refund.

Retaliatory Taxes (§ 9(d))

The bill establishes circumstances under which nondomestic insurers (i.e., insurers domiciled outside of Connecticut) may be exempt from the assessment. Under the bill, if another jurisdiction imposes a retaliatory fee on a Connecticut-domiciled insurer, fraternal benefit society, hospital or medical service corporation, HMO, or other entity, it may appeal to the Connecticut insurance commissioner within 60 days for a verification that the assessment is causing a retaliatory fee. If the commissioner verifies that the fee is retaliatory, he must exempt nondomestic insurers and nondomestic exempt insurers from the assessment.

These decisions can be appealed in the same manner as assessments under existing law as described above.

Regulations (§ 9(e))

The bill authorizes the commissioner to adopt implementing regulations for the bill's provisions on the CT-HIE fee.

Exchange Reporting (§ 12)

The exchange's chief executive officer must, beginning by January 1, 2023, annually report to the Appropriations, Human Services, and

Insurance and Real Estate committees on how funds in the CT-HIE account were spent and whether the funding was sufficient to (1) reduce the costs of QHPs, (2) make coverage affordable and available for people ineligible for QHPs, and (3) implement the state innovation waiver.

§§ 2, 11, 12 & 15 — DEMOGRAPHIC DATA REPORTING

The bill establishes demographic data collection procedures and requires OHS to establish standardized categories for this purpose. These procedures must (1) include self-reported ethnic and racial data, (2) use standardized categories developed by OHS, and (3) include an "other" category for individuals to self-identify, allowing individuals to select multiple ethnicities or races or provide their own.

For the fully insured plan required under the bill, the comptroller must establish these procedures to collect participants' and beneficiaries' demographic data. Starting by November 1, 2022, the comptroller must annually submit a report containing aggregate data collected the previous year to the Insurance and Real Estate Committee.

Similarly, if the exchange establishes a subsidiary to create a marketplace for health carriers to offer affordable health insurance coverage to people who are ineligible for QHPs as authorized under the bill, then the subsidiary must require each health carrier offering coverage through it to (1) collect demographic data to the same extent as described above and (2) report aggregate demographic data to the subsidiary annually, beginning by February 1, 2022.

The bill also requires the subsidiary to annually report this aggregate demographic data to the exchange annually, beginning by March 1, 2022.

If the exchange uses CT-HIE funds to establish premium and cost sharing subsidies, then the exchange must collect demographic data for subsidy recipients, at least annually, in the manner described above. Beginning by April 1, 2022, the exchange's chief executive

officer must annually report to the Insurance and Real Estate Committee aggregate demographic data it collects as well as the aggregate demographic data the subsidiary reports to the exchange.

§§ 11 & 18 — UNEMPLOYMENT REFERRALS

The bill requires the Department of Labor, within available appropriations, to notify people applying for unemployment assistance of their potential eligibility for health care subsidies or other assistance and refer them to the exchange. Under the bill, the exchange must determine their eligibility for free or subsidized health coverage and other assistance, including supplemental nutrition assistance (SNAP), and, if individuals are eligible, enroll them. (It is unclear whether the exchange can process a SNAP application).

§ 14 — QHPS OFFERED THROUGH ACCESS HEALTH CT

To the extent federal law allows, and regardless of any other state law, the bill expands the minimum coverage for individual market, silver-level QHPs. Beginning with the 2022 plan year, these plans must cover:

1. angiotensin converting enzyme inhibitors for individuals diagnosed with congestive heart failure, diabetes, or coronary artery disease;

2. anti-resorptive therapy for individuals diagnosed with osteoporosis or osteopenia;

3. beta-adrenergic blocking agents for individuals diagnosed with congestive heart failure or coronary artery disease;

4. blood pressure monitors for individuals diagnosed with hypertension;

5. inhaled corticosteroids and peak flow meters for individuals diagnosed with asthma;

6. insulin and other glucose lowering agents, retinopathy screening, glucometers and hemoglobin A1C testing for

diabetics;

7. international normalized ratio testing for individuals diagnosed with liver disease or a bleeding disorder;

8. low density lipoprotein testing for individuals diagnosed with heart disease;

9. selective serotonin reuptake inhibitors for individuals diagnosed with depression; and

10. statins for individuals diagnosed with heart disease or diabetes.

