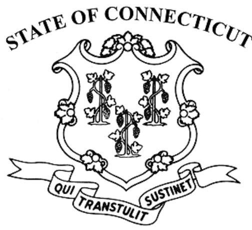

Senate

General Assembly

File No. 640

January Session, 2021

Substitute Senate Bill No. 842

Senate, May 10, 2021

The Committee on Finance, Revenue and Bonding reported through SEN. FONFARA of the 1st Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

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

1 Section 1. Section 3-123rrr of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2021*):

3 As used in this section, [and] sections 3-123sss to 3-123vvv, inclusive,
4 [and] section 3-123xxx, and sections 2 and 3 of this act:

5 (1) "Health Care Cost Containment Committee" means the committee
6 established in accordance with the ratified agreement between the state
7 and the State Employees Bargaining Agent Coalition pursuant to
8 subsection (f) of section 5-278.

9 (2) "Health enhancement program" means the program established in
10 accordance with the provisions of the Revised State Employees
11 Bargaining Agent Coalition agreement, approved by the General
12 Assembly on August 22, 2011, for state employees, as may be amended

13 by stipulated agreements.

14 (3) "Multiemployer plan" has the same meaning as provided in
15 Section 3 of the Employee Retirement Income Security Act of 1974, as
16 amended from time to time.

17 [(2)] (4) "Nonstate public employee" means any employee or elected
18 officer of a nonstate public employer.

19 [(3)] (5) "Nonstate public employer" means a municipality or other
20 political subdivision of the state, including a board of education, quasi-
21 public agency or public library. A municipality and a board of education
22 may be considered separate employers.

23 (6) "Nonprofit employer" means a nonprofit, nonstock corporation,
24 other than a nonstate public employer, that employs at least one
25 employee on the first day that such employer receives coverage under a
26 group hospitalization, medical, pharmacy and surgical insurance plan
27 offered by the Comptroller pursuant to this part.

28 (7) "Small employer" means an employer, other than a nonstate public
29 employer, that employed an average of at least one but not more than
30 fifty employees on business days during the preceding calendar year,
31 and employs at least one employee on the first day that such employer
32 receives coverage under a group hospitalization, medical, pharmacy
33 and surgical insurance plan offered by the Comptroller pursuant to this
34 part.

35 [(4)] (8) "State employee plan" means the group hospitalization,
36 medical, pharmacy and surgical insurance plan offered to state
37 employees and retirees pursuant to section 5-259.

38 [(5) "Health enhancement program" means the program established
39 in accordance with the provisions of the Revised State Employees
40 Bargaining Agent Coalition agreement, approved by the General
41 Assembly on August 22, 2011, for state employees, as may be amended
42 by stipulated agreements.]

43 **[**(6)**]** (9) "Value-based insurance design" means health benefit designs
44 that lower or remove financial barriers to essential, high-value clinical
45 services.

46 **[**(7) "Health care coverage type" means the type of health care
47 coverage offered by nonstate public employers, including, but not
48 limited to, coverage for a nonstate public employee, nonstate public
49 employee plus spouse and nonstate public employee plus family.**]**

50 Sec. 2. (NEW) (*Effective July 1, 2021*) (a) The Comptroller shall offer to
51 plan participants and beneficiaries in this state under a multiemployer
52 plan, nonprofit employers in this state, their employees and their
53 employees' dependents and small employers in this state, their
54 employees and their employees' dependents coverage under a fully
55 insured group hospitalization, medical, pharmacy and surgical
56 insurance plan developed by the Comptroller to provide coverage for
57 such plan participants, beneficiaries, employers, employees and
58 dependents. Except as otherwise provided in this section, coverage
59 offered by the Comptroller pursuant to this section shall comply with
60 all applicable provisions of title 38a of the general statutes. The
61 administrators of multiemployer plans, nonprofit employers and small
62 employers shall remit to the Comptroller payments for coverage
63 provided pursuant to this section. Such payments shall be equal to the
64 payments paid by the state for state employees covered under the state
65 employee plan, inclusive of any premiums paid by state employees
66 pursuant to the state employee plan, except:

67 (1) Premium payments may be adjusted to reflect:

68 (A) Age, in accordance with a uniform age rating curve that satisfies
69 the requirements established under the Patient Protection and
70 Affordable Care Act, P.L. 111-148, as amended from time to time, and
71 regulations adopted thereunder;

72 (B) Geographic area;

73 (C) Family size, provided premium payments for family coverage

74 shall not exceed the lesser of:

75 (i) The sum of the premium payments for all covered family
76 members; or

77 (ii) The sum of the premium payments for all covered family
78 members who are twenty-one years of age or older and the eldest three
79 covered dependents who are younger than twenty-one years of age;

80 (D) Actuarially justified differences in:

81 (i) Plan design;

82 (ii) A plan's health care provider network; or

83 (iii) Administrative costs that can be reasonably attributed to a plan;
84 and

85 (E) The actual performance of a multiemployer plan, nonprofit
86 employer or small employer receiving coverage provided by the
87 Comptroller pursuant to this section, provided such adjustment shall
88 not cause the premiums charged for such multiemployer plan, nonprofit
89 employer or small employer to increase or decrease by an amount that
90 is greater than three per cent of the premiums that would otherwise be
91 charged for such multiemployer plan, nonprofit employer or small
92 employer under this subdivision;

93 (2) Such payments shall be adjusted to include:

94 (A) The fee assessed by the Comptroller against multiemployer plans,
95 nonprofit employers and small employers pursuant to section 3 of this
96 act;

97 (B) The health and welfare fee assessed by the Insurance
98 Commissioner against multiemployer plans, nonprofit employers and
99 small employers pursuant to section 19a-7j of the general statutes, as
100 amended by this act, which the Comptroller shall annually collect from
101 the administrators of multiemployer plans, nonprofit employers and
102 small employers, and pay to the Insurance Commissioner, pursuant to

103 section 19a-7j of the general statutes, as amended by this act;

104 (C) The public health fee assessed by the Insurance Commissioner
105 against multiemployer plans, nonprofit employers and small employers
106 pursuant to section 19a-7p of the general statutes, as amended by this
107 act, which the Comptroller shall annually collect from the
108 administrators of multiemployer plans, nonprofit employers and small
109 employers, and pay to the Insurance Commissioner, pursuant to section
110 19a-7p of the general statutes, as amended by this act;

111 (D) The administrative fee assessed by the Comptroller pursuant to
112 subdivision (4) of subsection (c) of this section; and

113 (E) Any risk fund fee assessed by the Comptroller pursuant to
114 subdivision (2) of subsection (d) of this section; and

115 (3) Such payments may be adjusted to include a general
116 administrative fee assessed by the Comptroller against multiemployer
117 plans, nonprofit employers and small employers receiving coverage
118 provided by the Comptroller pursuant to this section which, if assessed,
119 shall be calculated on a per member, per month basis and may include
120 brokers' fees.

121 (b) (1) The coverage provided by the Comptroller pursuant to this
122 section shall:

123 (A) Be available to all plan participants and beneficiaries in this state
124 under a multiemployer plan, nonprofit employers in this state, their
125 employees and their employees' dependents and small employers in
126 this state, their employees and their employees' dependents regardless
127 of age, gender, health status or any other factor that might be predictive
128 of health care service usage;

129 (B) Include the health enhancement program;

130 (C) Be consistent with value-based insurance design principles;

131 (D) Be approved by the Insurance Department and Health Care Cost

132 Containment Committee during public meetings of the Insurance
133 Department and Health Care Cost Containment Committee;

134 (E) Include coverage for:

135 (i) All health care services and benefits that each group health
136 insurance policy providing coverage of the types specified in
137 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
138 statutes delivered, issued for delivery, renewed, amended or continued
139 in this state is required to cover under chapter 700c of the general
140 statutes; and

141 (ii) All health care services and benefits that are essential health
142 benefits, as defined in the Patient Protection and Affordable Care Act,
143 P.L. 111-148, as amended from time to time, and regulations adopted
144 thereunder;

145 (F) Include a process that enables entities that conduct independent
146 external reviews of adverse determinations and final adverse
147 determinations, as both terms are defined in section 38a-591a of the
148 general statutes, to review determinations made for benefits covered
149 pursuant to this section that are equivalent to adverse determinations
150 and final adverse determinations; and

151 (G) Enable plan participants and beneficiaries in this state under a
152 multiemployer plan, nonprofit employers in this state, their employees
153 and their employees' dependents and small employers in this state, their
154 employees and their employees' dependents receiving coverage
155 provided by the Comptroller pursuant to this section to access
156 assistance offered by the Office of the Healthcare Advocate under
157 section 38a-1041 of the general statutes, as amended by this act.

158 (2) (A) The Comptroller shall provide coverage pursuant to this
159 section for intervals lasting not less than:

160 (i) Three years for:

161 (I) Multiemployer plans; and

162 (II) Nonprofit employers that are not small employers; or

163 (ii) One year for small employers.

164 (B) The administrator of each multiemployer plan, nonprofit
165 employer or small employer receiving coverage provided by the
166 Comptroller pursuant to this section may apply to renew such coverage
167 before the interval applicable to such multiemployer plan, nonprofit
168 employer or small employer under subparagraph (A) of this subdivision
169 expires.

170 (3) The Comptroller shall require each administrator of a
171 multiemployer plan, nonprofit employer in this state and small
172 employer in this state receiving coverage provided by the Comptroller
173 pursuant to this section to offer such coverage to all of such
174 multiemployer plan's participants and beneficiaries in this state,
175 nonprofit employer's employees and their employees' dependents and
176 small employer's employees and their employees' dependents who are
177 eligible for health coverage. The administrator of such multiemployer
178 plan, nonprofit employer or small employer shall not offer coverage
179 under this section in addition to, or in conjunction with, any other health
180 coverage option, except active employees and retirees may be treated as
181 independent groups for the purposes of this subdivision.

182 (c) (1) The Comptroller shall develop and establish:

183 (A) Procedures by which the administrator of a multiemployer plan,
184 nonprofit employer or small employer may initially apply for, renew
185 and withdraw from coverage provided by the Comptroller pursuant to
186 this section;

187 (B) Rules of participation that the Comptroller, in the Comptroller's
188 discretion, deems necessary;

189 (C) Accounting procedures to track the premium payments paid by,
190 and claims paid for, multiemployer plans, nonprofit employers and
191 small employers receiving coverage provided by the Comptroller
192 pursuant to this section; and

193 (D) Procedures to collect demographic data, including, but not
194 limited to, self-reported ethnic and racial data, concerning the plan
195 participants and beneficiaries in this state under a multiemployer plan,
196 nonprofit employers in this state, their employees and their employees'
197 dependents and small employers in this state, their employees and their
198 employees' dependents receiving coverage provided by the
199 Comptroller pursuant to this section. Such procedures shall, at a
200 minimum, utilize standardized categories developed by the Office of
201 Health Strategy pursuant to subdivision (9) of subsection (b) of section
202 19a-754a of the general statutes, as amended by this act, include an
203 "other" category and allow an individual who is self-reporting ethnic or
204 racial data to write in such individual's ethnicity or race, and select
205 multiple ethnicities and races, on any form provided by the Comptroller
206 to collect such ethnic or racial data. Not later than November 1, 2022,
207 and annually thereafter, the Comptroller shall submit a report to the
208 joint standing committee of the General Assembly having cognizance of
209 matters relating to insurance, in accordance with the provisions of
210 section 11-4a of the general statutes, disclosing, in the aggregate, the
211 demographic data collected using the procedures developed and
212 established by the Comptroller pursuant to this subparagraph during
213 the immediately preceding fiscal year.

214 (2) The Comptroller shall:

215 (A) Retain an independent actuarial firm to:

216 (i) Set premium payments for coverage provided by the Comptroller
217 pursuant to this section that satisfy the requirements established in this
218 section and actuarial best practices; and

219 (ii) Not later than November 1, 2022, and annually thereafter,
220 examine the books and records maintained by the Comptroller in
221 providing coverage pursuant to this section, and any person engaged
222 by the Comptroller to provide services to the Comptroller in connection
223 with providing such coverage, and prepare a report concerning such
224 examination, which shall disclose:

225 (I) The number of multiemployer plans, nonprofit employers and
226 small employers that received coverage provided by the Comptroller
227 pursuant to this section during the immediately preceding fiscal year;

228 (II) The number of multiemployer plan participants and beneficiaries
229 in this state, nonprofit employers' employees and their employees'
230 dependents and small employers' employees and their employees'
231 dependents who received coverage provided by the Comptroller
232 pursuant to this section during the immediately preceding fiscal year;

233 (III) The aggregate amount of premiums collected, claims paid and
234 administrative costs incurred by the Comptroller in providing coverage
235 pursuant to this section for the immediately preceding fiscal year;

236 (IV) The most recent medical loss ratio available for coverage
237 provided by the Comptroller pursuant to this section;

238 (V) The balance of the account in which the Comptroller deposited
239 premiums, and from which the Comptroller paid claims, for coverage
240 provided by the Comptroller pursuant to this section at the beginning
241 and the end of the immediately preceding fiscal year, and a comparison
242 of such balance to the amount that the independent actuarial firm
243 recommends that the Comptroller maintain as a reserve for such
244 coverage;

245 (VI) A description, and the cost, of each risk mitigation strategy that
246 the Comptroller employed for the immediately preceding fiscal year to
247 minimize the risk that coverage provided by the Comptroller pursuant
248 to this section for such fiscal year poses to this state's finances; and

249 (VII) The independent actuarial firm's recommendations, if any, to
250 improve or update the risk mitigation strategies employed by the
251 Comptroller to minimize the risk that coverage provided by the
252 Comptroller pursuant to this section poses to this state's finances; and

253 (B) Such services, including, but not limited to, any services to ensure
254 compliance with the Employee Retirement Income Security Act of 1974,
255 as amended from time to time, and regulations adopted thereunder, that

256 the Comptroller deems necessary to administer coverage provided by
257 the Comptroller pursuant to this section.

