

SB 842 -- Redline

FIN Joint Favorable to File No. 640 -- AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

Deletions ~~struck~~ · Insertions underlined

Senate General Assembly ~~Substitute~~File-Bill No.

~~842~~640 January Session, 2021 ~~AN~~Substitute ~~ACT~~Senate ~~CONCERNING~~Bill ~~HEALTH~~No. ~~INSURANCE AND HEALTH CARE IN CONNECTICUT.~~

842 Senate, May 10, 2021 The Committee on Finance, Revenue and Bonding reported through SEN. FONFARA of the 1st Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

(2)"Healthenhancement program"meansthe programestablishedin accordance with the provisions of the Revised State Employees Bargaining Agent Coalition agreement, approved by the General Assembly on August 22, 2011, for state employees, as may be amended ~~bys~~SB842 stipulated/ agreements.File No.

640 1 sSB842 File No.

640 by stipulated agreements.

LC0[(2)] \\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00842-R1(4) of "Nonstate 50public SB.docxemployee" Substitutemeans Billany No. ~~employee or elected officer of a nonstate public employer.~~

~~842 [(2)] (4) "Nonstate public employee" means any employee or elected officer of a nonstate public employer.~~

[(5) "Health enhancement program" means the program established in accordance with the provisions of the Revised State Employees Bargaining Agent Coalition agreement, approved by the General Assembly on August 22, 2011, for state employees, as may be amended by stipulated agreements.] ~~[(6)]sSB842 (9)/ "Value-based~~File insuranceNo. ~~design" means health benefit designs that lower or remove financial barriers to essential, high-value clinical services.~~

~~[(7)640 "Health2 caresSB842 coverageFile type" means the type of health care LC0 {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0082 of 50 R02-SB.docx } Substitute Bill No.~~

~~842640 coverage[(6)] offered(9) by"Value-based nonstateinsurance publicdesign" employers,means including,health butbenefit notdesigns limitedthat to,lower coverageor forremove afinancial nonstatebarriers publicto employee,essential, nonstatehigh-value publicclinical employeeeservices.-plus spouse and nonstate public employee plus family.] Sec.~~

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

(C) Family size, provided premium payments for family coverage ~~shalls~~SB842 not/ exceedFile theNo. ~~lesser of;~~

640 3 sSB842 File No.

640 shall not exceed the lesser of:

or LC0(ii) {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0083The sum of 50the R02-SB.docxpremium }payments Substitutefor Billall No. ~~covered family members who are twenty-one years of age or older and the eldest three covered dependents who are younger than twenty-one years of age;~~

~~842 (ii) The sum of the premium payments for all covered family members who are twenty-one years of age or older and the eldest three covered dependents who are younger than twenty-one years of age;~~

(B) The health and welfare fee assessed by the Insurance Commissioner against multiemployer plans, nonprofit employers and small employers pursuant to section 19a-7j of the general statutes, as amended by this act, which the Comptroller shall annually collect from the administrators of multiemployer plans, nonprofit employers and small employers, and pay to the Insurance Commissioner, pursuant to ~~sections~~SB842 19a-7j/ ofFile theNo. ~~general statutes, as amended by this act;~~

~~(C)640 The4 publicSB842 healthFile fee assessed by the Insurance Commissioner LC0 {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0084 of 50 R02-SB.docx } Substitute Bill No.~~

~~842640 against multiemployer plans, nonprofit employers and small employers pursuant to section 19a-7p19a-7j of the general statutes, as amended by this act, which the Comptroller shall annually collect from the administrators of multiemployer plans, nonprofit employers and small employers, and pay to the Insurance Commissioner, pursuant to section 19a-7p of the general statutes, as amended by this act;~~

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

7p of the general statutes, as amended by this act;

(D) Be approved by the Insurance Department and Health Care Cost ~~Containment~~SB842 Committee/ duringFile
~~publicNo. meetings of the Insurance Department and Health Care Cost Containment Committee;~~

~~LC0640 {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0085 of sSB842 50File R02-SB.docx } Substitute Bill No.~~

~~842640 (E) Containment IncludeCommittee coverage during for; public meetings of the Insurance Department and Health Care Cost Containment Committee;~~

(E) Include coverage for:

and ~~(II) sSB842 Nonprofit/ employersFile thatNo. are not small employers;~~

~~or640 LC06 {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0086 sSB842 ofFile 50 R02-SB.docx } Substitute Bill No.~~

~~842640 (ii)(II) OneNonprofit yearemployers forthat are not small employers.employers;~~

or (ii) One year for small employers.

and ~~LC0 sSB842 {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0087/ ofFile 50 R02-SB.docx } Substitute Bill No.~~

~~842640 (D) Procedures sSB842 toFile collectNo. demographic data, including, but not limited to, self-reported ethnic and racial data, concerning the plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers in this state, their employees and their employees' dependents and small employers in this state, their employees and their employees' dependents receiving coverage provided by the Comptroller pursuant to this section.~~

640 (D) Procedures to collect demographic data, including, but not limited to, self-reported ethnic and racial data, concerning the plan participants and beneficiaries in this state under a multiemployer plan, nonprofit employers in this state, their employees and their employees' dependents and small employers in this state, their employees and their employees' dependents receiving coverage provided by the Comptroller pursuant to this section.

~~LC0 sSB842 {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0088/ ofFile 50 R02-SB.docx } Substitute Bill No.~~

~~842640 (I) 8 The sSB842 numberFile ofNo. multiemployer plans, nonprofit employers and small employers that received coverage provided by the Comptroller pursuant to this section during the immediately preceding fiscal year;~~

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

and (B) Such services, including, but not limited to, any services to ensure compliance with the Employee Retirement Income Security Act of 1974,

~~LC0 as amended from time to time, and regulations adopted thereunder, that {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0089 sSB842 of/ 50File R02-SB.docx } Substitute Bill No.~~

~~842640 as amended from time to time, and regulations adopted thereunder, that 9 the sSB842 ComptrollerFile deemsNo. necessary to administer coverage provided by the Comptroller pursuant to this section.~~

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

and (2) Establish a risk fund to pay claims that exceed the premiums ~~LC0 collected~~

~~{\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0010 for of a 50 multiemployer R02-SB.docx plan, } nonprofit Substitute employer Bill or small employer receiving coverage provided by the Comptroller pursuant to sSB842 / File No.~~

~~842640 collected10 for sSB842 aFile multiemployerNo. plan, nonprofit employer or small employer receiving coverage provided by the Comptroller pursuant to this section, fund such risk fund through a risk fund fee assessed by the Comptroller against such multiemployer plan, nonprofit employer or small employer and establish operating procedures for use of such fund.~~

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

(3) The Comptroller shall prominently display a link to each report card prepared pursuant to subdivision (1) of this subsection on the ~~LC0 Comptroller's {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0011 Internet of web 50 site. R02-SB.docx } Substitute Bill No.~~

~~842(f) Comptroller's Any Internet administrator web of site, a multiemployer plan, nonprofit employer sSB842 / File No.~~

~~(f) 640 Any11 administrator sSB842 ofFile aNo. multiemployer plan, nonprofit employer or small employer that files an application with the Comptroller for the coverage offered by the Comptroller pursuant to this section may submit a request to the Comptroller, in a form and manner prescribed by the Comptroller, for a provider disruption report.~~

640 or small employer that files an application with the Comptroller for the coverage offered by the Comptroller pursuant to this section may submit a request to the Comptroller, in a form and manner prescribed by the Comptroller, for a provider disruption report.

