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sHB-6447
AN ACT CREATING THE COVERED CONNECTICUT PROGRAM TO EXPAND ACCESS TO AFFORDABLE HEALTH CARE.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Insurance Dept.; Department of Revenue Services	GF - Revenue Gain	Approx. 30 million	Approx. 50 million
Department of Revenue Services	GF - Cost	None	Less than 100,000
Department of Revenue Services	GF - Potential Cost	Less than 500,000	Less than 500,000
The Exchange; Social Services, Dept.	GF - Potential Cost	See Below	See Below
The Exchange	GF - Potential Revenue Gain	None	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill requires the Office of Health Strategy (OHS), in consultation with the Connecticut Health Insurance Exchange ("exchange") and the Department of Social Services (DSS) and insurance commissioners, to create a plan for a Covered Connecticut program to reduce the state's uninsured rate. There is no anticipated cost to OHS to develop the plan.

The bill establishes the Covered Connecticut Account, a separate non-lapsing General Fund account, to contain all funding for the new program. The bill results in a revenue gain to this account of at least $30 million in FY 22 and at least $50 million in FY 23 and annually

thereafter. Revenue in FY 23 and thereafter comes from the combination of 1) fines on pharmaceutical manufacturers that violate the provisions of the bill and 2) an annual assessment on health insurers, HMOs, and exempt insurers collected by the Insurance Department (DOI) to cover the funding gap between the fine revenue and $50 million. In FY 22, the revenue is only from the health carriers' assessment, which is set at $30 million. The bill authorizes DOI to collect late fees of $100 a day and assess civil penalties of up to $15,000 for other than a "good faith discrepancy" in a carrier's reporting associated with the assessment, which could result in additional minimal revenue to the account. There is no anticipated cost to DOI to carry out the assessment, as it is similar to others the agency collects from the same entities.

The bill results in an annual cost to the exchange and DSS, up to the amount of funding available in the Covered Connecticut Account, to implement the Covered Connecticut program if the plan is approved by the Insurance and Real Estate Committee each year. The cost will vary based on the components included in the program and each component's design. The plan may call for the exchange to establish a state health insurance premium subsidy program, a reinsurance program, and apply for and implement a federal Section 1332 state innovation waiver. If the plan calls for the exchange to apply for a state innovation waiver, there will be a cost of at least $100,000 for an actuarial report to support the state's application. The plan may also call for DSS to expand eligibility for Medicaid. The cost of these components could easily match the available funding.

Conditional on seeking and receiving federal approval for a state innovation waiver, the bill may result in an additional revenue gain starting in FY 23 or later. Generally, state innovation waiver programs generate new state revenue from the federal government (known as "pass-through" funding) that can be used to partially fund the initiative. The amount is based on how much the program reduces

federal premium tax credits for Connecticut exchange enrollees.[1] Any such revenue would be received annually while the waiver was in effect.

The bill requires pharmaceutical manufacturers that violated the pricing provisions during the previous calendar year to annually pay the Department of Revenue Services (DRS) commissioner the civil penalty the bill imposes. This results in: 1) a potential revenue gain to the Covered Connecticut account beginning in FY 23, and 2) a one-time cost of less than $100,000 in FY 23 associated with tax form development, postage costs, and associated updates to the online Taxpayer Service Center.

It is unclear how violations of the bill's provisions by pharmaceutical manufacturers would be determined. To the extent the DRS is required to monitor pharmaceutical company sales and investigate potential violations, there is a cost to the agency beginning as early as FY 22. Any potential cost is anticipated to be less than $500,000 annually.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the fines and penalties assessed, the design of the annual OHS plan and its approval, including the number of any newly eligible individuals and associated costs under any expansion of Medicaid eligibility, and the actual amount of federal premium tax credit savings achieved under any federally approved state innovation waiver.

[1]For example, research by Wakely Consulting Group, LLC. conducted for the exchange in February 2020 estimated that a reinsurance program under a state innovation waiver with a state investment of $19.5 million could generate $23 million or more in federal pass-through funding.