258 (3) The independent actuarial firm retained by the Comptroller
259 pursuant to subparagraph (A) of subdivision (2) of this subsection shall,
260 not later than November 1, 2022, and annually thereafter, submit the
261 report that the independent actuarial firm prepared pursuant to
262 subparagraph (A)(ii) of subdivision (2) of this subsection for the
263 immediately preceding fiscal year to the Comptroller and the Office of
264 Policy and Management and to the joint standing committees of the
265 General Assembly having cognizance of matters relating to
266 appropriations and insurance in accordance with the provisions of
267 section 11-4a of the general statutes.

268 (4) The Comptroller shall assess an administrative fee on a per
269 member, per month basis against the multiemployer plans, nonprofit
270 employers and small employers receiving coverage provided by the
271 Comptroller pursuant to this section to recover the cost of the services
272 described in subdivisions (2) and (3) of this subsection.

273 (d) The Comptroller shall make reasonable efforts to minimize the
274 risk that coverage provided by the Comptroller pursuant to this section
275 poses to this state's finances. In making such reasonable efforts, the
276 Comptroller shall, at a minimum:

277 (1) Purchase:

278 (A) An aggregate stop-loss insurance policy for all multiemployer
279 plans, nonprofit employers and small employers receiving coverage
280 provided by the Comptroller pursuant to this section; or

281 (B) A stop-loss insurance policy for each individual multiemployer
282 plan, nonprofit employer or small employer receiving coverage
283 provided by the Comptroller pursuant to this section; and

284 (2) Establish a risk fund to pay claims that exceed the premiums
285 collected for a multiemployer plan, nonprofit employer or small
286 employer receiving coverage provided by the Comptroller pursuant to

287 this section, fund such risk fund through a risk fund fee assessed by the
288 Comptroller against such multiemployer plan, nonprofit employer or
289 small employer and establish operating procedures for use of such fund.

290 (e) (1) Not later than October 15, 2021, and annually thereafter, the
291 Comptroller shall prepare, in consultation with the Commissioner of
292 Public Health and the Insurance Commissioner, a report card for the
293 coverage offered by the Comptroller pursuant to this section. The report
294 card shall enable the administrators of multiemployer plans, nonprofit
295 employers and small employers that are eligible for the coverage offered
296 by the Comptroller pursuant to this section to compare such coverage
297 to private group health coverage that is available to such multiemployer
298 plans, nonprofit employers and small employers in this state to the same
299 extent that the consumer report card developed and distributed by the
300 Insurance Commissioner pursuant to section 38a-478*l* of the general
301 statutes permits consumer comparison across managed care
302 organizations.

303 (2) Each report card prepared by the Comptroller pursuant to
304 subdivision (1) of this subsection shall disclose:

305 (A) The medical loss ratio for the fully insured group hospitalization,
306 medical, pharmacy and surgical insurance plan developed and offered
307 by the Comptroller pursuant to this section;

308 (B) The medical loss ratio for private group health coverage that is
309 available to the multiemployer plans, nonprofit employers and small
310 employers that are eligible for the coverage offered by the Comptroller
311 pursuant to this section; and

312 (C) Any other information that the Comptroller deems relevant for
313 the purposes of this subsection.

314 (3) The Comptroller shall prominently display a link to each report
315 card prepared pursuant to subdivision (1) of this subsection on the
316 Comptroller's Internet web site.

317 (f) Any administrator of a multiemployer plan, nonprofit employer

318 or small employer that files an application with the Comptroller for the
319 coverage offered by the Comptroller pursuant to this section may
320 submit a request to the Comptroller, in a form and manner prescribed
321 by the Comptroller, for a provider disruption report. The Comptroller
322 shall provide the provider disruption report to such administrator,
323 nonprofit employer or small employer not later than thirty days after
324 such administrator, nonprofit employer or small employer submits such
325 request to the Comptroller.

326 (g) (1) Nothing in this section shall be construed to preclude the
327 Comptroller from:

328 (A) Procuring coverage for nonstate public employees from vendors
329 other than the vendors providing coverage to state employees; or

330 (B) Offering plan designs or benefit coverage levels pursuant to this
331 section that differ from the plan designs and benefit coverage levels
332 offered to state employees, provided the Comptroller shall not offer any
333 coverage pursuant to this section that imposes a deductible that is equal
334 to or greater than the minimum deductible required by the Internal
335 Revenue Service for such coverage to qualify as a high deductible health
336 plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal
337 Revenue Code of 1986, or any subsequent corresponding internal
338 revenue code of the United States, as amended from time to time.

339 (2) No coverage offered by the Comptroller pursuant to this section
340 shall be deemed to constitute a multiple employer welfare arrangement,
341 as defined in Section 3 of the Employee Retirement Income Security Act
342 of 1974, as amended from time to time.

343 (h) The Comptroller may adopt regulations, in accordance with
344 chapter 54 of the general statutes, to carry out the purposes of this
345 section.

346 Sec. 3. (NEW) (*Effective July 1, 2021*) (a) For each fiscal year beginning
347 on or after July 1, 2021, the Comptroller shall assess a fee against all
348 multiemployer plans, nonprofit employers and small employers

349 receiving coverage provided by the Comptroller pursuant to section 2
350 of this act, and the administrator of each such multiemployer plan and
351 each such nonprofit employer and small employer shall pay such
352 assessment to the Comptroller pursuant to this section for deposit in the
353 Connecticut Health Insurance Exchange account established under
354 section 13 of this act.

355 (b) Not later than July 15, 2021, and annually thereafter, the
356 Comptroller shall consult with the Insurance Commissioner to
357 determine the aggregate amount of the assessments due from the
358 multiemployer plans, nonprofit employers and small employers
359 receiving coverage provided by the Comptroller pursuant to section 2
360 of this act for the then current fiscal year. The aggregate amount of
361 assessments due for any fiscal year shall be equal to the amount that
362 would be due from the Comptroller for such fiscal year if the
363 Comptroller were a domestic insurance company under sections 38a-47
364 and 38a-48 of the general statutes during such fiscal year.

365 (c) Not later than July 31, 2021, and annually thereafter, the
366 Comptroller shall render to the administrator of each multiemployer
367 plan and each nonprofit employer and small employer that is liable for
368 the fee assessed by the Comptroller pursuant to subsection (a) of this
369 section the proposed assessment against such multiemployer plan,
370 nonprofit employer or small employer in the amount described in
371 subsection (b) of this section.

372 (d) On or before September first, annually, for each fiscal year
373 beginning on or after July 1, 2021, the Comptroller, after receiving any
374 objections to the proposed assessments made by the Comptroller
375 pursuant to this section and making such adjustments as in the
376 Comptroller's opinion may be indicated, shall assess against each
377 multiemployer plan, nonprofit employer or small employer an amount
378 equal to the proposed assessment as so adjusted. The administrator of
379 each multiemployer plan and each such nonprofit employer and small
380 employer shall pay to the Comptroller, on or before the following
381 December thirty-first and March thirty-first, annually, the proposed

382 assessment due from such multiemployer plan, nonprofit employer or
383 small employer in two equal installments.

384 (e) The administrator of any multiemployer plan, nonprofit employer
385 or small employer aggrieved because of a fee assessed by the
386 Comptroller pursuant to this section may appeal therefrom in
387 accordance with the provisions of section 38a-52 of the general statutes,
388 as amended by this act.

389 (f) If the administrator of a multiemployer plan, or a nonprofit
390 employer or small employer, that is liable for the fee assessed by the
391 Comptroller pursuant to this section fails to pay an assessment when
392 due under this section, the Comptroller shall add a penalty of twenty-
393 five dollars to such fee, and interest at the rate of six per cent per annum
394 shall be paid thereafter on such assessment and penalty, until such
395 assessment and penalty are paid.

396 (g) The Comptroller shall deposit all payments made pursuant to this
397 section in the Connecticut Health Insurance Exchange account
398 established under section 13 of this act.

399 (h) The Comptroller may adopt regulations, in accordance with
400 chapter 54 of the general statutes, to carry out the purposes of this
401 section.

402 Sec. 4. (NEW) (*Effective July 1, 2021*) (a) As used in this section:

403 (1) "Nonprofit employer" has the same meaning as provided in
404 section 3-123aaa of the general statutes;

405 (2) "Nonstate public employee" has the same meaning as provided in
406 sections 3-123aaa and 3-123rrr of the general statutes, as amended by
407 this act;

408 (3) "Nonstate public employer" has the same meaning as provided in
409 sections 3-123aaa and 3-123rrr of the general statutes, as amended by
410 this act;

411 (4) "Partnership plan" means (A) a health care benefit plan offered by
412 the Comptroller to (i) nonstate public employers or nonprofit employers
413 pursuant to section 3-123bbb of the general statutes, (ii) graduate
414 assistants at The University of Connecticut and The University of
415 Connecticut Health Center, (iii) postdoctoral trainees at The University
416 of Connecticut and The University of Connecticut Health Center, (iv)
417 graduate fellows at The University of Connecticut and The University
418 of Connecticut Health Center, and (v) graduate students of The
419 University of Connecticut participating in university-funded
420 internships as part of their graduate program, and (B) a group
421 hospitalization, medical, pharmacy and surgical insurance plan
422 developed by the Comptroller pursuant to (i) subsection (a) of section 3-
423 123sss of the general statutes, or (ii) section 2 of this act;

424 (5) "State employee plan" means the group hospitalization, medical,
425 pharmacy and surgical insurance plan offered to (A) state employees
426 and retirees pursuant to section 5-259 of the general statutes, and (B)
427 nonstate public employers, their nonstate public employees and, if
428 applicable, their retirees if the Comptroller offers coverage under such
429 plan to nonstate public employers, their nonstate public employees and,
430 if applicable, retirees under sections 3-123rrr to 3-123www, inclusive, of
431 the general statutes, as amended by this act; and

432 (6) "Third-party administrator" means any person who directly or
433 indirectly underwrites, collects premiums or charges from, or adjusts or
434 settles claims on, residents of this state in connection with health
435 coverage offered or provided by the Comptroller.

436 (b) Beginning on July 1, 2021, the Auditors of Public Accounts shall
437 audit the books and accounts of the State Comptroller, and any third-
438 party administrator engaged by the State Comptroller, maintained for
439 the partnership plan or plans or the state employee plan and certify the
440 results to the Governor.

441 Sec. 5. Section 19a-7j of the general statutes is repealed and the
442 following is substituted in lieu thereof (*Effective July 1, 2021*):

443 (a) As used in this section:

444 (1) "Exempt insurer" means a domestic insurer that administers self-
445 insured health benefit plans and is exempt from third-party
446 administrator licensure under subparagraph (C) of subdivision (11) of
447 section 38a-720 and section 38a-720a;

448 (2) "Health insurance" means health insurance providing coverage of
449 the types specified in subdivisions (1), (2), (4), (11) and (12) of section
450 38a-469;

451 (3) "Multiemployer plan" has the same meaning as provided in
452 Section 3 of the Employee Retirement Income Security Act of 1974, as
453 amended from time to time;

454 (4) "Nonprofit employer" has the same meaning as provided in
455 section 3-123rrr, as amended by this act; and

456 (5) "Small employer" has the same meaning as provided in section 3-
457 123rrr, as amended by this act.

458 [(a)] (b) Not later than September first, annually, the Secretary of the
459 Office of Policy and Management, in consultation with the
460 Commissioner of Public Health, shall:

461 (1) [determine] Determine the amount appropriated for the following
462 purposes:

463 (A) To purchase, store and distribute vaccines for routine
464 immunizations included in the schedule for active immunization
465 required by section 19a-7f;

466 (B) [to] To purchase, store and distribute:

467 (i) [vaccines] Vaccines to prevent hepatitis A and B in persons of all
468 ages, as recommended by the schedule for immunizations published by
469 the National Advisory Committee for Immunization Practices; [,]

470 (ii) [antibiotics] Antibiotics necessary for: [the]

471 (I) The treatment of tuberculosis and biologics; and [antibiotics
472 necessary for the]

473 (II) The detection and treatment of tuberculosis infections; [,] and

474 (iii) [antibiotics] Antibiotics to support treatment of patients in
475 communicable disease control clinics, as defined in section 19a-216a;

476 (C) [to] To administer the immunization program described in
477 section 19a-7f; and

478 (D) [to] To provide services needed to collect up-to-date information
479 on childhood immunizations for all children enrolled in Medicaid who
480 reach two years of age during the year preceding the current fiscal year,
481 to incorporate such information into the childhood immunization
482 registry, as defined in section 19a-7h; [,]

483 (2) [calculate] Calculate the difference between the amount expended
484 in the prior fiscal year for the purposes set forth in subdivision (1) of this
485 subsection and the amount of the appropriation used for the purpose of
486 the health and welfare fee established in [subparagraph (A) of]
487 subdivision [(2)] (1) of subsection [(b)] (c) of this section in that same
488 year; [,] and

489 (3) [inform] Inform the Insurance Commissioner of such amounts.

490 [(b) (1) As used in this subsection, (A) "health insurance" means
491 health insurance of the types specified in subdivisions (1), (2), (4), (11)
492 and (12) of section 38a-469, and (B) "exempt insurer" means a domestic
493 insurer that administers self-insured health benefit plans and is exempt
494 from third-party administrator licensure under subparagraph (C) of
495 subdivision (11) of section 38a-720 and section 38a-720a.]

496 [(2)] (c) (1) (A) Each domestic insurer [or] and domestic health care
497 center doing health insurance business in this state shall annually pay
498 to the Insurance Commissioner, for deposit in the Insurance Fund
499 established under section 38a-52a, a health and welfare fee assessed by
500 the Insurance Commissioner pursuant to this section.