~~LC0 Sec. {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0012 of 50 R02-SB.docx } Substitute Bill No.~~

~~842 Sec.~~

(NEW) (Effective July 1, 2021) (a) For each fiscal year beginning on or after July 1, 2021, the Comptroller shall assess a fee against all multiemployer plans, nonprofit employers and small employers ~~receiving SSB842 coverage/ provided File by No. the Comptroller pursuant to section 2 of this act, and the administrator of each such multiemployer plan and each such nonprofit employer and small employer shall pay such assessment to the Comptroller pursuant to this section for deposit in the Connecticut Health Insurance Exchange account established under section 13 of this act.~~

~~640 12 sSB842 File No.~~

~~640 receiving coverage provided by the Comptroller pursuant to section 2 of this act, and the administrator of each such multiemployer plan and each such nonprofit employer and small employer shall pay such assessment to the Comptroller pursuant to this section for deposit in the Connecticut Health Insurance Exchange account established under section 13 of this act.~~

The administrator of ~~LC0 each {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0013} multiemployer of plan 59 and R02-SB.docx each }~~ such ~~Substitute~~ nonprofit ~~Bill~~ employer and small employer shall pay to the Comptroller, on or before the following December thirty-first and March thirty-first, annually, the proposed sSB842 / ~~File No.~~

~~842 640 each 13 multiemployers SSB842 plan File and No. each such nonprofit employer and small employer shall pay to the Comptroller, on or before the following December thirty-first and March thirty-first, annually, the proposed assessment due from such multiemployer plan, nonprofit employer or small employer in two equal installments.~~

~~640 assessment due from such multiemployer plan, nonprofit employer or small employer in two equal installments.~~

~~LC0 (3) {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0014} "Nonstate public employer" has the same meaning as provided in sections 3-123aaa and 3-123rrr of 59 the R02-SB.docx general } statutes. Substitute as Bill amended No. by this act;~~

~~842 sSB842 (3) / "Nonstate File public No. employer" has the same meaning as provided in sections 3-123aaa and 3-123rrr of the general statutes, as amended by this act;~~

~~(4) 640 "Partnership 14 plan" sSB842 means File (A) No. a health care benefit plan offered by the Comptroller to (i) nonstate public employers or nonprofit employers pursuant to section 3-123bbb of the general statutes, (ii) graduate assistants at The University of Connecticut and The University of Connecticut Health Center, (iii) postdoctoral trainees at The University of Connecticut and The University of Connecticut Health Center, (iv) graduate fellows at The University of Connecticut and The University of Connecticut Health Center, and (v) graduate students of The University of Connecticut participating in university-funded internships as part of their graduate program, and (B) a group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller pursuant to (i) subsection (a) of section 3-123sss of the general statutes, or (ii) section 2 of this act;~~

~~640 (4) "Partnership plan" means (A) a health care benefit plan offered by the Comptroller to (i) nonstate public employers or nonprofit employers pursuant to section 3-123bbb of the general statutes, (ii) graduate assistants at The University of Connecticut and The University of Connecticut Health Center, (iii) postdoctoral trainees at The University of Connecticut and The University of Connecticut Health Center, (iv) graduate fellows at The University of Connecticut and The University of Connecticut Health Center, and (v) graduate students of The University of Connecticut participating in university-funded internships as part of their graduate program, and (B) a group hospitalization, medical, pharmacy and surgical insurance plan developed by the Comptroller pursuant to (i) subsection (a) of section 3-123sss of the general statutes, or (ii) section 2 of this act;~~

(b) Beginning on July 1, 2021, the Auditors of Public Accounts shall audit the books and accounts of the State Comptroller, and any third-party administrator engaged by the State Comptroller, maintained for the partnership plan or plans or the state employee plan and certify the ~~LC0 results~~

~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-008415 to of the 59 Governor. R02-SB.docx } Substitute Bill No.~~

~~842 results to the Governor.~~

~~(a) sSB842 As/ used File in No. this section:~~

~~640 15 sSB842 File No.~~

~~640 (a) As used in this section:~~

~~LC0 (i) {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0016} [vaccines] Vaccines to prevent hepatitis A and B in persons of 59 all R02-SB.docx ages, } as Substitute recommended Bill by No. the schedule for immunizations published by the National Advisory Committee for Immunization Practices;~~

~~842 (i) [vaccines] Vaccines to prevent hepatitis A and B in persons of all ages, as recommended by the schedule for immunizations published by the National Advisory Committee for Immunization Practices;~~

~~[the] (I) sSB842 The/ treatment File of No. tuberculosis and biologics;~~

~~640 16 sSB842 File No.~~

~~640 (I) The treatment of tuberculosis and biologics;~~

[(b) (1) As used in this subsection, (A) "health insurance" means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and (B) "exempt insurer" means a domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of ~~LC0~~subdivision ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0017}~~(11) of 59 section R02-SB.docx 38a-720 } ~~and Substitute Bill 38a-720a.~~ No. [(2)] (c) (1) (A) Each domestic insurer [or] and domestic health care center doing health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

~~842~~SB842 ~~subdivision/ (11) File of No. section 38a-720 and section 38a-720a.] [(2)] (c) (1) (A) Each domestic insurer [or] and domestic health care center doing health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.~~

~~(B) 640 Each 17 third-party administrator File licensed No. pursuant to section 38a-720a that provides administrative services for self-insured health benefit plans and each exempt insurer shall, on behalf of the self-insured health benefit plans for which such third-party administrator or exempt insurer provides administrative services, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.~~

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

[, each such] (A) Each domestic insurer [,] and domestic health care center [,] described in subparagraph (A) of subdivision (1) of this subsection, and each third-party administrator and exempt insurer described in subparagraph (B) of subdivision (1) of this subsection, shall report to the Insurance Commissioner, on a form designated by [said commissioner] the Insurance Commissioner, the number of insured or enrolled lives in this state as of the May first immediately preceding for which such domestic insurer, domestic health care center, third-party administrator or exempt insurer [is] was providing health insurance or administering a self-insured health benefit plan [that provides] providing coverage of ~~LC0 the {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0018} types of specified 59 in R02-SB.docx subdivisions }~~(1), Substitute (2), Bill (4), No. (11) and (12) of section 38a-469, [~~842 the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, [~~

[.] and (B) The Comptroller shall report to the Insurance Commissioner, in the form and manner prescribed by the Insurance Commissioner:

~~(i) sSB842 For/ each File multiemployer No. plan described in subparagraph (C) of subdivision (1) of this subsection, the number of such multiemployer plan's plan participants and beneficiaries in this state for whom the Comptroller was providing coverage pursuant to section 2 of this act as of the May first immediately preceding;~~

640 18 sSB842 File No.

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

Such fee shall be calculated by multiplying the number of lives reported to [said ~~LC0~~commissioner] ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0019} the Insurance Commissioner pursuant to subparagraph (A) of 59 subdivision R02-SB.docx [(3)] }~~(2) Substitute of Bill this subsection, and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of this subsection, by a factor, determined annually by [said commissioner] the Insurance Commissioner as set forth in this subdivision, to fully fund the amount determined under subdivision (1) of subsection [(a)] (b) of this section, adjusted for a health and welfare fee, by subtracting, if the amount appropriated was more than the sSB842 / File No.

~~842 640 commissioner] 19 the sSB842 Insurance File Commissioner No. pursuant to subparagraph (A) of subdivision [(3)] (2) of this subsection, and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of this subsection, by a factor, determined annually by [said commissioner] the Insurance Commissioner as set forth in this subdivision, to fully fund the amount determined under subdivision (1) of subsection [(a)] (b) of this section, adjusted for a health and welfare fee, by subtracting, if the amount appropriated was more than the amount expended or by adding, if the amount expended was more than the amount appropriated, the amount calculated under subdivision (2) of subsection [(a)] (b) of this~~

~~section.~~

640 amount expended or by adding, if the amount expended was more than the amount appropriated, the amount calculated under subdivision (2) of subsection [(a)] (b) of this section.

[Each] The Comptroller shall collect such fee from each such multiemployer plan, nonprofit employer and small employer described in subparagraph (C) of subdivision (1) of this subsection and pay such fee to the Insurance Commissioner, and each such domestic insurer, ~~LCO~~domestic ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0020}~~health of care ~~59~~center, ~~R02-SB.docx~~third-party administrator ~~Substitute and Bill~~exempt ~~No.~~insurer shall pay such fee to the Insurance Commissioner, not later than February first, annually.

