



General Assembly

**Substitute Bill No. 842**

January Session, 2021



**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 Section 3-123rrr of the general statutes is repealed and the  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-478l 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 (b) Not later than September first, annually, the Secretary of the Office  
459 of Policy and Management, in consultation with the Commissioner of  
460 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<sub>2</sub> [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 478l.

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)] (9) "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, as amended by this act, 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;

1456 (5) Whether to require qualified health plans to provide the essential  
1457 health benefits package, as described in Section 1302(a) of the  
1458 Affordable Care Act, or include additional state mandated benefits;

1459 (6) Whether to list dental benefits separately on the exchange's  
1460 Internet web site where a qualified health plan includes dental benefits;

- 1461 (7) The relationship of the exchange to insurance producers;
- 1462 (8) The capacity of the exchange to award Navigator grants pursuant  
1463 to section 38a-1087;
- 1464 (9) Ways to ensure that the exchange is financially sustainable by  
1465 2015, as required by the Affordable Care Act including, but not limited  
1466 to, assessments or user fees charged to carriers;
- 1467 (10) Methods to independently evaluate consumers' experience,  
1468 including, but not limited to, hiring consultants to act as secret shoppers;  
1469 and
- 1470 (11) The status of the implementation and administration of the all-  
1471 payer claims database program established under section 19a-755a.
- 1472 (b) Not later than January 1, 2012, and annually thereafter, the chief  
1473 executive officer of the exchange shall report, in accordance with section  
1474 11-4a, to the Governor and the General Assembly on:
- 1475 (1) Any private or federal funds received during the preceding  
1476 calendar year and, if applicable, how such funds were expended;
- 1477 (2) The adequacy of federal funds for the exchange prior to January  
1478 1, 2015;
- 1479 (3) The amount and recipients of any grants awarded; and
- 1480 (4) The current financial status of the exchange.
- 1481 (c) Not later than April 1, 2022, and annually thereafter, the chief  
1482 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] two hundred one 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	<i>July 1, 2021</i>	3-123rrr
Sec. 2	<i>July 1, 2021</i>	New section
Sec. 3	<i>July 1, 2021</i>	New section
Sec. 4	<i>July 1, 2021</i>	New section
Sec. 5	<i>July 1, 2021</i>	19a-7j
Sec. 6	<i>July 1, 2021</i>	19a-7p
Sec. 7	<i>July 1, 2021</i>	38a-52
Sec. 8	<i>July 1, 2021</i>	38a-1041
Sec. 9	<i>July 1, 2021</i>	New section
Sec. 10	<i>July 1, 2021</i>	38a-1080
Sec. 11	<i>July 1, 2021</i>	38a-1084
Sec. 12	<i>July 1, 2021</i>	38a-1089
Sec. 13	<i>July 1, 2021</i>	New section
Sec. 14	<i>July 1, 2021</i>	New section
Sec. 15	<i>July 1, 2021</i>	19a-754a(a) and (b)
Sec. 16	<i>July 1, 2021</i>	New section
Sec. 17	<i>July 1, 2021</i>	17b-261(a)
Sec. 18	<i>July 1, 2021</i>	New section

**INS**

*Joint Favorable Subst. C/R*

**FIN**