501 (B) Each third-party administrator licensed pursuant to section 38a-
502 720a that provides administrative services for self-insured health benefit
503 plans and each exempt insurer shall, on behalf of the self-insured health
504 benefit plans for which such third-party administrator or exempt
505 insurer provides administrative services, annually pay to the Insurance
506 Commissioner, for deposit in the Insurance Fund established under
507 section 38a-52a, a health and welfare fee assessed by the Insurance
508 Commissioner pursuant to this section.

509 (C) The Comptroller shall, on behalf of each multiemployer plan,
510 nonprofit employer and small employer receiving coverage provided
511 by the Comptroller pursuant to section 2 of this act, annually pay to the
512 Insurance Commissioner, for deposit in the Insurance Fund established
513 under section 38a-52a, a health and welfare fee assessed by the
514 Insurance Commissioner pursuant to this section.

515 **[**(3)**]** (2) Not later than September first, annually: **[**, each such**]**

516 (A) Each domestic insurer **[**,**]** and domestic health care center **[**,**]**
517 described in subparagraph (A) of subdivision (1) of this subsection, and
518 each third-party administrator and exempt insurer described in
519 subparagraph (B) of subdivision (1) of this subsection, shall report to the
520 Insurance Commissioner, on a form designated by **[**said commissioner**]**
521 the Insurance Commissioner, the number of insured or enrolled lives in
522 this state as of the May first immediately preceding for which such
523 domestic insurer, domestic health care center, third-party administrator
524 or exempt insurer **[**is**]** was providing health insurance or administering
525 a self-insured health benefit plan **[**that provides**]** providing coverage of
526 the types specified in subdivisions (1), (2), (4), (11) and (12) of section
527 38a-469, **[**. Such number shall not include**]** excluding any lives enrolled
528 in Medicare, any medical assistance program administered by the
529 Department of Social Services, workers' compensation insurance or
530 Medicare Part C plans; **[**.**]** and

531 (B) The Comptroller shall report to the Insurance Commissioner, in
532 the form and manner prescribed by the Insurance Commissioner:

533 (i) For each multiemployer plan described in subparagraph (C) of
534 subdivision (1) of this subsection, the number of such multiemployer
535 plan's plan participants and beneficiaries in this state for whom the
536 Comptroller was providing coverage pursuant to section 2 of this act as
537 of the May first immediately preceding;

538 (ii) For each nonprofit employer described in subparagraph (C) of
539 subdivision (1) of this subsection, the number of such nonprofit
540 employer's employees and their dependents in this state for whom the
541 Comptroller was providing coverage pursuant to section 2 of this act as
542 of the May first immediately preceding; and

543 (iii) For each small employer described in subparagraph (C) of
544 subdivision (1) of this subsection, the number of such small employer's
545 employees and their dependents in this state for whom the Comptroller
546 was providing coverage pursuant to section 2 of this act as of the May
547 first immediately preceding.

548 [(4)] (3) Not later than November first, annually, the Insurance
549 Commissioner shall determine the fee to be assessed for the current
550 fiscal year against each [such] domestic insurer [,] and domestic health
551 care center described in subparagraph (A) of subdivision (1) of this
552 subsection, third-party administrator and exempt insurer described in
553 subparagraph (B) of subdivision (1) of this subsection and
554 multiemployer plan, nonprofit employer and small employer described
555 in subparagraph (C) of subdivision (1) of this subsection. Such fee shall
556 be calculated by multiplying the number of lives reported to [said
557 commissioner] the Insurance Commissioner pursuant to subparagraph
558 (A) of subdivision [(3)] (2) of this subsection, and the number of plan
559 participants, beneficiaries, employees and dependents reported to the
560 Insurance Commissioner pursuant to subparagraph (B) of subdivision
561 (2) of this subsection, by a factor, determined annually by [said
562 commissioner] the Insurance Commissioner as set forth in this
563 subdivision, to fully fund the amount determined under subdivision (1)
564 of subsection [(a)] (b) of this section, adjusted for a health and welfare
565 fee, by subtracting, if the amount appropriated was more than the

566 amount expended or by adding, if the amount expended was more than
567 the amount appropriated, the amount calculated under subdivision (2)
568 of subsection [(a)] (b) of this section. The Insurance Commissioner shall
569 determine the factor by dividing the adjusted amount by the sum of the
570 total number of lives reported to [said commissioner] the Insurance
571 Commissioner pursuant to subparagraph (A) of subdivision [(3)] (2) of
572 this subsection and the number of plan participants, beneficiaries,
573 employees and dependents reported to the Insurance Commissioner
574 pursuant to subparagraph (B) of subdivision (2) of this subsection.

575 [(5)] (4) (A) Not later than December first, annually, the Insurance
576 Commissioner shall submit a statement to each [such] domestic insurer
577 [,] and domestic health care center [,] described in subparagraph (A) of
578 subdivision (1) of this subsection, each third-party administrator and
579 exempt insurer described in subparagraph (B) of subdivision (1) of this
580 subsection and the Comptroller for each multiemployer plan, nonprofit
581 employer or small employer described in subparagraph (C) of
582 subdivision (1) of this subsection that includes the proposed fee,
583 identified on such statement as the "Health and Welfare fee", for [the]
584 such domestic insurer, domestic health care center, third-party
585 administrator, [or] exempt insurer, multiemployer plan, nonprofit
586 employer or small employer calculated in accordance with this
587 subsection. [Each] The Comptroller shall collect such fee from each such
588 multiemployer plan, nonprofit employer and small employer described
589 in subparagraph (C) of subdivision (1) of this subsection and pay such
590 fee to the Insurance Commissioner, and each such domestic insurer,
591 domestic health care center, third-party administrator and exempt
592 insurer shall pay such fee to the Insurance Commissioner, not later than
593 February first, annually.

594 (B) Any [such] domestic insurer [,] or domestic health care center
595 described in subparagraph (A) of subdivision (1) of this subsection,
596 third-party administrator or exempt insurer described in subparagraph
597 (B) of subdivision (1) of this subsection or the administrator of a
598 multiemployer plan, a nonprofit employer or a small employer
599 described in subparagraph (C) of subdivision (1) of this subsection that

600 is aggrieved by an assessment levied under this subsection may appeal
601 therefrom in the same manner as provided for appeals under section
602 38a-52, as amended by this act.

603 [(6)] (5) Any domestic insurer, domestic health care center, third-
604 party administrator or exempt insurer that fails to file the report
605 required under subparagraph (A) of subdivision [(3)] (2) of this
606 subsection shall pay a late filing fee of one hundred dollars per day for
607 each day from the date such report was due. The Insurance
608 Commissioner may require [an] a domestic insurer, domestic health
609 care center, third-party administrator or exempt insurer subject to this
610 subsection to produce the records in its possession, and may require any
611 other person to produce the records in such person's possession, that
612 were used to prepare such report, for [said commissioner's] the
613 Insurance Commissioner's or [said commissioner's] the Insurance
614 Commissioner's designee's examination. If [said commissioner] the
615 Insurance Commissioner determines there is other than a good faith
616 discrepancy between the actual number of insured or enrolled lives that
617 should have been reported under subparagraph (A) of subdivision [(3)]
618 (2) of this subsection and the number actually reported, such domestic
619 insurer, domestic health care center, third-party administrator or
620 exempt insurer shall pay a civil penalty of not more than fifteen
621 thousand dollars for each report filed for which [said commissioner] the
622 Insurance Commissioner determines there is such a discrepancy.

623 [(7)] (6) (A) The Insurance Commissioner shall apply an overpayment
624 of the health and welfare fee by [an] a domestic insurer, domestic health
625 care center, third-party administrator or exempt insurer, or by the
626 Comptroller on behalf of a multiemployer plan, nonprofit employer or
627 small employer described in subparagraph (C) of subdivision (1) of this
628 subsection, for any fiscal year as a credit against the health and welfare
629 fee due from such domestic insurer, domestic health care center, third-
630 party administrator, [or] exempt insurer, multiemployer plan, nonprofit
631 employer or small employer for the succeeding fiscal year, subject to an
632 adjustment under subdivision [(4)] (3) of this subsection: [, if:]

633 (i) [The] If the amount of the overpayment exceeds five thousand
634 dollars; and

635 (ii) If, on or before June first of the calendar year of the overpayment,
636 [the] such domestic insurer, domestic health care center, third-party
637 administrator, [or] exempt insurer, multiemployer plan, nonprofit
638 employer or small employer:

639 (I) [notifies] Notifies the [commissioner] Insurance Commissioner of
640 the amount of the overpayment; [,] and

641 (II) [provides] Provides the [commissioner] Insurance Commissioner
642 with evidence sufficient to prove the amount of the overpayment.

643 (B) Not later than ninety days following receipt of notice and
644 supporting evidence under subparagraph [(A)] (A)(ii) of this
645 subdivision, the [commissioner] Insurance Commissioner shall:

646 (i) [determine] Determine whether the domestic insurer, domestic
647 health care center, third-party administrator, [or] exempt insurer,
648 multiemployer plan, nonprofit employer or small employer made an
649 overpayment; [,] and

650 (ii) [notify] Notify the domestic insurer, domestic health care center,
651 third-party administrator, [or] exempt insurer, multiemployer plan,
652 nonprofit employer or small employer of such determination.

653 (C) Failure of [an] a domestic insurer, domestic health care center,
654 third-party administrator, [or] exempt insurer, multiemployer plan,
655 nonprofit employer or small employer to notify the commissioner of the
656 amount of an overpayment within the time prescribed in subparagraph
657 [(A)] (A)(ii) of this subdivision constitutes a waiver of any demand of
658 the domestic insurer, domestic health care center, third-party
659 administrator, [or] exempt insurer, multiemployer plan, nonprofit
660 employer or small employer against the state on account of such
661 overpayment.

662 (D) Nothing in this subdivision shall be construed to prohibit or limit

663 the right of [an] a domestic insurer, domestic health care center, third-
664 party administrator, [or] exempt insurer, multiemployer plan, nonprofit
665 employer or small employer to appeal pursuant to subparagraph (B) of
666 subdivision [(5)] (4) of this [section] subsection.

667 Sec. 6. Section 19a-7p of the general statutes is repealed and the
668 following is substituted in lieu thereof (*Effective July 1, 2021*):

669 (a) As used in this section:

670 (1) "Health care center" has the same meaning as provided in section
671 38a-175;

672 (2) "Health insurance" means health insurance providing coverage of
673 the types specified in subdivisions (1), (2), (4), (11) and (12) of section
674 38a-469;

675 (3) "Multiemployer plan" has the same meaning as provided in
676 Section 3 of the Employee Retirement Income Security Act of 1974, as
677 amended from time to time;

678 (4) "Nonprofit employer" has the same meaning as provided in
679 section 3-123rrr, as amended by this act; and

680 (5) "Small employer" has the same meaning as provided in section 3-
681 123rrr, as amended by this act.

682 [(a)] (b) Not later than September first, annually, the Secretary of the
683 Office of Policy and Management, in consultation with the
684 Commissioner of Public Health, shall:

685 (1) [determine] Determine the amounts appropriated for the syringe
686 services program, AIDS services, breast and cervical cancer detection
687 and treatment, x-ray screening and tuberculosis care, sexually
688 transmitted disease control and children's health initiatives; and

689 (2) [inform] Inform the Insurance Commissioner of such amounts.

690 [(b) (1) As used in this section: (A) "Health insurance" means health

691 insurance of the types specified in subdivisions (1), (2), (4), (11) and (12)
692 of section 38a-469; and (B) "health care center" has the same meaning as
693 provided in section 38a-175.]

694 [(2)] (c) (1) Each domestic insurer [or] and domestic health care center
695 doing health insurance business in this state, and the Comptroller on
696 behalf of each multiemployer plan, nonprofit employer and small
697 employer receiving coverage provided by the Comptroller pursuant to
698 section 2 of this act, shall annually pay to the Insurance Commissioner,
699 for deposit in the Insurance Fund established under section 38a-52a, a
700 public health fee assessed by the Insurance Commissioner pursuant to
701 this section.

702 [(3)] (2) Not later than September first, annually: [, each such]

703 (A) Each domestic insurer [or] and domestic health care center
704 described in subdivision (1) of this subsection shall report to the
705 Insurance Commissioner, in the form and manner prescribed by [said
706 commissioner] the Insurance Commissioner, the number of insured or
707 enrolled lives in this state as of the May first immediately preceding [the
708 date] for which such domestic insurer or domestic health care center [is]
709 was providing health insurance [that provides] coverage, [of the types
710 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469.
711 Such number shall not include] excluding any lives enrolled in
712 Medicare, any medical assistance program administered by the
713 Department of Social Services, workers' compensation insurance or
714 Medicare Part C plans; [.] and

715 (B) The Comptroller shall report to the Insurance Commissioner, in
716 the form and manner prescribed by the Insurance Commissioner:

717 (i) For each multiemployer plan described in subdivision (1) of this
718 subsection, the number of such multiemployer plan's plan participants
719 and beneficiaries in this state for whom the Comptroller was providing
720 coverage pursuant to section 2 of this act as of the May first immediately
721 preceding;

722 (ii) For each nonprofit employer described in subdivision (1) of this
723 subsection, the number of such nonprofit employer's employees and
724 their dependents in this state for whom the Comptroller was providing
725 coverage pursuant to section 2 of this act as of the May first immediately
726 preceding; and

727 (iii) For each small employer described in subdivision (1) of this
728 subsection, the number of such small employer's employees and their
729 dependents in this state for whom the Comptroller was providing
730 coverage pursuant to section 2 of this act as of the May first immediately
731 preceding.