~~842(B) Any [such] domestic insurer [,] or domestic health care center, center described in subparagraph (A) of subdivision (1) of this subsection, third-party administrator and/or exempt insurer shall described pay in such subparagraph fee(B) to of subdivision (1) of this subsection or the Insurance administrator Commissioner, of not a later multiemployer than plan, February a first, nonprofit annually. employer or a small employer described in subparagraph (C) of subdivision (1) of this subsection that sSB842 / File No.~~

~~(B)640 Any20 [such]sSB842 domesticFile insurerNo. [,] or domestic health care center described in subparagraph (A) of subdivision (1) of this subsection, third-party administrator or exempt insurer described in subparagraph (B) of subdivision (1) of this subsection or the administrator of a multiemployer plan, a nonprofit employer or a small employer described in subparagraph (C) of subdivision (1) of this subsection that is aggrieved by an assessment levied under this subsection may appeal therefrom in the same manner as provided for appeals under section 38a-52, as amended by this act.~~

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

[(7)](6)(A)The Insurance Commissioner shall apply an overpayment ~~LCO~~of ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0021}~~the health and welfare fee by [an] a domestic insurer, domestic health care center, third-party administrator or exempt insurer, or by the Comptroller on behalf of ~~59a R02-SB.docx~~multiemployer }plan, ~~Substitute~~nonprofit ~~Bill~~employer ~~No.~~or small employer described in subparagraph (C) of subdivision (1) of this subsection, for any fiscal year as a credit against the health and welfare fee due from such domestic insurer, domestic health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small employer for the succeeding fiscal year, subject to an adjustment under subdivision [(4)] (3) of this subsection:

~~842[, of if:] the sSB842 health/ andFile welfareNo. fee by [an] a domestic insurer, domestic health care center, third-party administrator or exempt insurer, or by the Comptroller on behalf of a multiemployer plan, nonprofit employer or small employer described in subparagraph (C) of subdivision (1) of this subsection, for any fiscal year as a credit against the health and welfare fee due from such domestic insurer, domestic health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small employer for the succeeding fiscal year, subject to an adjustment under subdivision [(4)] (3) of this subsection:~~

~~[, 640 if:]21 (i)sSB842 [The]File IfNo. the amount of the overpayment exceeds five thousand dollars;~~
640 (i) [The] If the amount of the overpayment exceeds five thousand dollars;

~~LCO(C) {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00822}~~Failure of ~~59~~[an] ~~R02-SB.docxa~~ }domestic ~~Substitute~~insurer, ~~Bill~~domestic ~~No.~~health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small employer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph [(A)] (A)(ii) of this subdivision constitutes a waiver of any demand of the domestic insurer, domestic health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small employer against the state on account of such overpayment.

~~842(D) (C)Nothing Failure of [an] a domestic insurer, domestic health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small employer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph [(A)] (A)(ii) of this subdivision constitutes shall be waiver construed of to any prohibit demand of the domestic insurer, domestic health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small limit employer sSB842 against/ theFile stateNo. on account of such overpayment.~~

~~(D)640 Nothing22 in sSB842 thisFile subdivisionNo. shall be construed to prohibit or limit the right of [an] a domestic insurer, domestic health care center, third-party administrator, [or] exempt insurer, multiemployer plan, nonprofit employer or small employer to appeal pursuant to subparagraph (B) of subdivision [(5)] (4) of this [section] subsection.~~

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

~~LCO[(a)] {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0023}~~(b) Not later than September first, annually, the Secretary of ~~59~~the ~~R02-SB.docx~~Office }of ~~Substitute~~Policy ~~Bill~~and ~~No.~~Management, in consultation with

the Commissioner of Public Health, shall:

~~842 [(a)] (b) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall:~~

~~(A) "Health insurance" means health insurance~~SB842 of/ theFile typesNo. specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

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640 insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469:

Such number shall not include] excluding any lives enrolled in Medicare, any medical assistance program administered by the ~~LCO~~Department {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0024 of 59Social R02-SB.docx~~Services, }~~workers' Substitute~~compensation Bill~~insurance No. or Medicare Part C plans;

~~842 [.] Department and of (B) Social The Services, Comptroller workers' shall compensation report insurance to or the Medicare Insurance Part Commissioner, in plans; the form and manner prescribed by the Insurance Commissioner;~~

~~and (B) The Comptroller shall report to the Insurance Commissioner, in the form and manner prescribed by the Insurance Commissioner;~~

~~(ii) sSB842 For/ eachFile nonprofitNo. employer described in subdivision (1) of this subsection, the number of such nonprofit employer's employees and their dependents in this state for whom the Comptroller was providing coverage pursuant to section 2 of this act as of the May first immediately preceding;~~

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

Such fee shall be calculated by multiplying the number of lives reported to [said commissioner] the Insurance Commissioner pursuant to subparagraph (A) of subdivision [(3)] (2) of subsection [(b)] (c) of this section, and the number of plan participants, beneficiaries, employees and dependents reported to the Insurance Commissioner pursuant to subparagraph (B) of subdivision (2) of subsection (c) of this section, by a factor, determined annually by [said commissioner] the Insurance ~~LCO~~Commissioner {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-008425 as set forth in this subsection, to fully fund the aggregate amount determined under subdivision (1) of 59 subsection R02-SB.docx [(a)] } (b) Substitute of Bill this No. section.

~~842 Commissioner as set forth in this subsection, to fully fund the aggregate amount determined under subdivision (1) of subsection [(a)] (b) of this section.~~

~~[(d)] (e) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each [such] domestic insurer and sSB842 domestic/ healthFile careNo. center described in subdivision (1) of subsection (c) of this section, and to the Comptroller for each multiemployer plan, nonprofit employer or small employer described in subdivision (1) of subsection (c) of this section, that includes the proposed fee, identified on such statement as the "Public Health fee", for [the] such domestic insurer, [or] domestic health care center, multiemployer plan, nonprofit employer or small employer, calculated in accordance with this section.~~

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640 and domestic health care center described in subdivision (1) of subsection (c) of this section, and to the Comptroller for each multiemployer plan, nonprofit employer or small employer described in subdivision (1) of subsection (c) of this section, that includes the proposed fee, identified on such statement as the "Public Health fee", for [the] such domestic insurer, [or] domestic health care center, multiemployer plan, nonprofit employer or small employer, calculated in accordance with this section.

[Each such] The Comptroller shall collect such fee from each such multiemployer plan, nonprofit employer and small employer and pay such fee to the Insurance ~~LCO~~Commissioner,

~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0026 and of each 59 such R02-SB.docx domestic } insurer Substitute and Bill domestic No. health care center shall pay such fee to the Insurance Commissioner, not later than February first, annually.~~

~~842 Commissioner, and each such domestic insurer and domestic health care center shall pay such fee to the Insurance Commissioner, not later than February first, annually.~~

~~[(f)] (g) (1) The Insurance Commissioner shall apply an overpayment of the public health fee by [an] a domestic insurer or domestic health care sSB842 center, / orFile byNo. the Comptroller on behalf of a multiemployer plan, nonprofit employer or small employer described in subdivision (1) of subsection (c) of this section, for any fiscal year as a credit against the public health fee due from such domestic insurer, [or] domestic health care center, multiemployer plan, nonprofit employer or small employer for the succeeding fiscal year, subject to an adjustment under subsection [(c)] (d) of this section.~~

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640 care center, or by the Comptroller on behalf of a multiemployer plan, nonprofit employer or small employer described in subdivision (1) of subsection (c) of this section, for any fiscal year as a credit

against the public health fee due from such domestic insurer, [or] domestic health care center, multiemployer plan, nonprofit employer or small employer for the succeeding fiscal year, subject to an adjustment under subsection [(c)] (d) of this section:

LC0(A) {\PRDFS1\SCOUSERS\FORZANOF\WS\2021SB-00827[determine] ofDetermine 59whether R02-SB.docxthe }domestic Substituteinsurer, Bill[or] No.-domestic health care center, multiemployer plan, nonprofit employer or small employer made an overpayment;

~~842 (A) [determine] Determine whether the domestic insurer, [or] domestic health care center, multiemployer plan, nonprofit employer or small employer made an overpayment;~~

(3) Failure of [an] a domestic insurer, [or] domestic health care center, multiemployer plan, nonprofit employer or small employer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph (B) of subdivision (1) of this subsection constitutes a waiver of any demand of the domestic insurer, [or] domestic sSB842 health/ careFile center, No.-multiemployer plan, nonprofit employer or small employer against the state on account of such overpayment.

