



House of Representatives

General Assembly

File No. 856

January Session, 2007

Substitute House Bill No. 7314

House of Representatives, May 21, 2007

The Committee on Finance, Revenue and Bonding reported through REP. STAPLES of the 96th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE STATE HEALTH INSURANCE PURCHASING POOL PROGRAM.

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

1 Section 1. (NEW) (*Effective July 1, 2008*) As used in sections 1 to 14,
2 inclusive, of this act:

3 (1) "Benchmark policy" means a health insurance policy as described
4 in section 3 of this act.

5 (2) "Eligible individual" means an individual who is (A) a state
6 resident, as defined in 42 CFR 435.403, as from time to time amended,
7 (B) under sixty-five years of age, and (C) not covered by employer-
8 sponsored insurance, except that "eligible individual" does not include
9 an individual who has been a state resident for less than six months
10 and lives in a household without at least one family member who is
11 employed full-time in the state.

12 (3) "Family" means individuals who may be included on a single

13 state income tax return.

14 (4) "Program" means the State Health Insurance Purchasing Pool
15 program.

16 Sec. 2. (NEW) (*Effective July 1, 2008*) (a) There is established, within
17 the Office of the Comptroller, the State Health Insurance Purchasing
18 Pool program to provide health insurance policies, as defined in
19 section 38a-469 of the general statutes, to ensure affordable health care
20 for eligible individuals.

21 (b) The Comptroller shall arrange and procure health insurance
22 policies for enrollees in the program. The Comptroller shall negotiate
23 and contract with insurance companies and health care centers
24 authorized to do insurance business in the state, in accordance with the
25 provisions of section 38a-41 of the general statutes, to provide health
26 insurance policies to the program. Such health insurance policies shall
27 be approved by the Comptroller in accordance with the provisions of
28 title 38a of the general statutes.

29 (c) The Comptroller shall educate state residents about the health
30 insurance policies available under the program, by means including,
31 but not limited to, preparation of educational materials; conducting
32 informational sessions or workshops; contracting with nonprofit
33 organizations and community-based organizations for outreach to
34 hard-to-reach populations and training, consulting with and
35 reimbursing licensed health insurance brokers for assistance in
36 educating residents.

37 (d) The Comptroller shall promote the use of information
38 technology by insurance companies and health care centers providing
39 health insurance policies to the program, individuals applying to,
40 enrolled in or seeking information about the program and persons
41 providing information to the program and shall arrange for the
42 provision of technical support, training and assistance to assure the
43 effective use of such information technology. The Comptroller shall
44 require each insurance company and health care center providing

45 health insurance policies to the program to operate an electronic health
46 record system not later than October 1, 2008, certified by the
47 Comptroller, that meets interoperability standards established by the
48 Comptroller, by regulations adopted in accordance with section 14 of
49 this act, for such electronic health record systems.

50 Sec. 3. (NEW) (*Effective July 1, 2008*) (a) The Comptroller shall make
51 available to each eligible individual seeking enrollment in the program
52 a choice of health insurance policies, affordable to most state residents,
53 offering a wide range of benefit options, including at least one
54 benchmark policy, as described in subsection (b) of this section. The
55 Comptroller shall survey employer-based health insurance coverage in
56 New England to determine the actuarial value of benchmark policy
57 coverage. The actuarial value shall be adjusted annually to reflect
58 necessary increases in health care.

59 (b) The benchmark policy shall:

60 (1) Have an actuarial value that is not less than the sum of (A) the
61 actuarial value of all coverage, excluding dental coverage, for average
62 New England enrollees in employer-based insurance during the
63 previous year; and (B) the actuarial value of dental coverage for
64 average New England enrollees in employer-based insurance during
65 the previous year;

66 (2) Offer benefits including, but not limited to, office visits, inpatient
67 and outpatient hospital care, mental and behavioral health care,
68 including substance abuse treatment, prescription drugs, including
69 brand name and generic drugs, maternity care, including prenatal and
70 postpartum care, oral contraceptives, durable medical equipment,
71 speech, physical and occupational therapy, home health care, hospice
72 services and extended care as alternatives to institutionalization;
73 preventive and restorative dental care, basic vision care and, as
74 prescribed by a physician, personalized nutrition and exercise plans
75 and smoking cessation services; and

76 (3) Be in compliance with the provisions of section 4 of this act.