732 [(c)] (d) Not later than November first, annually, the Insurance
733 Commissioner shall determine the fee to be assessed for the current
734 fiscal year against each [such] domestic insurer, [and] domestic health
735 care center, multiemployer plan, nonprofit employer or small employer
736 described in subdivision (1) of subsection (c) of this section. Such fee
737 shall be calculated by multiplying the number of lives reported to [said
738 commissioner] the Insurance Commissioner pursuant to subparagraph
739 (A) of subdivision [(3)] (2) of subsection [(b)] (c) of this section, and the
740 number of plan participants, beneficiaries, employees and dependents
741 reported to the Insurance Commissioner pursuant to subparagraph (B)
742 of subdivision (2) of subsection (c) of this section, by a factor,
743 determined annually by [said commissioner] the Insurance
744 Commissioner as set forth in this subsection, to fully fund the aggregate
745 amount determined under subdivision (1) of subsection [(a)] (b) of this
746 section. The Insurance Commissioner shall determine the factor by
747 dividing the aggregate amount by the sum of the total number of lives
748 reported to [said commissioner] the Insurance Commissioner pursuant
749 to subparagraph (A) of subdivision [(3)] (2) of subsection [(b)] (c) of this
750 section and the number of plan participants, beneficiaries, employees
751 and dependents reported to the Insurance Commissioner pursuant to
752 subparagraph (B) of subdivision (2) of subsection (c) of this section.

753 [(d)] (e) Not later than December first, annually, the Insurance
754 Commissioner shall submit a statement to each [such] domestic insurer

755 and domestic health care center described in subdivision (1) of
756 subsection (c) of this section, and to the Comptroller for each
757 multiemployer plan, nonprofit employer or small employer described
758 in subdivision (1) of subsection (c) of this section, that includes the
759 proposed fee, identified on such statement as the "Public Health fee", for
760 [the] such domestic insurer, [or] domestic health care center,
761 multiemployer plan, nonprofit employer or small employer, calculated
762 in accordance with this section. Not later than December twentieth,
763 annually, [any] a domestic insurer, [or] domestic health care center, or
764 the Comptroller acting on behalf of a multiemployer plan, nonprofit
765 employer or small employer, may submit an objection to the Insurance
766 Commissioner concerning the proposed public health fee. The
767 Insurance Commissioner, after making any adjustment that [said
768 commissioner] the Insurance Commissioner deems necessary, shall, not
769 later than January first, annually, submit a final statement to the
770 Comptroller for each multiemployer plan, nonprofit employer and
771 small employer described in subdivision (1) of subsection (c) of this
772 section that includes the final fee for such multiemployer plan, nonprofit
773 employer or small employer and to each domestic insurer and domestic
774 health care center that includes the final fee for [the] such domestic
775 insurer or domestic health care center. [Each such] The Comptroller
776 shall collect such fee from each such multiemployer plan, nonprofit
777 employer and small employer and pay such fee to the Insurance
778 Commissioner, and each such domestic insurer and domestic health
779 care center shall pay such fee to the Insurance Commissioner, not later
780 than February first, annually.

781 [(e)] (f) Any [such] domestic insurer, [or] domestic health care center,
782 multiemployer plan, nonprofit employer or small employer described
783 in subdivision (1) of subsection (c) of this section that is aggrieved by an
784 assessment levied under this section may appeal therefrom in the same
785 manner as provided for appeals under section 38a-52, as amended by
786 this act.

787 [(f)] (g) (1) The Insurance Commissioner shall apply an overpayment
788 of the public health fee by [an] a domestic insurer or domestic health

789 care center, or by the Comptroller on behalf of a multiemployer plan,
790 nonprofit employer or small employer described in subdivision (1) of
791 subsection (c) of this section, for any fiscal year as a credit against the
792 public health fee due from such domestic insurer, [or] domestic health
793 care center, multiemployer plan, nonprofit employer or small employer
794 for the succeeding fiscal year, subject to an adjustment under subsection
795 [(c)] (d) of this section: [, if:]

796 (A) [The] If the amount of the overpayment exceeds five thousand
797 dollars; and

798 (B) If, on or before June first of the calendar year of the overpayment,
799 [the] such domestic insurer, [or] domestic health care center,
800 multiemployer plan, nonprofit employer or small employer:

801 (i) [notifies] Notifies the [commissioner] Insurance Commissioner of
802 the amount of the overpayment; [,] and

803 (ii) [provides] Provides the [commissioner] Insurance Commissioner
804 with evidence sufficient to prove the amount of the overpayment.

805 (2) Not later than ninety days following receipt of notice and
806 supporting evidence under subdivision (1) of this subsection, the
807 [commissioner] Insurance Commissioner shall:

808 (A) [determine] Determine whether the domestic insurer, [or]
809 domestic health care center, multiemployer plan, nonprofit employer or
810 small employer made an overpayment; [,] and

811 (B) [notify] Notify the domestic insurer, [or] domestic health care
812 center, multiemployer plan, nonprofit employer or small employer of
813 such determination.

814 (3) Failure of [an] a domestic insurer, [or] domestic health care center,
815 multiemployer plan, nonprofit employer or small employer to notify the
816 commissioner of the amount of an overpayment within the time
817 prescribed in subparagraph (B) of subdivision (1) of this subsection
818 constitutes a waiver of any demand of the domestic insurer, [or]

819 domestic health care center, multiemployer plan, nonprofit employer or
820 small employer against the state on account of such overpayment.

821 (4) Nothing in this subsection shall be construed to prohibit or limit
822 the right of [an] a domestic insurer, [or] domestic health care center,
823 multiemployer plan, nonprofit employer or small employer to appeal
824 pursuant to subsection [(e)] (f) of this section.

825 Sec. 7. Section 38a-52 of the general statutes is repealed and the
826 following is substituted in lieu thereof (*Effective July 1, 2021*):

827 Any (1) domestic insurance company or other domestic entity
828 aggrieved because of any assessment levied under section 38a-48, (2)
829 fraternal benefit society or foreign or alien insurance company or other
830 entity aggrieved because of any assessment levied under the provisions
831 of sections 38a-49 to 38a-51, inclusive, [or] (3) domestic insurer, domestic
832 health care center [,] or third-party administrator licensed pursuant to
833 section 38a-720a, or exempt insurer, administrator of a multiemployer
834 plan, nonprofit employer or small employer as defined in [subdivision
835 (1) of] subsection [(b)] (a) of section 19a-7j, as amended by this act,
836 aggrieved because of any assessment levied under said section 19a-7j,
837 as amended by this act, or (4) domestic insurer or domestic health care
838 center, or administrator of a multiemployer plan, nonprofit employer or
839 small employer as defined in subsection (a) of section 19a-7p, as
840 amended by this act, aggrieved because of any assessment levied under
841 said section 19a-7p, as amended by this act, may, within one month from
842 the time provided for the payment of such assessment, appeal therefrom
843 to the superior court for the judicial district of New Britain, which
844 appeal shall be accompanied by a citation to the commissioner to appear
845 before said court. Such citation shall be signed by the same authority,
846 and such appeal shall be returnable at the same time and served and
847 returned in the same manner, as is required in case of a summons in a
848 civil action. The authority issuing the citation shall take from the
849 appellant a bond or recognizance to the state, with surety to prosecute
850 the appeal to effect and to comply with the orders and decrees of the
851 court in the premises. Such appeals shall be preferred cases, to be heard,

852 unless cause appears to the contrary, at the first session, by the court or
853 by a committee appointed by the court. Said court may grant such relief
854 as may be equitable, and, if such assessment has been paid prior to the
855 granting of such relief, may order the Treasurer to pay the amount of
856 such relief, with interest at the rate of six per cent per annum, to the
857 aggrieved company. If the appeal has been taken without probable
858 cause, the court may tax double or triple costs, as the case demands; and,
859 upon all such appeals which may be denied, costs may be taxed against
860 the appellant at the discretion of the court, but no costs shall be taxed
861 against the state.

862 Sec. 8. Section 38a-1041 of the general statutes is repealed and the
863 following is substituted in lieu thereof (*Effective July 1, 2021*):

864 (a) There is established an Office of the Healthcare Advocate which
865 shall be within the Insurance Department for administrative purposes
866 only.

867 (b) The Office of the Healthcare Advocate may:

868 (1) Assist health insurance consumers with managed care plan
869 selection by providing information, referral and assistance to
870 individuals about means of obtaining health insurance coverage and
871 services;

872 (2) Assist health insurance consumers to understand their rights and
873 responsibilities under managed care plans;

874 (3) Provide information to the public, agencies, legislators and others
875 regarding problems and concerns of health insurance consumers and
876 make recommendations for resolving those problems and concerns;

877 (4) Assist consumers with the filing of complaints and appeals,
878 including filing appeals with a managed care organization's internal
879 appeal or grievance process and the external appeal process established
880 under sections 38a-591d to 38a-591g, inclusive;

881 (5) Analyze and monitor the development and implementation of

882 federal, state and local laws, regulations and policies relating to health
883 insurance consumers and recommend changes it deems necessary;

884 (6) Facilitate public comment on laws, regulations and policies,
885 including policies and actions of health insurers;

886 (7) Ensure that health insurance consumers have timely access to the
887 services provided by the office;

888 (8) Review the health insurance records of a consumer who has
889 provided written consent for such review;

890 (9) Create and make available to employers a notice, suitable for
891 posting in the workplace, concerning the services that the Healthcare
892 Advocate provides;

893 (10) Establish a toll-free number, or any other free calling option, to
894 allow customer access to the services provided by the Healthcare
895 Advocate;

896 (11) Pursue administrative remedies on behalf of and with the
897 consent of any health insurance consumers;

898 (12) Adopt regulations, pursuant to chapter 54, to carry out the
899 provisions of sections 38a-1040 to 38a-1050, inclusive; and

900 (13) Take any other actions necessary to fulfill the purposes of
901 sections 38a-1040 to 38a-1050, inclusive.

902 (c) The Office of the Healthcare Advocate shall make a referral to the
903 Insurance Commissioner if the Healthcare Advocate finds that a
904 preferred provider network may have engaged in a pattern or practice
905 that may be in violation of sections 38a-479aa to 38a-479gg, inclusive, or
906 38a-815 to 38a-819, inclusive.

907 (d) The Healthcare Advocate and the Insurance Commissioner shall
908 jointly compile a list of complaints received against managed care
909 organizations and preferred provider networks and the commissioner
910 shall maintain the list, except the names of complainants shall not be

911 disclosed if such disclosure would violate the provisions of section 4-
912 61dd or 38a-1045.

913 (e) On or before October 1, 2005, the Managed Care Ombudsman
914 shall establish a process to provide ongoing communication among
915 mental health care providers, patients, state-wide and regional business
916 organizations, managed care companies and other health insurers to
917 assure: (1) Best practices in mental health treatment and recovery; (2)
918 compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a
919 and 38a-489; and (3) the relative costs and benefits of providing effective
920 mental health care coverage to employees and their families. On or
921 before January 1, 2006, and annually thereafter, the Healthcare
922 Advocate shall report, in accordance with the provisions of section 11-
923 4a, on the implementation of this subsection to the joint standing
924 committees of the General Assembly having cognizance of matters
925 relating to public health and insurance.

926 (f) On or before October 1, 2008, the Office of the Healthcare Advocate
927 shall, within available appropriations, establish and maintain a
928 healthcare consumer information web site on the Internet for use by the
929 public in obtaining healthcare information, including but not limited to:
930 (1) The availability of wellness programs in various regions of
931 Connecticut, such as disease prevention and health promotion
932 programs; (2) quality and experience data from hospitals licensed in this
933 state; and (3) a link to the consumer report card developed and
934 distributed by the Insurance Commissioner pursuant to section 38a-
935 478*l*.

936 (g) Not later than January 1, 2015, the Office of the Healthcare
937 Advocate shall establish an information and referral service to help
938 residents and providers receive behavioral health care information,
939 timely referrals and access to behavioral health care providers. In
940 developing and implementing such service, the Healthcare Advocate,
941 or the Healthcare Advocate's designee, shall: (1) Collaborate with
942 stakeholders, including, but not limited to, (A) state agencies, (B) the
943 Behavioral Health Partnership established pursuant to section 17a-22h,

944 (C) community collaboratives, (D) the United Way's 2-1-1 Infoline
945 program, and (E) providers; (2) identify any basis that prevents
946 residents from obtaining adequate and timely behavioral health care
947 services, including, but not limited to, (A) gaps in private behavioral
948 health care services and coverage, and (B) barriers to access to care; (3)
949 coordinate a public awareness and educational campaign directing
950 residents to the information and referral service; and (4) develop data
951 reporting mechanisms to determine the effectiveness of the service,
952 including, but not limited to, tracking (A) the number of referrals to
953 providers by type and location of providers, (B) waiting time for
954 services, and (C) the number of providers who accept or reject requests
955 for service based on type of health care coverage. Not later than
956 February 1, 2016, and annually thereafter, the Office of the Healthcare
957 Advocate shall submit a report, in accordance with the provisions of
958 section 11-4a, to the joint standing committees of the General Assembly
959 having cognizance of matters relating to children, human services,
960 public health and insurance. The report shall identify gaps in services
961 and the resources needed to improve behavioral health care options for
962 residents.

963 (h) The Office of the Healthcare Advocate shall provide assistance to
964 the plan participants and beneficiaries in this state under multiemployer
965 plans, nonprofit employers' employees and their dependents and small
966 employers' employees and their dependents receiving coverage
967 provided by the Comptroller pursuant to section 2 of this act that is
968 equivalent to the assistance that the Office of the Healthcare Advocate
969 provides to other health insurance consumers.

970 Sec. 9. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this
971 section:

972 (1) "Connecticut Health Insurance Exchange account" means the
973 Connecticut Health Insurance Exchange account established under
974 section 13 of this act;

975 (2) "Exchange" has the same meaning as provided in section 38a-1080
976 of the general statutes, as amended by this act;

977 (3) "Exempt insurer" means an insurer that administers self-insured
978 health benefit plans and is exempt from third-party administrator
979 licensure under subparagraph (C) of subdivision (11) of section 38a-720
980 of the general statutes and section 38a-720a of the general statutes; and

981 (4) "Office of Health Strategy" means the Office of Health Strategy
982 established under section 19a-754a of the general statutes, as amended
983 by this act.