640 27 sSB842 File No.

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

Any (1) domestic insurance company or other domestic entity aggrieved because of any assessment levied under section 38a-48, (2) fraternal benefit society or foreign or alien insurance company or other entity aggrieved because of any assessment levied under the provisions of sections 38a-49 to 38a-51, inclusive, [or] (3) domestic insurer, domestic health care center [,] or third-party administrator licensed pursuant to section 38a-720a, or exempt insurer, administrator of a multiemployer plan, nonprofit employer or small employer as defined in [subdivision (1) of] subsection [(b)] (a) of section 19a-7j, as amended by this act, aggrieved because of any assessment levied under said section 19a-7j, as amended by this act, or (4) domestic insurer or domestic health care center, or administrator of a multiemployer plan, nonprofit employer or LC0small {\PRDFS1\SCOUSERS\FORZANOF\WS\2021SB-0028employer as defined in subsection (a) of 59section R02-SB.docx19a-7p, }as Substituteamended Billby No.-this act, aggrieved because of any assessment levied under saidsection19a-7p,asamendedbythisact,may,withinonemonthfrom thetimeprovidedforthepaymentofsuchassessment,appealtherefrom to the superior court for the judicial district of New Britain, which appealshall beaccompaniedby acitationto thecommissioner to appear before said court.

~~842 small employer as defined in subsection (a) of section 19a-7p, as amended by this act, aggrieved because of any assessment levied under saidsection19a-7p,asamendedbythisact,may,withinonemonthfrom thetimeprovidedforthepaymentofsuchassessment,appealtherefrom to the superior court for the judicial district of New Britain, which appealshall beaccompaniedby acitationto thecommissioner to appear before said court.~~

Such appeals shall be preferred cases, to be heard, unless sSB842 cause/ appearsFile toNo.-the contrary, at the first session, by the court or by a committee appointed by the court.

640 28 sSB842 File No.

640 unless cause appears to the contrary, at the first session, by the court or by a committee appointed by the court.

(1) Assist health insurance consumers with managed care plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and LC0services; {\PRDFS1\SCOUSERS\FORZANOF\WS\2021SB-0020 of 59 R02-SB.docx } Substitute Bill No.

~~842 services;~~

(5) Analyze and monitor the development and implementation of federal, sSB842 state/ andFile localNo. laws, regulations and policies relating to health insurance consumers and recommend changes it deems necessary;

640 29 sSB842 File No.

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

LC0(12) {\PRDFS1\SCOUSERS\FORZANOF\WS\2021SB-0030Adopt ofregulations, 59pursuant R02-SB.docxto }chapter Substitute54, Billto No.-carry out the provisions of sections 38a-1040 to 38a-1050, inclusive;

~~842 (12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive;~~

(d) The Healthcare Advocate and the Insurance Commissioner shall jointly compile a list of complaints received against managed care organizations and preferred provider networks and the commissioner shall maintain the list, except the names of complainants shall not be disclosed sSB842 if/ suchFile disclosureNo.-would violate the provisions of section 4- 61dd or 38a-1045.

640 30 sSB842 File No.

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

(f) On or before October 1, 2008, the Office of the Healthcare Advocate shall, within available appropriations,

establish and maintain a healthcare consumer information web site on the Internet for use by the ~~LC0 public~~ ~~{\\PRDFS1\SCOUERS\FORZANO\WS\2021SB-0031}~~ ~~in of obtaining 50 healthcare R02-SB.docx information,~~ ~~}including Substitute but Bill not No. limited to:~~

~~842 public in obtaining healthcare information, including but not limited to:~~

(1) Collaborate with stakeholders, including, but not limited to, (A) state agencies, (B) the Behavioral Health Partnership established pursuant to section 17a-22h, ~~(C)sSB842 community/ collaboratives, File~~ ~~(D)No. the United Way's 2-1-1 Infoline program, and (E) providers;~~

~~640 31 sSB842 File No.~~

~~640 (C) community collaboratives, (D) the United Way's 2-1-1 Infoline program, and (E) providers;~~

~~LC0(h) {\\PRDFS1\SCOUERS\FORZANO\WS\2021SB-0032}The Office of 50the R02-SB.docxHealthcare }Advocate Substitute shall Bill provide No. assistance to the plan participants and beneficiaries in this state under multiemployer plans, nonprofit employers' employees and their dependents and small employers' employees and their dependents receiving coverage provided by the Comptroller pursuant to section 2 of this act that is equivalent to the assistance that the Office of the Healthcare Advocate provides to other health insurance consumers.~~

~~842 (h) The Office of the Healthcare Advocate shall provide assistance to the plan participants and beneficiaries in this state under multiemployer plans, nonprofit employers' employees and their dependents and small employers' employees and their dependents receiving coverage provided by the Comptroller pursuant to section 2 of this act that is equivalent to the assistance that the Office of the Healthcare Advocate provides to other health insurance consumers.~~

~~(2)sSB842 "Exempt/ insurer" File means No. an insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section 38a-720 of the general statutes and section 38a-720a of the general statutes;~~

~~640 32 sSB842 File No.~~

~~640 (3) "Exempt insurer" means an insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section 38a-720 of the general statutes and section 38a-720a of the general statutes;~~

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

~~(i) Determine the amount that the exchange requires to perform its LC0 duties {\\PRDFS1\SCOUERS\FORZANO\WS\2021SB-0033} under subparagraph (C) of 50 subdivision R02-SB.docx (28) } of Substitute section Bill 38a-1084 No. of the general statutes, as amended by this act;~~

~~842 duties under subparagraph (C) of subdivision (28) of section 38a-1084 of the general statutes, as amended by this act;~~

~~(2)sSB842 Not/ later File than No. July 1, 2021, and annually thereafter, each insurer, health care center and exempt insurer described in subdivision (1) of this subsection shall report to the commissioner, on a form designated by the commissioner, the number of insured or enrolled lives in this state as of the May first immediately preceding for which such insurer, health care center or exempt insurer was providing health insurance coverage, or administering a self-insured health benefit plan providing coverage, of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes.~~

~~640 33 sSB842 File No.~~

~~640 (2) Not later than July 1, 2021, and annually thereafter, each insurer, health care center and exempt insurer described in subdivision (1) of this subsection shall report to the commissioner, on a form designated by the commissioner, the number of insured or enrolled lives in this state as of the May first immediately preceding for which such insurer, health care center or exempt insurer was providing health insurance coverage, or administering a self-insured health benefit plan providing coverage, of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes.~~

~~(3) Not later than August 1, 2021, and annually thereafter, the commissioner shall determine the fee to be assessed for that year against each insurer, health care center and exempt insurer described in LC0 subdivision {\\PRDFS1\SCOUERS\FORZANO\WS\2021SB-0034} (1) of 50 this R02-SB.docx subsection. } Substitute Bill No.~~

~~842 subdivision (1) of this subsection.~~

~~Each such insurer, health care center and exempt insurer sSB842 shall/ pay File such No. fee to the commissioner not later than November first of that year.~~

~~640 34 sSB842 File No.~~

~~640 insurer shall pay such fee to the commissioner not later than November first of that year.~~

The commissioner may require an insurer, health care center or exempt ~~LCQ~~insurer ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0035~~subject of to 59this R02-SB.docxsubsection }to ~~Substitute~~produce Billany No.records in its possession, and may require any other person to produce any records in such other person's possession, that were used to prepare such report for examination by the commissioner or the commissioner's designee.