To the extent permitted by federal law and regardless of any other state law, the bill also requires these plans to have a minimum actuarial value of 70% and provide insureds with the broadest provider network available under QHPs offered by the carrier.

§ 16 — MEDICAID DEMONSTRATION PROJECT WAIVER

The bill requires OHS to consult with DSS and the exchange to determine whether Connecticut should seek a federal Medicaid demonstration project waiver to reduce costs to moderate- and low-income families. If OHS determines the state should proceed, it may submit a report to the Appropriations, Human Services, and Insurance and Real Estate committees disclosing its determination and reasons. The bill does not establish a deadline for OHS to make its determination or submit its report. Under existing law, DSS must generally submit Medicaid waiver applications to the Appropriations and Human Services committees for approval (CGS § 17b-8).

§ 17 — EXPANDING HUSKY A

By law, DSS provides Medicaid coverage to children under age 19 and their parents or caretaker relatives through HUSKY A. The bill expands HUSKY A eligibility by raising the income limit for parents and caretaker relatives from 155% of FPL to 201% of FPL.

BACKGROUND

Related Bills

SB 956 (File 516), favorably reported by the Human Services Committee, requires DSS to provide medical assistance to people regardless of immigration status so long as they otherwise meet income limit requirements.

sSB 1056 (File 521), favorably reported by the Human Services Committee, generally increases the income limit for Medicaid to 200% of FPL.

sSB 1090 (File 526), favorably reported by the Human Services Committee, establishes a commission to study a single payer, universal health care program.

ERISA

ERISA generally governs employee insurance and pension plans ("employee welfare plans") but does not apply to governmental plans (29 U.S.C. § 1003). As a result, opening up the state health insurance plan to private employers may impact this exemption.

A plan subject to ERISA requirements must, among other things:

1. manage plans for the exclusive benefit of participants and beneficiaries;

2. comply with limitations on certain plans' investments in employer securities and properties; and

3. report and disclose information on the operations and financial condition of plans to the government and participants.

Essential Health Benefits and Mandated Benefits

Under state and federal law, "essential health benefits" are health care services and benefits that fall within the following categories:

1. ambulatory patient services;

2. emergency services;

3. hospitalization;

4. maternity and newborn health care;

5. mental health and substance use disorder services, including behavioral health treatment;

6. prescription drugs;

7. rehabilitative and habilitative services and devices;

8. laboratory services;

9. preventive and wellness services and chronic disease management; and

10. pediatric services, including oral and vision care.

In addition to essential health benefits, the state mandates that fully insured plans cover a range of health services ("health insurance benefit mandates"). These benefits include services such as diabetes screening, drugs and devices, and breast cancer screening.

COMMENT

The bill has conflicting provisions regarding the nature of the health insurance plan the comptroller must establish. It requires the comptroller to develop a fully insured group health insurance plan, which is generally one in which a health insurance carrier provides insurance and the insured party (i.e., the state under this bill) pays premiums for the coverage. However, the bill requires the comptroller to perform a number of duties that would generally be performed by the insurance carrier for a fully insured plan, including, for example, establishing a risk-fund and an associated fee to pay claims above premiums (§ 2); establishing and collecting premiums (§ 2); and assessing the Health and Welfare and Public Health fees (§§ 5-7). Additionally, the bill requires the comptroller to purchase stop-loss insurance (§ 2), but fully-insured policy holders do not typically do so.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute Change of Reference - FIN
Yea 12 Nay 6 (03/11/2021)

Finance, Revenue and Bonding Committee

Joint Favorable
Yea 31 Nay 17 (04/22/2021)