984 (b) (1) Subject to the approval required under subsection (d) of section
985 16 of this act and, with respect to the matters for which the exchange
986 seeks a state innovation waiver pursuant to subparagraph (B) of
987 subdivision (28) of section 38a-1084 of the general statutes, as amended
988 by this act, issuance of such state innovation waiver, the Office of Health
989 Strategy shall:

990 (A) Not later than July 1, 2022, and annually thereafter:

991 (i) Determine the amount that the exchange requires to perform its
992 duties under subparagraph (C) of subdivision (28) of section 38a-1084 of
993 the general statutes, as amended by this act; and

994 (ii) Report the amount determined pursuant to subparagraph (A)(i)
995 of this subdivision to the Insurance Commissioner; and

996 (B) Not later than July 1, 2021, report to the Insurance Commissioner
997 that the amount described in subparagraph (A)(i) of this subdivision is
998 fifty million dollars for the year 2022.

999 (2) The amount determined pursuant to subparagraph (A)(i) of
1000 subdivision (1) of this subsection shall not exceed fifty million dollars
1001 for any year.

1002 (c) (1) Each insurer and health care center doing health insurance
1003 business in this state, and each exempt insurer, shall annually pay to the
1004 Insurance Commissioner, for deposit in the Connecticut Health
1005 Insurance Exchange account, a fee assessed by the commissioner
1006 pursuant to this section.

1007 (2) Not later than July 1, 2021, and annually thereafter, each insurer,
1008 health care center and exempt insurer described in subdivision (1) of
1009 this subsection shall report to the commissioner, on a form designated
1010 by the commissioner, the number of insured or enrolled lives in this
1011 state as of the May first immediately preceding for which such insurer,
1012 health care center or exempt insurer was providing health insurance
1013 coverage, or administering a self-insured health benefit plan providing
1014 coverage, of the types specified in subdivisions (1), (2), (4), (11) and (12)
1015 of section 38a-469 of the general statutes. Such number shall not include
1016 insured or enrolled lives covered under fully insured group health
1017 insurance policies sold in the small group market, Medicare, any
1018 medical assistance program administered by the Department of Social
1019 Services, workers' compensation insurance or Medicare Part C plans.

1020 (3) Not later than August 1, 2021, and annually thereafter, the
1021 commissioner shall determine the fee to be assessed for that year against
1022 each insurer, health care center and exempt insurer described in
1023 subdivision (1) of this subsection. Such fee shall be determined by
1024 multiplying the number of insured or enrolled lives reported to the
1025 commissioner pursuant to subdivision (2) of this subsection by a factor,
1026 determined annually by the commissioner, to fully fund the amount
1027 reported by the Office of Health Strategy to the commissioner pursuant
1028 to subparagraph (A)(ii) or (B) of subdivision (1) of subsection (b) of this
1029 section. The commissioner shall determine the factor by dividing the
1030 amount reported by the Office of Health Strategy to the commissioner
1031 pursuant to subparagraph (A)(ii) or (B) of subdivision (1) of subsection
1032 (b) of this section by the total number of insured or enrolled lives
1033 reported to the commissioner pursuant to subdivision (2) of this
1034 subsection.

1035 (4) (A) Not later than August 1, 2021, and annually thereafter, the
1036 commissioner shall submit a statement to each insurer, health care
1037 center and exempt insurer described in subdivision (1) of this subsection
1038 that includes the proposed fee imposed under this section for such
1039 insurer, health care center or exempt insurer determined in accordance
1040 with this subsection. Each such insurer, health care center and exempt

1041 insurer shall pay such fee to the commissioner not later than November
1042 first of that year.

1043 (B) Any insurer, health care center or exempt insurer described in
1044 subdivision (1) of this subsection that is aggrieved by an assessment
1045 levied under this subsection may appeal therefrom in the same manner
1046 as provided for appeals under section 38a-52 of the general statutes, as
1047 amended by this act.

1048 (5) Any insurer, health care center or exempt insurer that fails to file
1049 the report required under subdivision (2) of this subsection, or pay the
1050 fee assessed under subdivision (1) of this subsection, shall pay a late
1051 filing or payment fee, as applicable, of one hundred dollars per day for
1052 each day from the date such report or payment was due. The
1053 commissioner shall deposit all late fees paid pursuant to this
1054 subdivision in the Connecticut Health Insurance Exchange account. The
1055 commissioner may require an insurer, health care center or exempt
1056 insurer subject to this subsection to produce any records in its
1057 possession, and may require any other person to produce any records
1058 in such other person's possession, that were used to prepare such report
1059 for examination by the commissioner or the commissioner's designee. If
1060 the commissioner determines there exists anything other than a good
1061 faith discrepancy between the actual number of insured or enrolled lives
1062 that should have been reported to the commissioner pursuant to
1063 subdivision (2) of this subsection and the number actually reported,
1064 such insurer, health care center or exempt insurer shall be liable to this
1065 state for a civil penalty of not more than fifteen thousand dollars for each
1066 report filed for which the commissioner determines there is such a
1067 discrepancy.

1068 (6) (A) The commissioner shall apply any overpayment of the fee
1069 imposed under this section by an insurer, health care center or exempt
1070 insurer for a given year as a credit against the fee due from such insurer,
1071 health care center or exempt insurer under this section for the
1072 succeeding year if:

1073 (i) The amount of the overpayment exceeds five thousand dollars;

1074 and

1075 (ii) On or before April first of the year of the overpayment, the
1076 insurer, health care center or exempt insurer:

1077 (I) Notifies the commissioner of the amount of the overpayment; and

1078 (II) Provides the commissioner with evidence sufficient to prove the
1079 amount of the overpayment.

1080 (B) Not later than ninety days after the commissioner receives the
1081 notice and supporting evidence under subparagraph (A)(ii) of this
1082 subdivision, the commissioner shall:

1083 (i) Determine whether the insurer, health care center or exempt
1084 insurer made an overpayment; and

1085 (ii) Notify the insurer, health care center or exempt insurer of the
1086 commissioner's determination under subparagraph (B)(i) of this
1087 subdivision.

1088 (C) Failure of an insurer, health care center or exempt insurer to
1089 notify the commissioner of the amount of an overpayment within the
1090 time prescribed in subparagraph (A)(ii) of this subdivision constitutes a
1091 waiver of any demand of the insurer, health care center or exempt
1092 insurer against this state on account of such overpayment.

1093 (D) Nothing in this subdivision shall be construed to prohibit or limit
1094 the right of an insurer, health care center or exempt insurer to appeal
1095 pursuant to subparagraph (B) of subdivision (4) of this subsection.

1096 (d) If another state, territory or district of the United States, or a
1097 foreign country, imposes on a Connecticut domiciled insurer, fraternal
1098 benefit society, hospital service corporation, medical service
1099 corporation, health care center or other domestic entity a retaliatory
1100 charge for the fee imposed under this section, such domestic entity may,
1101 not later than sixty days after receipt of notice of the imposition of the
1102 retaliatory charge for such fee, appeal to the Insurance Commissioner

1103 for a verification that the fee imposed under this section is subject to
1104 retaliation by another state, territory or district of the United States, or a
1105 foreign country. If the commissioner verifies, upon appeal to and
1106 certification by the commissioner, that the fee imposed under this
1107 section is the subject of a retaliatory tax, fee, assessment or other
1108 obligation by another state, territory or district of the United States, or a
1109 foreign country, such fee shall not be assessed against nondomestic
1110 insurers and nondomestic exempt insurers pursuant to this section. Any
1111 such domestic insurer, fraternal benefit society, hospital service
1112 corporation, medical service corporation, health care center or other
1113 entity aggrieved by the commissioner's decision issued under this
1114 subsection may appeal therefrom in the same manner as provided
1115 under section 38a-52 of the general statutes, as amended by this act.

1116 (e) The Insurance Commissioner may adopt regulations, in
1117 accordance with chapter 54 of the general statutes, to implement the
1118 provisions of this section.

1119 Sec. 10. Section 38a-1080 of the general statutes is repealed and the
1120 following is substituted in lieu thereof (*Effective July 1, 2021*):

1121 For purposes of this section, sections **[**38a-1080**]** 38a-1081 to 38a-1093,
1122 inclusive, and sections 13 and 14 of this act:

1123 (1) "Affordable Care Act" means the Patient Protection and
1124 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
1125 Education Reconciliation Act, P.L. 111-152, as both may be amended
1126 from time to time, and regulations adopted thereunder;

1127 **[**(1)**]** (2) "Board" means the board of directors of the Connecticut
1128 Health Insurance Exchange;

1129 **[**(2)**]** (3) "Commissioner" means the Insurance Commissioner;

1130 **[**(3)**]** (4) "Exchange" means the Connecticut Health Insurance
1131 Exchange established pursuant to section 38a-1081;

1132 **[**(4) "Affordable Care Act" means the Patient Protection and

1133 Affordable Care Act, P.L. 111-148, as amended by the Health Care and
1134 Education Reconciliation Act, P.L. 111-152, as both may be amended
1135 from time to time, and regulations adopted thereunder;]

1136 (5) (A) "Health benefit plan" means an insurance policy or contract
1137 offered, delivered, issued for delivery, renewed, amended or continued
1138 in the state by a health carrier to provide, deliver, pay for or reimburse
1139 any of the costs of health care services.

1140 (B) "Health benefit plan" does not include:

1141 (i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9),
1142 (14), (15) and (16) of section 38a-469 or any combination thereof;

1143 (ii) Coverage issued as a supplement to liability insurance;

1144 (iii) Liability insurance, including general liability insurance and
1145 automobile liability insurance;

1146 (iv) Workers' compensation insurance;

1147 (v) Automobile medical payment insurance;

1148 (vi) Credit insurance;

1149 (vii) Coverage for on-site medical clinics; or

1150 (viii) Other similar insurance coverage specified in regulations issued
1151 pursuant to the Health Insurance Portability and Accountability Act of
1152 1996, P.L. 104-191, as amended from time to time, under which benefits
1153 for health care services are secondary or incidental to other insurance
1154 benefits.

1155 (C) "Health benefit plan" does not include the following benefits if
1156 they are provided under a separate insurance policy, certificate or
1157 contract or are otherwise not an integral part of the plan:

1158 (i) Limited scope dental or vision benefits;

1159 (ii) Benefits for long-term care, nursing home care, home health care,

1160 community-based care or any combination thereof; or

1161 (iii) Other similar, limited benefits specified in regulations issued
1162 pursuant to the Health Insurance Portability and Accountability Act of
1163 1996, P.L. 104-191, as amended from time to time;

1164 (iv) Other supplemental coverage, similar to coverage of the type
1165 specified in subdivisions (9) and (14) of section 38a-469, provided under
1166 a group health plan.

1167 (D) "Health benefit plan" does not include coverage of the type
1168 specified in subdivisions (3) and (13) of section 38a-469 or other fixed
1169 indemnity insurance if (i) such coverage is provided under a separate
1170 insurance policy, certificate or contract, (ii) there is no coordination
1171 between the provision of the benefits and any exclusion of benefits
1172 under any group health plan maintained by the same plan sponsor, and
1173 (iii) the benefits are paid with respect to an event without regard to
1174 whether benefits were also provided under any group health plan
1175 maintained by the same plan sponsor;

1176 (6) "Health care services" has the same meaning as provided in
1177 section 38a-478;

1178 (7) "Health carrier" means an insurance company, fraternal benefit
1179 society, hospital service corporation, medical service corporation, health
1180 care center or other entity subject to the insurance laws and regulations
1181 of the state or the jurisdiction of the commissioner that contracts or
1182 offers to contract to provide, deliver, pay for or reimburse any of the
1183 costs of health care services;

1184 (8) "Internal Revenue Code" means the Internal Revenue Code of
1185 1986, or any subsequent corresponding internal revenue code of the
1186 United States, as amended from time to time;

1187 **[**(9) "Person" has the same meaning as provided in section 38a-1;

1188 (10)**]** <u>(9)</u> "Qualified dental plan" means a limited scope dental plan
1189 that has been certified in accordance with subsection (e) of section 38a-

1190 1086;

1191 [(11)] (10) "Qualified employer" has the same meaning as provided in
1192 Section 1312 of the Affordable Care Act;

1193 [(12)] (11) "Qualified health plan" means a health benefit plan that has
1194 in effect a certification that the plan meets the criteria for certification
1195 described in Section 1311(c) of the Affordable Care Act and section 38a-
1196 1086;

1197 [(13)] (12) "Qualified individual" has the same meaning as provided
1198 in Section 1312 of the Affordable Care Act;

1199 [(14)] (13) "Secretary" means the Secretary of the United States
1200 Department of Health and Human Services; and

1201 [(15)] (14) "Small employer" has the same meaning as provided in
1202 section 38a-564.