~~842 insurer subject to this subsection to produce any records in its possession, and may require any other person to produce any records in such other person's possession, that were used to prepare such report for examination by the commissioner or the commissioner's designee.~~

~~and sSB842 (ii) OnFile orNo. before April first of the year of the overpayment, the insurer, health care center or exempt insurer;~~

640 35 sSB842 File No.

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

and ~~LCQ~~(ii) ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0036~~Notify the insurer, health care center or exempt insurer of 59the R02-SB.docxcommissioner's }determination ~~Substitute~~under Billsubparagraph No.(B)(i) of this subdivision.

~~842 (ii) Notify the insurer, health care center or exempt insurer of the commissioner's determination under subparagraph (B)(i) of this subdivision.~~

(d) If another state, territory or district of the United States, or a foreign country, imposes on a Connecticut domiciled insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other domestic entity a retaliatory charge for the fee imposed under this section, such domestic entity may, not later than sixty days after receipt of notice of the imposition of the retaliatory charge for such fee, appeal to the Insurance Commissioner ~~for sSB842 a/ verification~~File thatNo. the fee imposed under this section is subject to retaliation by another state, territory or district of the United States, or a foreign country.

640 36 sSB842 File No.

640 for a verification that the fee imposed under this section is subject to retaliation by another state, territory or district of the United States, or a foreign country.

(e) The Insurance Commissioner may adopt regulations, in ~~LCQ~~accordance ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-008437~~with chapter 54 of 59the R02-SB.docxgeneral }statutes, ~~Substitute~~to Billimplement No.the provisions of this section.

~~842 accordance with chapter 54 of the general statutes, to implement the provisions of this section.~~

[(4) "Affordable Care Act" means the Patient Protection and ~~Affordable~~sSB842 Care/ Act,File P.L.No.

640 37 sSB842 File No.

640 Affordable Care Act, P.L.

~~LCQ~~(iii) ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0038~~Liability of insurance, 59including R02-SB.docxgeneral }liability ~~Substitute~~insurance Billand No-automobile liability insurance;

~~842 (iii) Liability insurance, including general liability insurance and automobile liability insurance;~~

(ii) Benefits for long-term care, nursing home care, home health care, ~~community-based~~sSB842 care/ orFile anyNo.-combination thereof;

640 38 sSB842 File No.

640 community-based care or any combination thereof;

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination ~~LCQ~~between ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0084239~~the provision of 59the R02-SB.docxbenefits }and ~~Substitute~~any Bill exclusion No.of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

~~842 between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;~~

(10)] (9) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 38a- ~~1086~~sSB842 / File No.

640 39 sSB842 File No.

640 1086;

~~LCQ~~[(14)] ~~{\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-008440~~(13) "Secretary" means the Secretary of 59the R02-SB.docxUnited }States ~~Substitute~~Department Bill of No.Health and Human Services;

~~842 [(14)] (13) "Secretary" means the Secretary of the United States Department of Health and Human~~

Services;

(5) Provide for enrollment periods, as provided under Section ~~1311(c)(6)~~ sSB842 of/ theFile AffordableNo. Care Act;

640 40 sSB842 File No.

640 1311(c)(6) of the Affordable Care Act;

(7) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs ~~LC0 of {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0041}the of exchange,~~ 59 including R02-SB.docx information }on Substitute moneys Bill lost No. to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

~~842 of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;~~

~~{11}sSB842 Collaborate/ withFile theNo. Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY A or any other state or local public program, to remain enrolled in a qualified health plan;~~

640 41 sSB842 File No.

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

(13) Establish a program for small employers through which ~~LC0 qualified {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0042}employers may access coverage for their employees and that shall enable any qualified employer to specify a level of 59 coverage R02-SB.docxso }that Substitute any Bill of No. its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;~~

~~842 qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;~~

(A) A list of the individuals granted a certification under subdivision ~~{15}sSB842 of/ thisFile section, No. including the name and taxpayer identification number of each individual;~~

640 42 sSB842 File No.

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

or ~~LC0(ii) {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0043}The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of 59the R02-SB.docxInternal }Revenue Substitute Code Bill to No. be unaffordable to the employee or not provide the required minimum actuarial value;~~

~~842 (ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value;~~

~~{A}sSB842 Conduct/ publicFile educationNo. activities to raise awareness of the availability of qualified health plans;~~

640 43 sSB842 File No.

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

~~LC0(D) {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0044}Provide referrals to the Office of 59the R02-SB.docxHealthcare }Advocate Substitute or Billhealth No. insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage;~~

~~842 and (D)(E) Provide referrals information to in thea Office manner of that theis Healthcareculturally Advocateand or linguistically healthappropriate insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, the needsof the or populationbeing any servedby other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee'sexchange; health benefit plan, coverage or a determination under that plan or coverage;~~

~~and (E) Provide information in a manner that is culturally and linguistically appropriate to the needsof the populationbeing servedby the exchange;~~

~~(A) Individuals who are knowledgeable about the healthcare system, have background or experience in making have background or informed decisions regarding experience in making informed decisions regarding health, sSB842 medical/ and File scientificNo. matters and are enrollees in qualified health plans;~~

640 44 sSB842 File No.

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

~~LCQ(D) {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0045}The Department of 59Social R02-SB.docxServices; } Substitute Bill No.~~

~~842 (D) The Department of Social Services;~~

~~(24) (A) Seek to include the most comprehensive health benefit plans that sSB842 offer/ highFile-quality benefits at the most affordable price in the exchange, (B) encourage health carriers to offer tiered health care provider network plans that have different cost-sharing rates for different health care provider tiers and reward enrollees for choosing low-cost, high-quality health care providers by offering lower copayments, deductibles or other out-of-pocket expenses, and (C) offer any such tiered health care provider network plans through the LCQ {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0046 of 59 R02-SB.docx } Substitute Bill No.~~

~~842640 exchange;45 sSB842 File No.~~

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

~~(I) sSB842 Collect/ demographicFile-data, including, but not limited to, self-reported ethnic and racial data, concerning the individuals receiving such coverage by, at a minimum, utilizing standardized categories developed by the Office of Health Strategy pursuant to subdivision (9) of subsection (b) of section 19a-754a of the general statutes, as amended by this act, including an "other" category and allowing any individual LCQ {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00847 of 59 R02-SB.docx } Substitute Bill No.~~

~~842640 who46 is sSB842 self-reportingFile ethnicNo.-or racial data to write in such individual's ethnicity or race, and select multiple ethnicities and races, on any form provided by such health carrier to collect such ethnic or racial data;~~

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

~~(i) Utilizing standardized categories developed by the Office of Health Strategy pursuant to subdivision (9) of subsection (b) of section 19a-754a sSB842 of/ theFile generalNo.-statutes, as amended by this act; 640 47 sSB842 File No.~~

640 19a-754a of the general statutes, as amended by this act;

and LCQ(29) {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00848}Determine whether individuals referred to the exchange by the Labor Commissioner pursuant to section 18 of 59this R02-SB.docxact }are Substituteeligible Billfor No-free or subsidized health coverage or other assistance or benefits, including, but not limited to, assistance under the supplemental nutrition assistance program, and, if such individuals are eligible for such coverage, assistance or benefits, enroll such individuals in such coverage, assistance or benefits.