1203 Sec. 11. Section 38a-1084 of the general statutes is repealed and the
1204 following is substituted in lieu thereof (*Effective July 1, 2021*):

1205 The exchange shall:

1206 (1) Administer the exchange for both qualified individuals and
1207 qualified employers;

1208 (2) Commission surveys of individuals, small employers and health
1209 care providers on issues related to health care and health care coverage;

1210 (3) Implement procedures for the certification, recertification and
1211 decertification, consistent with guidelines developed by the Secretary
1212 under Section 1311(c) of the Affordable Care Act, and section 38a-1086,
1213 of health benefit plans as qualified health plans;

1214 (4) Provide for the operation of a toll-free telephone hotline to
1215 respond to requests for assistance;

1216 (5) Provide for enrollment periods, as provided under Section

1217 1311(c)(6) of the Affordable Care Act;

1218 (6) Maintain an Internet web site through which enrollees and
1219 prospective enrollees of qualified health plans may obtain standardized
1220 comparative information on such plans including, but not limited to, the
1221 enrollee satisfaction survey information under Section 1311(c)(4) of the
1222 Affordable Care Act and any other information or tools to assist
1223 enrollees and prospective enrollees evaluate qualified health plans
1224 offered through the exchange;

1225 (7) Publish the average costs of licensing, regulatory fees and any
1226 other payments required by the exchange and the administrative costs
1227 of the exchange, including information on moneys lost to waste, fraud
1228 and abuse, on an Internet web site to educate individuals on such costs;

1229 (8) On or before the open enrollment period for plan year 2017, assign
1230 a rating to each qualified health plan offered through the exchange in
1231 accordance with the criteria developed by the Secretary under Section
1232 1311(c)(3) of the Affordable Care Act, and determine each qualified
1233 health plan's level of coverage in accordance with regulations issued by
1234 the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

1235 (9) Use a standardized format for presenting health benefit options in
1236 the exchange, including the use of the uniform outline of coverage
1237 established under Section 2715 of the Public Health Service Act, 42 USC
1238 300gg-15, as amended from time to time;

1239 (10) Inform individuals, in accordance with Section 1413 of the
1240 Affordable Care Act, of eligibility requirements for the Medicaid
1241 program under Title XIX of the Social Security Act, as amended from
1242 time to time, the Children's Health Insurance Program (CHIP) under
1243 Title XXI of the Social Security Act, as amended from time to time, or
1244 any applicable state or local public program, and enroll an individual in
1245 such program if the exchange determines, through screening of the
1246 application by the exchange, that such individual is eligible for any such
1247 program;

1248 (11) Collaborate with the Department of Social Services, to the extent
1249 possible, to allow an enrollee who loses premium tax credit eligibility
1250 under Section 36B of the Internal Revenue Code and is eligible for
1251 HUSKY A or any other state or local public program, to remain enrolled
1252 in a qualified health plan;

1253 (12) Establish and make available by electronic means a calculator to
1254 determine the actual cost of coverage after application of any premium
1255 tax credit under Section 36B of the Internal Revenue Code and any cost-
1256 sharing reduction under Section 1402 of the Affordable Care Act;

1257 (13) Establish a program for small employers through which
1258 qualified employers may access coverage for their employees and that
1259 shall enable any qualified employer to specify a level of coverage so that
1260 any of its employees may enroll in any qualified health plan offered
1261 through the exchange at the specified level of coverage;

1262 (14) Offer enrollees and small employers the option of having the
1263 exchange collect and administer premiums, including through
1264 allocation of premiums among the various insurers and qualified health
1265 plans chosen by individual employers;

1266 (15) Grant a certification, subject to Section 1411 of the Affordable
1267 Care Act, attesting that, for purposes of the individual responsibility
1268 penalty under Section 5000A of the Internal Revenue Code, an
1269 individual is exempt from the individual responsibility requirement or
1270 from the penalty imposed by said Section 5000A because:

1271 (A) There is no affordable qualified health plan available through the
1272 exchange, or the individual's employer, covering the individual; or

1273 (B) The individual meets the requirements for any other such
1274 exemption from the individual responsibility requirement or penalty;

1275 (16) Provide to the Secretary of the Treasury of the United States the
1276 following:

1277 (A) A list of the individuals granted a certification under subdivision

1278 (15) of this section, including the name and taxpayer identification
1279 number of each individual;

1280 (B) The name and taxpayer identification number of each individual
1281 who was an employee of an employer but who was determined to be
1282 eligible for the premium tax credit under Section 36B of the Internal
1283 Revenue Code because:

1284 (i) The employer did not provide minimum essential health benefits
1285 coverage; or

1286 (ii) The employer provided the minimum essential coverage but it
1287 was determined under Section 36B(c)(2)(C) of the Internal Revenue
1288 Code to be unaffordable to the employee or not provide the required
1289 minimum actuarial value; and

1290 (C) The name and taxpayer identification number of:

1291 (i) Each individual who notifies the exchange under Section
1292 1411(b)(4) of the Affordable Care Act that such individual has changed
1293 employers; and

1294 (ii) Each individual who ceases coverage under a qualified health
1295 plan during a plan year and the effective date of that cessation;

1296 (17) Provide to each employer the name of each employee, as
1297 described in subparagraph (B) of subdivision (16) of this section, of the
1298 employer who ceases coverage under a qualified health plan during a
1299 plan year and the effective date of the cessation;

1300 (18) Perform duties required of, or delegated to, the exchange by the
1301 Secretary or the Secretary of the Treasury of the United States related to
1302 determining eligibility for premium tax credits, reduced cost-sharing or
1303 individual responsibility requirement exemptions;

1304 (19) Select entities qualified to serve as Navigators in accordance with
1305 Section 1311(i) of the Affordable Care Act and award grants to enable
1306 Navigators to:

1307 (A) Conduct public education activities to raise awareness of the
1308 availability of qualified health plans;

1309 (B) Distribute fair and impartial information concerning enrollment
1310 in qualified health plans and the availability of premium tax credits
1311 under Section 36B of the Internal Revenue Code and cost-sharing
1312 reductions under Section 1402 of the Affordable Care Act;

1313 (C) Facilitate enrollment in qualified health plans;

1314 (D) Provide referrals to the Office of the Healthcare Advocate or
1315 health insurance ombudsman established under Section 2793 of the
1316 Public Health Service Act, 42 USC 300gg-93, as amended from time to
1317 time, or any other appropriate state agency or agencies, for any enrollee
1318 with a grievance, complaint or question regarding the enrollee's health
1319 benefit plan, coverage or a determination under that plan or coverage;
1320 and

1321 (E) Provide information in a manner that is culturally and
1322 linguistically appropriate to the needs of the population being served by
1323 the exchange;

1324 (20) Review the rate of premium growth within and outside the
1325 exchange and consider such information in developing
1326 recommendations on whether to continue limiting qualified employer
1327 status to small employers;

1328 (21) Credit the amount, in accordance with Section 10108 of the
1329 Affordable Care Act, of any free choice voucher to the monthly
1330 premium of the plan in which a qualified employee is enrolled and
1331 collect the amount credited from the offering employer;

1332 (22) Consult with stakeholders relevant to carrying out the activities
1333 required under sections 38a-1080 to 38a-1090, inclusive, as amended by
1334 this act, including, but not limited to:

1335 (A) Individuals who are knowledgeable about the health care system,
1336 have background or experience in making informed decisions regarding

1337 health, medical and scientific matters and are enrollees in qualified
1338 health plans;

1339 (B) Individuals and entities with experience in facilitating enrollment
1340 in qualified health plans;

1341 (C) Representatives of small employers and self-employed
1342 individuals;

1343 (D) The Department of Social Services; and

1344 (E) Advocates for enrolling hard-to-reach populations;

1345 (23) Meet the following financial integrity requirements:

1346 (A) Keep an accurate accounting of all activities, receipts and
1347 expenditures and annually submit to the Secretary, the Governor, the
1348 Insurance Commissioner and the General Assembly a report concerning
1349 such accountings;

1350 (B) Fully cooperate with any investigation conducted by the Secretary
1351 pursuant to the Secretary's authority under the Affordable Care Act and
1352 allow the Secretary, in coordination with the Inspector General of the
1353 United States Department of Health and Human Services, to:

1354 (i) Investigate the affairs of the exchange;

1355 (ii) Examine the properties and records of the exchange; and

1356 (iii) Require periodic reports in relation to the activities undertaken
1357 by the exchange; and

1358 (C) Not use any funds in carrying out its activities under sections 38a-
1359 1080 to 38a-1089, inclusive, <u>as amended by this act,</u> that are intended for
1360 the administrative and operational expenses of the exchange, for staff
1361 retreats, promotional giveaways, excessive executive compensation or
1362 promotion of federal or state legislative and regulatory modifications;

1363 (24) (A) Seek to include the most comprehensive health benefit plans

1364 that offer high quality benefits at the most affordable price in the
1365 exchange, (B) encourage health carriers to offer tiered health care
1366 provider network plans that have different cost-sharing rates for
1367 different health care provider tiers and reward enrollees for choosing
1368 low-cost, high-quality health care providers by offering lower
1369 copayments, deductibles or other out-of-pocket expenses, and (C) offer
1370 any such tiered health care provider network plans through the
1371 exchange; **[**and**]**

1372 (25) Report at least annually to the General Assembly on the effect of
1373 adverse selection on the operations of the exchange and make legislative
1374 recommendations, if necessary, to reduce the negative impact from any
1375 such adverse selection on the sustainability of the exchange, including
1376 recommendations to ensure that regulation of insurers and health
1377 benefit plans are similar for qualified health plans offered through the
1378 exchange and health benefit plans offered outside the exchange. The
1379 exchange shall evaluate whether adverse selection is occurring with
1380 respect to health benefit plans that are grandfathered under the
1381 Affordable Care Act, self-insured plans, plans sold through the
1382 exchange and plans sold outside the exchange; **[**.**]**

1383 (26) Administer the Connecticut Health Insurance Exchange account
1384 established under section 13 of this act;

1385 (27) Consult with the Office of Health Strategy established under
1386 section 19a-754a, as amended by this act, for the purposes set forth in
1387 subsection (b) of section 16 of this act;

1388 (28) Subject to the approval required under subsection (d) of section
1389 16 of this act:

1390 (A) Establish the subsidiary described in subdivision (1) of subsection
1391 (b) of section 16 of this act not later than November 1, 2021, which, if
1392 established, shall:

1393 (i) Require each health carrier offering coverage through such
1394 subsidiary to:

1395 (I) Collect demographic data, including, but not limited to, self-
1396 reported ethnic and racial data, concerning the individuals receiving
1397 such coverage by, at a minimum, utilizing standardized categories
1398 developed by the Office of Health Strategy pursuant to subdivision (9)
1399 of subsection (b) of section 19a-754a of the general statutes, as amended
1400 by this act, including an "other" category and allowing any individual
1401 who is self-reporting ethnic or racial data to write in such individual's
1402 ethnicity or race, and select multiple ethnicities and races, on any form
1403 provided by such health carrier to collect such ethnic or racial data; and

1404 (II) Not later than February 1, 2022, and annually thereafter, submit a
1405 report to such subsidiary disclosing, in the aggregate, the demographic
1406 data collected by such health carrier pursuant to subparagraph (A)(i)(I)
1407 of this subdivision; and

1408 (ii) Not later than March 1, 2022, and annually thereafter, submit a
1409 report to the exchange disclosing, in the aggregate, the demographic
1410 data that health carriers submitted to such subsidiary pursuant to
1411 subparagraph (A)(i)(II) of this subdivision for the preceding calendar
1412 year;

1413 (B) Seek the state innovation waiver described in subdivision (2) of
1414 subsection (b) of section 16 of this act not later than November 1, 2021;
1415 and

1416 (C) Use the moneys deposited in the Connecticut Health Insurance
1417 Exchange account established under section 13 of this act for the
1418 purposes set forth in subdivision (3) of subsection (b) of section 16 of
1419 this act and, if the exchange uses any funds deposited in said account to
1420 provide premium and cost-sharing subsidies described in
1421 subparagraph (B) of subdivision (3) of subsection (b) of section 16 of this
1422 act, collect, at least annually, demographic data, including, but not
1423 limited to, self-reported ethnic and racial data, concerning the
1424 individuals receiving such subsidies by, at a minimum:

1425 (i) Utilizing standardized categories developed by the Office of
1426 Health Strategy pursuant to subdivision (9) of subsection (b) of section

1427 19a-754a of the general statutes, as amended by this act; and

1428 (ii) Including an "other" category and allowing any individual who is
1429 self-reporting ethnic or racial data to write in such individual's ethnicity
1430 or race and select multiple ethnicities and races on any form provided
1431 by the exchange to collect such ethnic or racial data; and

1432 (29) Determine whether individuals referred to the exchange by the
1433 Labor Commissioner pursuant to section 18 of this act are eligible for
1434 free or subsidized health coverage or other assistance or benefits,
1435 including, but not limited to, assistance under the supplemental
1436 nutrition assistance program, and, if such individuals are eligible for
1437 such coverage, assistance or benefits, enroll such individuals in such
1438 coverage, assistance or benefits.

1439 Sec. 12. Section 38a-1089 of the general statutes is repealed and the
1440 following is substituted in lieu thereof (*Effective July 1, 2021*):

1441 (a) Not later than January 1, 2012, and annually thereafter until
1442 January 1, 2014, the chief executive officer of the exchange shall report,
1443 in accordance with section 11-4a, to the Governor and the General
1444 Assembly on a plan, and any revisions or amendments to such plan, to
1445 establish a health insurance exchange in the state. Such report shall
1446 address:

1447 (1) Whether to establish two separate exchanges, one for the
1448 individual health insurance market and one for the small employer
1449 health insurance market, or to establish a single exchange;

1450 (2) Whether to merge the individual and small employer health
1451 insurance markets;

1452 (3) Whether to revise the definition of "small employer" from not
1453 more than fifty employees to not more than one hundred employees;

1454 (4) Whether to allow large employers to participate in the exchange
1455 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) Whether to list dental benefits separately on the exchange's Internet web site where a qualified health plan includes dental benefits;

(7) The relationship of the exchange to insurance producers;

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

(9) 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;

(10) Methods to independently evaluate consumers' experience, including, but not limited to, hiring consultants to act as secret shoppers; and

(11) The status of the implementation and administration of the all-payer claims database program established under section 19a-755a.

(b) Not later than January 1, 2012, and annually thereafter, the chief executive officer of the exchange shall report, in accordance with section 11-4a, to the Governor and the General Assembly on:

(1) Any private or federal funds received during the preceding calendar year and, if applicable, how such funds were expended;

(2) The adequacy of federal funds for the exchange prior to January 1, 2015;

(3) The amount and recipients of any grants awarded; and

(4) The current financial status of the exchange.