~~842 (20) Determine whether individuals referred to the exchange by the Labor Commissioner pursuant to section 18 of this act are eligible for free or subsidized health coverage or other assistance or benefits, including, but not limited to, assistance under the supplemental nutrition assistance program, and, if such individuals are eligible for such coverage, assistance or benefits, enroll such individuals in such coverage, assistance or benefits.~~

~~(5) sSB842 Whether/ toFile requireNo.-qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the Affordable Care Act, or include additional state mandated benefits;~~

~~640 48 sSB842 File No.~~

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

~~LCQ(7) {\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0049}The relationship of 59the R02-SB.docxexchange }to Substituteinsurance Billproducers; No.~~

~~842 (7) The relationship of the exchange to insurance producers;~~

~~(c) Not later than April 1, 2022, and annually thereafter, the chief executive officer of the exchange shall submit a report, in accordance with sSB842 section/ 11-4a,File toNo.-the joint standing committee of the General Assembly having cognizance of matters relating to insurance disclosing, in the aggregate, the demographic data, if any, that:~~

~~(1) 640 The49 subsidiary sSB842 establishedFile pursuant to subparagraph (A) of subdivision (28) of~~

~~section 38a-1084, as amended by this act, reported to LCO (\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0050 of 50 R02-SB.docx } Substitute Bill No.~~

~~842640 thewith exchange~~ section pursuant 11-4a, to subparagraph the (A)(ii) joint standing committee of subdivision the (28) General of Assembly section having 38a-1084, cognizance as of matters relating amended to by insurance this disclosing, act, in for the aggregate, the preceding demographic calendar data, year, if any, that:

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

~~(b) sSB842 Notwithstanding/ any File provision No. of the general statutes and to the extent permitted by federal law, each qualified health plan that is offered through the exchange, in the individual market and at a silver level of coverage for plan year 2022 or any subsequent plan year shall provide coverage for the following benefits:~~

~~LC0640 (\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-005150 of sSB842 50 File R02-SB.docx } Substitute Bill No.~~

~~842640 (1)(b) Angiotensin Notwithstanding converting any enzyme provision inhibitors of for the an general enrollee statutes who and is to diagnosed the with extent congestive permitted heart by failure, federal diabetes law, or each coronary qualified artery health disease plan by that is licensed offered health through care the provider exchange, who in is the acting individual within market such and health at care a provider's silver scope level of practice; coverage for plan year 2022 or any subsequent plan year shall provide coverage for the following benefits:~~

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

~~(8) sSB842 Low/ density File lipoprotein No. testing for an enrollee who is diagnosed with heart disease by a licensed health care provider who is acting within such health care provider's scope of practice;~~

~~(9) 640 Selective 51 serotonin sSB842 reuptake File inhibitors for an enrollee who is LCO~~

~~(\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-008452 of 50 R02-SB.docx } Substitute Bill No.~~

~~842640 (8) Low density lipoprotein testing for an enrollee who is diagnosed with depression heart disease by a licensed health care provider who is acting within such health care provider's scope of practice;~~

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

The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties therein prescribed.

~~(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated sSB842 state/ health File care No. cost containment strategy;~~

~~(2) 640 Promoting 52 effective sSB842 health File planning and the provision of quality health care in the state in a manner that ensures access for all state LCO (\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00853 of 50 R02-SB.docx } Substitute Bill No.~~

~~842640 residents coordinated to state cost-effective health care services, cost avoids containment the strategy; duplication of such services and improves the availability and financial stability of such services throughout the state;~~

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

~~(8) Developing a plan pursuant to subsection (b) of section 16 of this act and submitting a report containing such plan pursuant to subsection (c) sSB842 of/ section File 16 No. of this act;~~

~~and 640 (9) 53 Developing sSB842 standardized File categories that enable (A) the LCO~~

~~(\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0054 of 50 R02-SB.docx } Substitute Bill No.~~

~~842640 Comptroller to collect demographic data pursuant to subparagraph (D) of subdivision (1) of subsection (c) of section 216 of this act, act; (B) health carriers to collect and submit demographic data pursuant to subparagraph (A) of subdivision (28) of section 38a-1084, as amended by this act, and (C) the exchange to collect demographic data pursuant to subparagraph (C) of subdivision (28) of section 38a-1084, as amended by this act.~~

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

~~(2) Seek a state innovation waiver pursuant to Section 1332 of the Affordable sSB842 Care/ Act File for No. the purpose of:~~

~~LC0640 {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-005554 of sSB842 59 File R02-SB.docx } Substitute Bill No. 842640 (A) Affordable ReducingCare theAct cost of health insurance coverage in this state, including, but not limited to, premiums and cost-sharing for suchthe coverage;purpose of:~~

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

(c) Not later than August 1, 2021, the Office of Health Strategy shall ~~LC0sSB842 {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-008456/ of File 59 R02-SB.docx } Substitute Bill No.~~

~~842640 submit55 asSB842 report,File inNo. accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance.~~

640 submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate ~~LC0region {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00857 of 59 residence R02-SB.docx and } if Substitute such Bill person is an institutionalized individual sSB842 / File No.~~

~~842640 region56 of sSB842 residenceFile andNo. if such person is an institutionalized individual as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section.~~

640 as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section.

Any income in excess of the applicable amounts shall ~~LC0be {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0058 applied of as 59 may R02-SB.docx be } required Substitute by Billsaid federal law, and assistance shall sSB842 / File No.~~

~~842640 be57 applied sSB842 asFile mayNo. be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance.~~

640 be granted for the balance of the cost of authorized medical assistance.

~~LC0sSB842 {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-0059/ of File 60 R02-SB.docx } Substitute Bill No.~~

~~842640 This58 actsSB842 shallFile takeNo. effect as follows and shall amend the following sections:~~

640 This act shall take effect as follows and shall amend the following sections:

4 July 1, 2021 New section ~~July 1, 2021~~ Sec.

5 July 1, 2021 19a-7j Sec.

C/R FIN FIN Joint Favorable ~~LC0sSB842 {\\PRDFS1\SCOUSERS\FORZANO\WS\2021SB-00842-/ 60 File of No. 60 R02-SB.docx }~~

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640 The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose.

In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge.

Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note State Impact:

Agency Affected Fund-Effect FY 22 \$ FY 23 \$ Office of the State Comptroller GF - Cost At least See Below 600,000 Office of the State Comptroller GF - Potential 135,936 135,936 Cost State Comptroller - Fringe GF - Potential 55,935 55,935 Benefits1 Cost Connecticut Health Insurance CT HIEA - Approx 50 Approx 50 Exchange Potential million million Revenue Gain Connecticut Health Insurance Other - Potential Up to 15.3 Up to 12.5 Exchange Cost million million Connecticut Health Insurance CT HIEA - Approx 50 Approx 50 Exchange Potential Cost million million Resources of the General Fund GF - Potential None See Below Revenue Gain Resources of the General Fund GF - Potential See Below See Below Cost Social Services, Dept.

GF - Cost 36.0 million 61.3 million Note:

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

None Explanation The bill makes various changes regarding health insurance, including requiring the Office of the State Comptroller (OSC) to establish a group health plan for small employers, nonprofits, and multiemployer plans and expanding eligibility for HUSKY A.

The bill 1The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller.

The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

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640 also requires the Office of Health Strategy (OHS) to develop a plan to lower consumer costs for individual-market health insurance using funds collected from a new fee on health insurers and requires the Connecticut Health Insurance Exchange ("exchange") to implement it.

2 The bill makes various other changes and is anticipated to result in the fiscal impacts described below.

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

There is a cost of at least \$600,000 to OSC in FY 22 for consulting services, including actuarial and legal services, to assist with the design and implementation of the plan, evaluate claims experience, and to comply with the Employee Retirement Income Security Act of 1974 (ERISA).

Ongoing costs beyond FY 22 will vary depending on the continued need for such services but are anticipated to be less after initial design and implementation.

Due to the auditing requirements of the bill, there may be a potential cost to purchase utilization and other health-related data from the plan's carriers.

The requirements of the bill may result in a cost to OSC for two additional benefit officers to support eligible groups who opt for coverage under the new plan.

The total annualized salary and fringe benefit costs associated with these two positions is approximately \$191,371.

After initial design and implementation, costs related to the administration and support for the new plan may be completely offset by administrative fees when the plan is in place.

It is anticipated that anyadministrativefeeschargedbycarrierswilloffsetthecontinuedcost of providing the fully-insured plan.

2The exchange is a quasi-public agency that funds its operations by charging an assessment on health carriers of 1.65% of premiums in the individual and small group markets.

This generated \$34.2 million in FY 20.

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640 Some of the bill's requirements are inconsistent with a fully insured model and it is therefore unclear if some of the costs are duplicative or will ultimately be incurred.

The bill requires that the Comptroller purchase stop loss insurance, assess a risk fee to participants, and assess administrative fees.