(c) Not later than April 1, 2022, and annually thereafter, the chief executive officer of the exchange shall submit a report, in accordance

1483 with section 11-4a, to the joint standing committee of the General
1484 Assembly having cognizance of matters relating to insurance disclosing,
1485 in the aggregate, the demographic data, if any, that:

1486 (1) The subsidiary established pursuant to subparagraph (A) of
1487 subdivision (28) of section 38a-1084, as amended by this act, reported to
1488 the exchange pursuant to subparagraph (A)(ii) of subdivision (28) of
1489 section 38a-1084, as amended by this act, for the preceding calendar
1490 year; and

1491 (2) The exchange collected pursuant to subparagraph (C) of
1492 subdivision (28) of section 38a-1084, as amended by this act, for the
1493 preceding calendar year.

1494 (d) Not later than January 1, 2023, and annually thereafter, the chief
1495 executive officer of the exchange shall submit a report, in accordance
1496 with section 11-4a, to the joint standing committees of the General
1497 Assembly having cognizance of matters relating to appropriations,
1498 human services and insurance regarding expenditures from the
1499 Connecticut Health Insurance Exchange account established under
1500 section 13 of this act for the preceding calendar year and disclosing
1501 whether such funds were sufficient to carry out the purposes set forth
1502 in subdivision (3) of subsection (b) of section 16 of this act for such
1503 preceding calendar year.

1504 Sec. 13. (NEW) (*Effective July 1, 2021*) There is established an account
1505 to be known as the "Connecticut Health Insurance Exchange account"
1506 which shall be a separate, nonlapsing account within the General Fund.
1507 The account shall contain any moneys required by law to be deposited
1508 in the account. Moneys in the account shall be expended by the
1509 exchange for the purposes set forth in subparagraph (C) of subdivision
1510 (28) of section 38a-1084 of the general statutes, as amended by this act.

1511 Sec. 14. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this
1512 section, "individual market" has the same meaning as provided in
1513 Section 1304 of the Affordable Care Act.

1514 (b) Notwithstanding any provision of the general statutes and to the
1515 extent permitted by federal law, each qualified health plan that is
1516 offered through the exchange, in the individual market and at a silver
1517 level of coverage for plan year 2022 or any subsequent plan year shall
1518 provide coverage for the following benefits:

1519 (1) Angiotensin converting enzyme inhibitors for an enrollee who is
1520 diagnosed with congestive heart failure, diabetes or coronary artery
1521 disease by a licensed health care provider who is acting within such
1522 health care provider's scope of practice;

1523 (2) Anti-resorptive therapy for an enrollee who is diagnosed with
1524 osteoporosis or osteopenia by a licensed health care provider who is
1525 acting within such health care provider's scope of practice;

1526 (3) Beta-adrenergic blocking agents for an enrollee who is diagnosed
1527 with congestive heart failure or coronary artery disease by a licensed
1528 health care provider who is acting within such health care provider's
1529 scope of practice;

1530 (4) Blood pressure monitors for an enrollee who is diagnosed with
1531 hypertension by a licensed health care provider who is acting within
1532 such health care provider's scope of practice;

1533 (5) Inhaled corticosteroids and peak flow meters for an enrollee who
1534 is diagnosed with asthma by a licensed health care provider who is
1535 acting within such health care provider's scope of practice;

1536 (6) Insulin and other glucose lowering agents, retinopathy screening,
1537 glucometers and hemoglobin A1C testing for an enrollee who is
1538 diagnosed with diabetes by a licensed health care provider who is acting
1539 within such health care provider's scope of practice;

1540 (7) International normalized ratio testing for an enrollee who is
1541 diagnosed with liver disease or a bleeding disorder by a licensed health
1542 care provider who is acting within such health care provider's scope of
1543 practice;

1544 (8) Low density lipoprotein testing for an enrollee who is diagnosed
1545 with heart disease by a licensed health care provider who is acting
1546 within such health care provider's scope of practice;

1547 (9) Selective serotonin reuptake inhibitors for an enrollee who is
1548 diagnosed with depression by a licensed health care provider who is
1549 acting within such health care provider's scope of practice; and

1550 (10) Statins for an enrollee who is diagnosed with heart disease or
1551 diabetes by a licensed health care provider who is acting within such
1552 health care provider's scope of practice.

1553 (c) Notwithstanding any provision of the general statutes and to the
1554 extent permitted by federal law, each qualified health plan described in
1555 subsection (b) of this section shall:

1556 (1) Have a minimum actuarial value of at least seventy per cent; and

1557 (2) Provide enrollees with access to the broadest provider network
1558 available under the qualified health plans offered by the health carrier
1559 through the exchange.

1560 Sec. 15. Subsections (a) and (b) of section 19a-754a of the general
1561 statutes are repealed and the following is substituted in lieu thereof
1562 (*Effective July 1, 2021*):

1563 (a) There is established an Office of Health Strategy, which shall be
1564 within the Department of Public Health for administrative purposes
1565 only. The department head of said office shall be the executive director
1566 of the Office of Health Strategy, who shall be appointed by the Governor
1567 in accordance with the provisions of sections 4-5 to 4-8, inclusive, with
1568 the powers and duties therein prescribed.

1569 (b) The Office of Health Strategy shall be responsible for the
1570 following:

1571 (1) Developing and implementing a comprehensive and cohesive
1572 health care vision for the state, including, but not limited to, a

1573 coordinated state health care cost containment strategy;

1574 (2) Promoting effective health planning and the provision of quality
1575 health care in the state in a manner that ensures access for all state
1576 residents to cost-effective health care services, avoids the duplication of
1577 such services and improves the availability and financial stability of
1578 such services throughout the state;

1579 (3) Directing and overseeing the State Innovation Model Initiative
1580 and related successor initiatives;

1581 (4) (A) Coordinating the state's health information technology
1582 initiatives, (B) seeking funding for and overseeing the planning,
1583 implementation and development of policies and procedures for the
1584 administration of the all-payer claims database program established
1585 under section 19a-775a, (C) establishing and maintaining a consumer
1586 health information Internet web site under section 19a-755b, and (D)
1587 designating an unclassified individual from the office to perform the
1588 duties of a health information technology officer as set forth in sections
1589 17b-59f and 17b-59g;

1590 (5) Directing and overseeing the Health Systems Planning Unit
1591 established under section 19a-612 and all of its duties and
1592 responsibilities as set forth in chapter 368z; **[**and**]**

1593 (6) Convening forums and meetings with state government and
1594 external stakeholders, including, but not limited to, the Connecticut
1595 Health Insurance Exchange, to discuss health care issues designed to
1596 develop effective health care cost and quality strategies; **[**.**]**

1597 (7) Annually (A) determining the amount described in subparagraph
1598 (A)(i) of subdivision (1) of subsection (b) of section 9 of this act, and (B)
1599 reporting such amount to the Insurance Commissioner pursuant to
1600 subparagraph (A)(ii) or (B) of subdivision (1) of subsection (b) of section
1601 9 of this act;

1602 (8) Developing a plan pursuant to subsection (b) of section 16 of this
1603 act and submitting a report containing such plan pursuant to subsection

1604 (c) of section 16 of this act; and

1605 (9) Developing standardized categories that enable (A) the
1606 Comptroller to collect demographic data pursuant to subparagraph (D)
1607 of subdivision (1) of subsection (c) of section 2 of this act, (B) health
1608 carriers to collect and submit demographic data pursuant to
1609 subparagraph (A) of subdivision (28) of section 38a-1084, as amended
1610 by this act, and (C) the exchange to collect demographic data pursuant
1611 to subparagraph (C) of subdivision (28) of section 38a-1084, as amended
1612 by this act.

1613 Sec. 16. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this
1614 section:

1615 (1) "Account" means the Connecticut Health Insurance Exchange
1616 account established under section 13 of this act;

1617 (2) "Affordable Care Act" has the same meaning as provided in
1618 section 38a-1080 of the general statutes, as amended by this act;

1619 (3) "Exchange" has the same meaning as provided in section 38a-1080
1620 of the general statutes, as amended by this act;

1621 (4) "Office of Health Strategy" means the Office of Health Strategy
1622 established under section 19a-754a of the general statutes, as amended
1623 by this act; and

1624 (5) "Qualified health plan" has the same meaning as provided in
1625 section 38a-1080 of the general statutes, as amended by this act.

1626 (b) The Office of Health Strategy shall, in consultation with the
1627 exchange, develop a plan for the exchange to:

1628 (1) Establish a subsidiary, in the manner set forth in section 38a-1093
1629 of the general statutes, to create a marketplace for health carriers to offer
1630 affordable health insurance coverage to persons who are ineligible for
1631 coverage under the qualified health plans offered through the exchange;

1632 (2) Seek a state innovation waiver pursuant to Section 1332 of the

1633 Affordable Care Act for the purpose of:

1634 (A) Reducing the cost of health insurance coverage in this state,
1635 including, but not limited to, premiums and cost-sharing for such
1636 coverage; and

1637 (B) Making health insurance coverage available to persons in this
1638 state who are ineligible for coverage under a qualified health plan
1639 offered through the exchange; and

1640 (3) For plan year 2022 and subsequent plan years, use the moneys
1641 deposited in the account to:

1642 (A) Reduce the cost of qualified health plans offered through the
1643 exchange by, among other things:

1644 (i) Eliminating premiums for such qualified health plans for persons
1645 with a household income not exceeding two hundred one per cent of the
1646 federal poverty level;

1647 (ii) Reducing premiums and cost-sharing for such qualified health
1648 plans for persons with a household income exceeding two hundred one
1649 per cent of the federal poverty level; and

1650 (iii) Establishing a reinsurance program, provided the exchange shall
1651 not use more than twenty million dollars in the account to fund the
1652 reinsurance program for any fiscal year;

1653 (B) Make coverage affordable for persons who are ineligible for
1654 coverage under a qualified health plan offered through the exchange by,
1655 among other things, providing premium and cost-sharing subsidies to
1656 such persons which, in the aggregate for all such persons, shall not
1657 exceed twenty-five million dollars per year; and

1658 (C) Implement the provisions of the state innovation waiver
1659 described in subdivision (2) of this subsection if the federal government
1660 issues such waiver for this state.

1661 (c) Not later than August 1, 2021, the Office of Health Strategy shall

1662 submit a report, in accordance with section 11-4a of the general statutes,
1663 to the joint standing committee of the General Assembly having
1664 cognizance of matters relating to insurance. Such report shall contain
1665 the plan developed pursuant to subsection (b) of this section.

1666 (d) Not later than October 1, 2021, the joint standing committee of the
1667 General Assembly having cognizance of matters relating to insurance
1668 shall advise the Office of Health Strategy and the exchange of its
1669 approval or rejection of the plan contained in the report submitted by
1670 the Office of Health Strategy pursuant to subsection (c) of this section. If
1671 the committee does not act on or before said date, said plan shall be
1672 deemed rejected.

1673 (e) The Office of Health Strategy shall consult with the Department
1674 of Social Services and the exchange to determine whether this state
1675 should seek a waiver from the federal government under Section 1115
1676 of the Social Security Act, 42 USC 1315, as amended from time to time,
1677 to reduce costs to moderate and low income families. If, following such
1678 consultation, the Office of Health Strategy determines that this state
1679 should seek such waiver, the Office of Health Strategy may submit a
1680 report, in accordance with section 11-4a of the general statutes, to the
1681 joint standing committees of the General Assembly having cognizance
1682 of matters relating to appropriations, human services and insurance
1683 disclosing such determination and the reasons therefor.

1684 Sec. 17. Subsection (a) of section 17b-261 of the general statutes is
1685 repealed and the following is substituted in lieu thereof (*Effective July 1,*
1686 *2021*):

1687 (a) Medical assistance shall be provided for any otherwise eligible
1688 person whose income, including any available support from legally
1689 liable relatives and the income of the person's spouse or dependent
1690 child, is not more than one hundred forty-three per cent, pending
1691 approval of a federal waiver applied for pursuant to subsection (e) of
1692 this section, of the benefit amount paid to a person with no income
1693 under the temporary family assistance program in the appropriate
1694 region of residence and if such person is an institutionalized individual

1695 as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3),
1696 and has not made an assignment or transfer or other disposition of
1697 property for less than fair market value for the purpose of establishing
1698 eligibility for benefits or assistance under this section. Any such
1699 disposition shall be treated in accordance with Section 1917(c) of the
1700 Social Security Act, 42 USC 1396p(c). Any disposition of property made
1701 on behalf of an applicant or recipient or the spouse of an applicant or
1702 recipient by a guardian, conservator, person authorized to make such
1703 disposition pursuant to a power of attorney or other person so
1704 authorized by law shall be attributed to such applicant, recipient or
1705 spouse. A disposition of property ordered by a court shall be evaluated
1706 in accordance with the standards applied to any other such disposition
1707 for the purpose of determining eligibility. The commissioner shall
1708 establish the standards for eligibility for medical assistance at one
1709 hundred forty-three per cent of the benefit amount paid to a household
1710 of equal size with no income under the temporary family assistance
1711 program in the appropriate region of residence. In determining
1712 eligibility, the commissioner shall not consider as income Aid and
1713 Attendance pension benefits granted to a veteran, as defined in section
1714 27-103, or the surviving spouse of such veteran. Except as provided in
1715 section 17b-277 and section 17b-292, the medical assistance program
1716 shall provide coverage to persons under the age of nineteen with
1717 household income up to one hundred ninety-six per cent of the federal
1718 poverty level without an asset limit and to persons under the age of
1719 nineteen, who qualify for coverage under Section 1931 of the Social
1720 Security Act, with household income not exceeding one hundred
1721 ninety-six per cent of the federal poverty level without an asset limit,
1722 and their parents and needy caretaker relatives, who qualify for
1723 coverage under Section 1931 of the Social Security Act, with household
1724 income not exceeding **[**one hundred fifty-five**]** <u>two hundred one</u> per cent
1725 of the federal poverty level without an asset limit. Such levels shall be
1726 based on the regional differences in such benefit amount, if applicable,
1727 unless such levels based on regional differences are not in conformance
1728 with federal law. Any income in excess of the applicable amounts shall
1729 be applied as may be required by said federal law, and assistance shall

1730 be granted for the balance of the cost of authorized medical assistance.
1731 The Commissioner of Social Services shall provide applicants for
1732 assistance under this section, at the time of application, with a written
1733 statement advising them of (1) the effect of an assignment or transfer or
1734 other disposition of property on eligibility for benefits or assistance, (2)
1735 the effect that having income that exceeds the limits prescribed in this
1736 subsection will have with respect to program eligibility, and (3) the
1737 availability of, and eligibility for, services provided by the Nurturing
1738 Families Network established pursuant to section 17b-751b. For
1739 coverage dates on or after January 1, 2014, the department shall use the
1740 modified adjusted gross income financial eligibility rules set forth in
1741 Section 1902(e)(14) of the Social Security Act and the implementing
1742 regulations to determine eligibility for HUSKY A, HUSKY B and
1743 HUSKY D applicants, as defined in section 17b-290. Persons who are
1744 determined ineligible for assistance pursuant to this section shall be
1745 provided a written statement notifying such persons of their ineligibility
1746 and advising such persons of their potential eligibility for one of the
1747 other insurance affordability programs as defined in 42 CFR 435.4.