These requirements are typically features of a self- insured plan.

Under a fully insured model, the administrator of the plan would set and collect premiums, bear the plan's risk, and assess administrative fees to participants.

Sections 5 to 7 requirethe Comptroller to assess the small employers, nonprofits, and multiemployer plans participating in the Comptroller's group health plan for a share of two existing health insurance industry assessments, the Health and Welfare Fee and the Public Health Fee, to be deposited in the Insurance Fund.

This does not result in a fiscal impact to the state.

The bill does not change the revenue for the Insurance Fund to be collected from these assessments, which is based on the cost of certain Insurance Fund accounts.

The Insurance Fund general assessment, which is also determined based on the cost of certain agencies and accounts, is also unchanged by the bill, to be divided among domestic insurers.

There is no fiscal impact to the Office of the Healthcare Advocate (OHA)toassistenrolleesunderthe Comptroller'snewplanlikeitassists privately insured consumers, as required in section 8.

Section 9 results in a potential revenue gain of approximately \$50 million in FY 22 and up to approximately \$50 million in FY 23 and annually thereafter to the "Connecticut health insurance exchange (CT HIE) account".

The CT HIE account is a separate, non-lapsing General Fund account established pursuant to section 13 of the bill.

The revenue gain will be realized if the Insurance and Real Estate Committee approves the plan provided by the Office of Health Strategy (OHS) and the exchange, pursuant to section 16.

The revenue would be collected as an assessment by the Insurance Department (DOI) on each insurer,

health care center and exempt insurer to cover the plan cost reported by OHS, which cannot exceed \$50 million per year.

OHS must report that sSB842 / File No.

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640 the plan cost is \$50 million for 2022.

There is no anticipated cost to DOI to carry out the assessment, as it is like others the agency collects from the same entities. In addition to the amount of the assessment, there may be additional minimal revenue deposited in the CT HIE account from fines or penalties assessed by the Insurance Commissioner associated with collecting the new assessment.

There is also potential revenue to the CT HIE account from the coverage fee to be assessed by the Comptroller pursuant to section 3, depending on plan enrollment.

3 Sections 10, 11 and 16 result in potential costs for the exchange from the exchange's own resources and the CT HIE account (state costs), dependent on the plan developed by OHS being approved.

If the plan is approved, the exchange would incur costs, presumably from its own resources, of (1) at least \$100,000 in FY 22 for an actuarial report to support the state's application for a Section 1332 State Innovation Waiver and (2) up to \$14.4 million in FY 22 and up to \$12.5 million annually thereafter to establish the subsidiary exchange and operate it.

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

(1) up to \$25 million annually for subsidies for people ineligible to buy qualified health plans (OHP) on the exchange, 3The amount would equal the amount of the Insurance Fund fee a domestic insurance company would pay for providing the same amount of fully-insured coverage as the Comptroller under the new plan.

The Insurance Fund fee is set to the amount required to fund certain appropriations less the fund balance and was \$33.2 million for FY 21.

It applies to all types of admitted domestic insurers (including life, property and casualty, etc.).

4\$100,000 reflects the cost of a report to support a waiver for a reinsurance program;

there may be additional consulting services costs to demonstrate that other proposed program aspects meet the federal requirements for state innovation waiver approval.

5Most anticipated costs are for technology and vendor contracts for operations.

The ability for the exchange to leverage existing functionality is anticipated to be limited by rules in the federal Affordable Care Act (ACA).

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640 (2) up to \$20 million annually to fund a reinsurance program, 6 (3) \$1.7 to \$3.5 million in FY 22 and \$5.3 to \$7.5 million in FY 23 to eliminate premium costs for exchange enrollees with household incomes up to 200% of the federal poverty level (FPL).

7 (4) significant costs, the amount of which is dependent on the design of the program, to reduce the cost of premiums and cost-sharing for exchange enrollees with household incomes greater than 200% FPL and any other actions necessary to implement the Section waiver program if federal approval for it is granted.

As an example, the cost for an average subsidy of \$1,000 for the approximately 75,000 exchange enrollees with household incomes above 200% of FPL would be \$75 million, excluding administration.

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

These sections may also result in a revenue gain to the General Fund beginning as early as FY 23.

Generally, Section 1332 waiver programs generate new state revenue from the federal government (known as "pass-through" funding) which can partially fund the program.

The amount is based on how much the program reduces federal premium tax credits for Connecticut exchange enrollees.

Previous research has estimated that a reinsurance program with a state investment of \$19.5 million could generate \$23 million or more in federal pass-through 6The cost of a reinsurance program is primarily for reinsurance payments but would also include \$150,000 to \$500,000 in annual expenses for administration, depending on program complexity and assuming the Health Reinsurance Association would operate the program through a third-party administrator.

7These estimates include the impact of temporarily increased federal subsidies for exchange enrollees in 2021 and 2022 and reflect the assumption that exchange enrollees likely to be eligible for HUSKY A under the bill will switch to that coverage.

Premium inflation of 2% and 5% over 2021 rates is assumed for FY 22, and FY 23 costs, respectively.

Future year costs would be higher unless the increased federal subsidies are extended.

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640 funding.

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

Section 14 may result in a cost to the state going forward pursuant to the federal Affordable Care Act (ACA) for costs related to the coverage of blood pressure monitors and peak flow meters under QHP sold on the exchange.

While most of the mandated benefits in Section 14 are understood to be included in the benchmark plan, and therefore not anticipated to trigger any ACA-required defrayment of the premium cost for exchange enrollees, coverage under the benchmark plan for blood pressure monitors and peak flow meters is understood to be restricted to enrollees participating in certain carrier programs.

To the extent that expanding coverage of those devices to all those specified in the bill results in higher premium costs, the state will be responsible for the corresponding premium increases in exchange plans, which are not expected to be significant.

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

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

10 Research by Wakely Consulting Group, LLC.

commissioned by the exchange and reported in February 2020.

Note that such estimates may no longer be accurate due to significant shifts in the individual insurance market from the COVID-19 pandemic and changes to federal subsidies under the American Rescue Plan.

9The ACA requires that QHP offered on the exchange include the federally-defined essential health benefits package (EHB).

States can mandate benefits in excess of the EHB, however if the benefits are not already covered under the state's benchmark plan, federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage.

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

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

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

Sources:

ConnectiCare benchmark plan and formulary documents Connecticut Health Insurance Exchange Department of Social Services Office of the State Comptroller sSB842 / File No.

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640 OLR Bill Analysis SB 842 AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

SUMMARY This bill requires the comptroller to establish a fully insured group health insurance and pharmacy plan for multiemployer plans, nonprofit employers, and smaller employers.

Under the bill, a "small employer" is an employer with 50 or fewer employees;

it excludes nonstate public employers (i.e., municipalities).

Coverage offered under the bill must generally comply with all existing state insurance laws and health insurance benefit mandates, except where noted below.

The bill has conflicting provisions regarding the nature of the health insurance plan the comptroller must establish (see COMMENT).

The bill establishes the Connecticut Health Insurance Exchange account (CT-HIE) as a separate, nonlapsing account within the General Fund.

It contains any money required to be deposited into it by law, including money generated from a fee on health insurers the bill imposes.

The initial aggregate assessment for an insurer for 2022 is \$50 million, which is also the maximum assessment in any subsequent year.

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

1.

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

2.

provide up to \$25 million annually for premium and cost-sharing subsidies for individuals ineligible for qualified health plans sSB842 / File No.

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640 (QHPs) (e.g., undocumented immigrants);

and 3.

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

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

The bill also requires the Department of Labor to inform people applying for unemployment assistance of potential health care subsidies and refer them to the exchange.

Under the bill, the exchange must enroll these individuals in assistance if eligible.

The bill also increases the income eligibility for Husky A Medicaid assistance for parents and caretakers from 155% of FPL to 201% of FPL.

It also requires OHS to determine whether Connecticut should seek a federal Medicaid demonstration project waiver to reduce costs to moderate- and low-income families.

Lastly, the bill requires the Auditors of Public Accounts to audit the comptroller's books and accounts maintained for partnership plans, the state employee plan, and coverage offered by the comptroller under the bill, including any maintained by a third-party administrator.

They must do beginning on July 1, 2021, and certify the results to the governor (Sec. 4).

EFFECTIVE DATE:

July 1, 2021 Sec. Sec. 1-3 & 5-7-- FULLY INSURED HEALTH INSURANCE PLAN The bill requires the comptroller to develop a fully insured group health insurance and pharmacy plan and offer it to plan participants and beneficiaries (including dependents, as applicable) under multiemployer plans, nonprofit employers and their employees, and small employers and their employees.

Under federal law, a sSB842 / File No.

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640 multiemployer plan is a collectively bargained health insurance plan covering employees of more than one employer (also called a "Taft- Hartley Plan").

Generally, for a fully insured plan, the insurer assumes the plan's financial risk in return for premium payments.

In this case, presumably, the state pays a premium to one or more insurance carriers to cover the cost of the health care plan.

Several of the bill's provisions may be duplicative of, or in conflict with, procedures an insurer must carry out in servicing a fully insured plan (see COMMENT).

Premiums and Fees (Sec. 2) Insurance coverage payments, which must be paid by participating multiemployer plan administrators, nonprofits, and small employers to the comptroller, must be the same as those paid by the state for state employees, including premiums paid by state employees themselves.

However, the bill allows the comptroller to adjust the premiums to reflect certain risk factors and requires him to adjust them to include certain administrative and other fees.

Optional Premium Adjustments.

Under the bill, premiums may be adjusted for:

1.

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

2.

geography;

3.

family size, so long as family premiums are not greater than the sum of premium payments for (1) all

covered family members or (2) all covered family members age 21 and older and the three eldest covered dependents younger than 21;

4.

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

and 5.

the actual plan performance of the multiemployer, nonprofit, or small employer seeking coverage, so long as it does not cause the premiums to increase or decrease by more than 3% of the sSB842 / File No.

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640 premiums that would otherwise be charged.

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

Required Premium Adjustments.

The bill requires these premium payments to be adjusted to include:

1.

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

2.

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

3.

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

and 4.

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

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

Coverage Requirements (Sec. 2) Under the bill, coverage provided by the comptroller (presumably under a new plan he establishes) must:

1.

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

2.

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

3.

be consistent with value-based insurance design (i.e., a plan design that lowers or removes financial barriers to essential, sSB842 / File No.

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640 high-value clinical services);

4.

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

and 5.

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

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

Adverse Determination Reviews.

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

Plan Administration (Sec. 2) The comptroller must provide coverage for intervals of at least (1) three years for multiemployer plans and nonprofits with more than 50 employees and (2) one year for small employers.

Plan administrators may apply to the comptroller for renewals any time before expiration.

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

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

1.

procuring coverage for nonstate public employees from different vendors than those that service state employees or 2.

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

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640 Exclusivity.

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

However, the bill allows participants to offer separate plans to active employees and retirees.

Claim Tracking.

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

Auditing and Compliance.

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

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

The report must include:

1.

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

2.

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

3.

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

4.

the most recent available medical loss ratio (MLR);

5.

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

6.

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

and 7.

the description and cost of each strategy the comptroller sSB842 / File No.

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640 employed to mitigate the risk of the plan to state finances, along with any recommendations to improve or update the strategies (see COMMENT).

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

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

Risk Mitigation and Stop-Loss.

The bill requires the comptroller to make reasonable efforts to minimize any risk the plan poses to state finances (see COMMENT).

In doing so, the bill requires him to at least (1) purchase aggregate stop-loss insurance on behalf of all plan participants (i.e., multiemployer plans, nonprofits, and small employers) or individual stop loss on each participant and (2) establish a risk fund to pay claims that exceed premiums, fund it through an assessment on plan participants, and adopt operating procedures.

Multiple Employer Welfare Arrangement.

The bill deems that any coverage offered by the comptroller is not a multiple employer welfare arrangement (MEWA).

(It appears that the federal, not state law, determines whether a plan fulfills the criteria to be defined as a MEWA.) Health Insurance Report Card (Sec. 2) Starting by October 15, 2021, the comptroller must annually prepare a report card in consultation with the Department of Public Health and Insurance Department commissioners.

The report card must enable plan participants and administrators to compare the coverage offered by the comptroller to coverage offered on the private market to the same extent that the Consumer Report Card on Health Insurance Carriers in Connecticut permits similar comparisons.

(By law, the consumer report card is an annual report issued by the insurance commissioner that contains certain comparative information on HMOs and the 15 largest health insurers that use provider networks in the state.) sSB842 / File No.

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640 The report card must be prominently displayed on the comptroller's website and disclose (1) the MLR for any fully insured coverage provided under the bill, (2) the MLR for private group health coverage available to plan participants, and (3) any other information the comptroller deems relevant.

Provider Disruption Report (Sec. 2) The bill allows a plan participant that applies for coverage to request a "provider disruption report" from the comptroller in a form and manner he prescribes.

The comptroller must provide the report within days.

Neither the bill nor existing law define "provider disruption report." Coverage Fee (Sec. 3) By law, domestic insurers annually pay an insurance fund fee proportionate to their total net direct premiums sufficient to fund the insurance department, the OHA, and certain other programs (CGS Sec. 38a-47 & -48).

Starting with FY 22, the bill requires the comptroller to annually assess a fee on plan participants and administrators equivalent to the insurance fund fee the comptroller would pay for plan coverage if he were a domestic insurer offering fully insured group health coverage.

(Because the comptroller's coverage under the bill is fully insured already, it appears that plan participants are assessed the fee twice (see COMMENT).) Revenue from the fee must be deposited into the CT-HIE account, which the bill establishes (Sec. 13).

(The bill requires funds in the CT-HIE account to be spent for specified purposes (Sec. 13) but establishes a separate fee to fully fund the amount needed for those purposes (Sec. 9(c)).

It is therefore unclear how the money generated by this coverage fee may be spent under the bill.) Similar to existing law's mechanisms for establishing the insurance fund fee, the bill requires the comptroller to annually provide each administrator or plan participant the proposed assessment amount and allow time for them to object.

Beginning by July 15, 2021, he must sSB842 / File No.

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640 annually consult with the insurance commissioner to determine the fee.

He must provide the proposed amount to plan participants annually beginning by July 31 and assess it (after incorporating any objections he feels appropriate) by September 1, and it must be paid in two equal installments by the following December 31 and March 31.

The assessment may be appealed to the New Britain Superior Court in the same manner as the insurance fund fee may be appealed under existing law (CGS Sec. 38a-52).

If the fee is not paid on time, the comptroller must impose a \$25 per day late fee and 6% annual interest.

Regulations (Sec. Sec. 2 & 3) The bill authorizes the commissioner to adopt implementing regulations for fully insured health insurance plans and the coverage fee.

Health and Welfare and Public Health Fees (Sec. Sec. 5-7) By law, the insurance department assesses domestic insurers for specific programs, including programs related to (1) childhood vaccinations and other treatments through the Health and Welfare Fee (CGS Sec. 19a-7j) and (2) breast and cervical cancer detection and treatment, AIDS services, and syringe services through the Public Health Fee (CGS Sec. 19a-7p).

The bill requires the comptroller to pay these fees to the insurance commissioner on behalf of plan participants.

It makes corresponding changes (1) requiring the comptroller to report to the insurance commissioner, in a form and manner he prescribes, the number of plan participants and beneficiaries as of the prior May 1 (data that is used to calculate the fee) and (2) incorporating the comptroller into certain existing statutes governing these fees.

Among other things, this allows plan administrators and employers covered under the plan to appeal the fee to the New Britain Superior Court (CGS Sec. 38a-52) and be eligible for a refund if they overpaid it.

In a fully insured plan, as required under the bill, these fees are already assessed on health insurers providing the plan.

Thus, these fees appear to be in addition to fees assessed under existing law (see COMMENT).

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