1748 Sec. 18. (NEW) (*Effective July 1, 2021*) The Labor Commissioner shall,
1749 within available appropriations, notify individuals applying for
1750 unemployment compensation benefits under chapter 567 of the general
1751 statutes that such individuals may be eligible for free or subsidized
1752 health coverage or other assistance or benefits, including, but not
1753 limited to, assistance under the supplemental nutrition assistance
1754 program. The commissioner shall refer such individuals to the exchange
1755 for the purpose of determining their eligibility for such coverage,
1756 assistance or benefits and, if such individuals are eligible for such
1757 coverage, assistance or benefits, enrolling such individuals in such
1758 coverage, assistance or benefits. For the purposes of this section,
1759 "exchange" and "qualified health plan" have the same meanings as
1760 provided in section 38a-1080 of the general statutes, as amended by this
1761 act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2021*	3-123rrr
Sec. 2	*July 1, 2021*	New section
Sec. 3	*July 1, 2021*	New section
Sec. 4	*July 1, 2021*	New section
Sec. 5	*July 1, 2021*	19a-7j
Sec. 6	*July 1, 2021*	19a-7p
Sec. 7	*July 1, 2021*	38a-52
Sec. 8	*July 1, 2021*	38a-1041
Sec. 9	*July 1, 2021*	New section
Sec. 10	*July 1, 2021*	38a-1080
Sec. 11	*July 1, 2021*	38a-1084
Sec. 12	*July 1, 2021*	38a-1089
Sec. 13	*July 1, 2021*	New section
Sec. 14	*July 1, 2021*	New section
Sec. 15	*July 1, 2021*	19a-754a(a) and (b)
Sec. 16	*July 1, 2021*	New section
Sec. 17	*July 1, 2021*	17b-261(a)
Sec. 18	*July 1, 2021*	New section

INS *Joint Favorable Subst. C/R* FIN

FIN *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Office of the State Comptroller	GF - Cost	At least 600,000	See Below
Office of the State Comptroller	GF - Potential Cost	135,936	135,936
State Comptroller - Fringe Benefits[1]	GF - Potential Cost	55,935	55,935
Connecticut Health Insurance Exchange	CT HIEA - Potential Revenue Gain	Approx 50 million	Approx 50 million
Connecticut Health Insurance Exchange	Other - Potential Cost	Up to 15.3 million	Up to 12.5 million
Connecticut Health Insurance Exchange	CT HIEA - Potential Cost	Approx 50 million	Approx 50 million
Resources of the General Fund	GF - Potential Revenue Gain	None	See Below
Resources of the General Fund	GF - Potential Cost	See Below	See Below
Social Services, Dept.	GF - Cost	36.0 million	61.3 million

Note: GF=General Fund, CT HIEA=Connecticut Health Insurance Exchange Account

Municipal Impact: None

Explanation

The bill makes various changes regarding health insurance, including requiring the Office of the State Comptroller (OSC) to establish a group health plan for small employers, nonprofits, and multiemployer plans and expanding eligibility for HUSKY A. The bill

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

also requires the Office of Health Strategy (OHS) to develop a plan to lower consumer costs for individual-market health insurance using funds collected from a new fee on health insurers and requires the Connecticut Health Insurance Exchange ("exchange") to implement it.[2] The bill makes various other changes and is anticipated to result in the fiscal impacts described below.

Sections 2 to 3 result in a cost of at least $750,000 in FY 22 to OSC for administrative and personnel costs related to providing health coverage to certain small employers, nonprofits, and multiemployer plans through a fully-insured plan.

There is a cost of at least $600,000 to OSC in FY 22 for consulting services, including actuarial and legal services, to assist with the design and implementation of the plan, evaluate claims experience, and to comply with the Employee Retirement Income Security Act of 1974 (ERISA). Ongoing costs beyond FY 22 will vary depending on the continued need for such services but are anticipated to be less after initial design and implementation. Due to the auditing requirements of the bill, there may be a potential cost to purchase utilization and other health-related data from the plan's carriers.

The requirements of the bill may result in a cost to OSC for two additional benefit officers to support eligible groups who opt for coverage under the new plan. The total annualized salary and fringe benefit costs associated with these two positions is approximately $191,371.

After initial design and implementation, costs related to the administration and support for the new plan may be completely offset by administrative fees when the plan is in place. It is anticipated that any administrative fees charged by carriers will offset the continued cost of providing the fully-insured plan.

[2] The exchange is a quasi-public agency that funds its operations by charging an assessment on health carriers of 1.65% of premiums in the individual and small group markets. This generated $34.2 million in FY 20.

Some of the bill's requirements are inconsistent with a fully insured model and it is therefore unclear if some of the costs are duplicative or will ultimately be incurred. The bill requires that the Comptroller purchase stop loss insurance, assess a risk fee to participants, and assess administrative fees. These requirements are typically features of a self-insured plan. Under a fully insured model, the administrator of the plan would set and collect premiums, bear the plan's risk, and assess administrative fees to participants.

Sections 5 to 7 require the Comptroller to assess the small employers, nonprofits, and multiemployer plans participating in the Comptroller's group health plan for a share of two existing health insurance industry assessments, the Health and Welfare Fee and the Public Health Fee, to be deposited in the Insurance Fund. This does not result in a fiscal impact to the state. The bill does not change the revenue for the Insurance Fund to be collected from these assessments, which is based on the cost of certain Insurance Fund accounts. The Insurance Fund general assessment, which is also determined based on the cost of certain agencies and accounts, is also unchanged by the bill, to be divided among domestic insurers.

There is no fiscal impact to the Office of the Healthcare Advocate (OHA) to assist enrollees under the Comptroller's new plan like it assists privately insured consumers, as required in **section 8**.

Section 9 results in a potential revenue gain of approximately $50 million in FY 22 and up to approximately $50 million in FY 23 and annually thereafter to the "Connecticut health insurance exchange (CT HIE) account". The CT HIE account is a separate, non-lapsing General Fund account established pursuant to section 13 of the bill. The revenue gain will be realized if the Insurance and Real Estate Committee approves the plan provided by the Office of Health Strategy (OHS) and the exchange, pursuant to section 16. The revenue would be collected as an assessment by the Insurance Department (DOI) on each insurer, health care center and exempt insurer to cover the plan cost reported by OHS, which cannot exceed $50 million per year. OHS must report that

the plan cost is $50 million for 2022. There is no anticipated cost to DOI to carry out the assessment, as it is like others the agency collects from the same entities. In addition to the amount of the assessment, there may be additional minimal revenue deposited in the CT HIE account from fines or penalties assessed by the Insurance Commissioner associated with collecting the new assessment. There is also potential revenue to the CT HIE account from the coverage fee to be assessed by the Comptroller pursuant to section 3, depending on plan enrollment.[3]

Sections 10, 11 and 16 result in potential costs for the exchange from the exchange's own resources and the CT HIE account (state costs), dependent on the plan developed by OHS being approved. If the plan is approved, the exchange would incur costs, presumably from its own resources, of (1) at least $100,000 in FY 22 for an actuarial report to support the state's application for a Section 1332 State Innovation Waiver[4] and (2) up to $14.4 million in FY 22 and up to $12.5 million annually thereafter to establish the subsidiary exchange and operate it.[5]

Using funds in the CT HIE account, the exchange would incur the following state costs:

(1) up to $25 million annually for subsidies for people ineligible to buy qualified health plans (QHP) on the exchange,

[3] The amount would equal the amount of the Insurance Fund fee a domestic insurance company would pay for providing the same amount of fully-insured coverage as the Comptroller under the new plan. The Insurance Fund fee is set to the amount required to fund certain appropriations less the fund balance and was $33.2 million for FY 21. It applies to all types of admitted domestic insurers (including life, property and casualty, etc.).

[4] $100,000 reflects the cost of a report to support a waiver for a reinsurance program; there may be additional consulting services costs to demonstrate that other proposed program aspects meet the federal requirements for state innovation waiver approval.

[5] Most anticipated costs are for technology and vendor contracts for operations. The ability for the exchange to leverage existing functionality is anticipated to be limited by rules in the federal Affordable Care Act (ACA).

(2) up to $20 million annually to fund a reinsurance program,[6]

(3) $1.7 to $3.5 million in FY 22 and $5.3 to $7.5 million in FY 23 to eliminate premium costs for exchange enrollees with household incomes up to 200% of the federal poverty level (FPL).[7]

(4) significant costs, the amount of which is dependent on the design of the program, to reduce the cost of premiums and cost-sharing for exchange enrollees with household incomes greater than 200% FPL and any other actions necessary to implement the Section 1332 waiver program if federal approval for it is granted. As an example, the cost for an average subsidy of $1,000 for the approximately 75,000 exchange enrollees with household incomes above 200% of FPL would be $75 million, excluding administration.

As the state costs could easily exceed the moneys available in the CT HIE account designated by the bill to pay for these requirements (approximately $50 million), it is unclear what aspects of the plan would be funded and at what level.

These sections may also result in a revenue gain to the General Fund beginning as early as FY 23. Generally, Section 1332 waiver programs generate new state revenue from the federal government (known as "pass-through" funding) which can partially fund the program. The amount is based on how much the program reduces federal premium tax credits for Connecticut exchange enrollees. Previous research has estimated that a reinsurance program with a state investment of $19.5 million could generate $23 million or more in federal pass-through

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[6] The cost of a reinsurance program is primarily for reinsurance payments but would also include $150,000 to $500,000 in annual expenses for administration, depending on program complexity and assuming the Health Reinsurance Association would operate the program through a third-party administrator.

[7] These estimates include the impact of temporarily increased federal subsidies for exchange enrollees in 2021 and 2022 and reflect the assumption that exchange enrollees likely to be eligible for HUSKY A under the bill will switch to that coverage. Premium inflation of 2% and 5% over 2021 rates is assumed for FY 22, and FY 23 costs, respectively. Future year costs would be higher unless the increased federal subsidies are extended.

funding.[8] Any such revenue would be received annually while the waiver was in effect, after the waiver was applied for and approved.

Section 14 may result in a cost to the state going forward pursuant to the federal Affordable Care Act (ACA) for costs related to the coverage of blood pressure monitors and peak flow meters under QHP sold on the exchange.[9] While most of the mandated benefits in Section 14 are understood to be included in the benchmark plan, and therefore not anticipated to trigger any ACA-required defrayment of the premium cost for exchange enrollees, coverage under the benchmark plan for blood pressure monitors and peak flow meters is understood to be restricted to enrollees participating in certain carrier programs. To the extent that expanding coverage of those devices to all those specified in the bill results in higher premium costs, the state will be responsible for the corresponding premium increases in exchange plans, which are not expected to be significant.

Section 16, which also requires that OHS submit a report, made in consultation with the Department of Social Services (DSS) and the exchange, on whether or not the state should seek a Section 1115 waiver, is not anticipated to result in a fiscal impact to OHS, nor are other provisions of the bill.

Section 17 results in a cost to DSS of approximately $36 million in FY 22 and $61.3 million in FY 23 associated with increasing income eligibility under HUSKY A to 206% of the federal poverty level (FPL) from 160% FPL, inclusive of the income disregard.[10]

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[8] Research by Wakely Consulting Group, LLC. commissioned by the exchange and reported in February 2020. Note that such estimates may no longer be accurate due to significant shifts in the individual insurance market from the COVID-19 pandemic and changes to federal subsidies under the American Rescue Plan.

[9] The ACA requires that QHP offered on the exchange include the federally-defined essential health benefits package (EHB). States can mandate benefits in excess of the EHB, however if the benefits are not already covered under the state's benchmark plan, federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage.

[10] The 5% income disregard under modified adjusted gross income (MAGI) standards effectively makes 201% equal 206% FPL.

Section 18 results in a cost to the exchange, from its own resources, of up to $750,000 for technology upgrades to its system necessary for receiving referrals from the Labor Department and determining eligibility for coverage or assistance of those applying for unemployment compensation benefits.

The Out Years

The fiscal impacts identified above will continue subject to approval of the OHS plan, enrollment in the Comptroller's group health plan, enrollment and premiums in the individual health insurance market on the exchange and its subsidiary exchange, federal approval of a Section 1332 waiver, actual savings to the federal government under an approved Section 1332 waiver, federal action on health insurance subsidies, and the number of newly eligible individuals and associated costs under HUSKY A.

Sources: ConnectiCare benchmark plan and formulary documents
Connecticut Health Insurance Exchange
Department of Social Services
Office of the State Comptroller

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)