77 Sec. 4. (NEW) (*Effective July 1, 2008*) (a) As used in this section:

78 (1) "Class of coverage" means single adult coverage, two adult
79 coverage and variations of coverage with children as approved by the
80 Comptroller; and

81 (2) "Designated provider" means (A) a federally qualified health
82 center, (B) a health center determined by the Comptroller, in
83 conjunction with the Commissioner of Public Health, to be
84 substantially similar to a federally qualified health center, (C) a school-
85 based health clinic, or (D) a primary care clinic or other primary care
86 provider designated by the Department of Public Health as comprising
87 such an essential part of a local community's primary care
88 infrastructure that, if members of the community could not obtain
89 health care through such provider, such community members would
90 lack sufficient access to primary care.

91 (b) Each health insurance policy under the program shall be in
92 compliance with the provisions of chapter 700c of the general statutes,
93 and any other applicable state or federal law, and shall:

94 (1) Require payment of the same premium for each class of
95 coverage;

96 (2) Cover preexisting conditions;

97 (3) Guarantee issue;

98 (4) Cover, without cost-sharing, complete examinations for every
99 adult and child, including all screenings and immunizations that are
100 appropriate to the individual's age, gender, culture, race and ethnicity;
101 and

102 (5) Treat each designated provider as a preferred provider to which
103 the health insurance policy's lowest schedule of primary care
104 copayments or coinsurance applies, except that a health insurance
105 policy need not extend such status to a designated provider if the
106 Department of Public Health certifies that such health insurance policy

107 provides alternate arrangements for primary care that do not reduce
108 access to primary care for the policy's enrollees that live in the
109 community served by the designated provider.

110 Sec. 5. (NEW) (*Effective July 1, 2008*) (a) Any state resident may
111 purchase health insurance coverage under the program at the full cost
112 for such coverage, as determined by the Comptroller, if such resident:

113 (1) Has not been a state resident for six months or more and lives in
114 a household without at least one family member who is employed full
115 time in the state; or

116 (2) Is sixty-five years of age or older and is employed by, or whose
117 spouse is employed by, an employer that: (A) Offered employer-
118 sponsored insurance on or before October 1, 2006, but no longer offers
119 such insurance, and (B) would have qualified to participate in such
120 employer-sponsored insurance in effect on October 1, 2006.

121 (b) Any employer may purchase either full or partial coverage
122 under the program for a retired employee who is a state resident at the
123 full cost for such coverage, as determined by the Comptroller.

124 Sec. 6. (NEW) (*Effective July 1, 2008*) (a) On and after July 1, 2008, any
125 eligible individual, or individual purchasing coverage in the program
126 in accordance with the provisions of section 5 of this act, may apply to
127 the program through the Office of the Comptroller or the Department
128 of Social Services.

129 (b) The Comptroller shall establish a health consumer assistance
130 program which shall be available to counsel eligible individuals and
131 individuals purchasing coverage in the program in accordance with
132 the provisions of section 5 of this act concerning the health insurance
133 policies offered under the program and to enroll such individuals in
134 the program. The health consumer assistance program may be
135 established within the Office of the Comptroller, or the Comptroller
136 may contract with a nonprofit organization to operate such health
137 consumer assistance program, provided such nonprofit organization is

138 financially independent from all insurance companies and health care
139 centers providing health insurance policies to the program and does
140 not receive any financial benefit, direct or indirect, from an enrollee's
141 choice of any health insurance policy under the program.

142 (c) Enrollees may change health insurance policies:

143 (1) During any open enrollment period established by the
144 Comptroller, which shall occur at least once per calendar year; and

145 (2) At any other time, for good cause, consistent with regulations
146 established by the Comptroller, in accordance with section 14 of this
147 act.

148 Sec. 7. (NEW) (*Effective July 1, 2008*) (a) On and after July 1, 2008, an
149 eligible individual not yet enrolled in the program shall be enrolled by
150 default when any of the following occurs:

151 (1) Such individual's income is reported to the Department of
152 Revenue Services or the Labor Department;

153 (2) A state income tax form is filed on which such individual is
154 listed as a member of the household; or

155 (3) Such individual seeks health care.

156 (b) When an eligible individual is enrolled in the program under
157 subsection (a) of this section, a fee-for-service health insurance policy
158 shall be issued to the individual until the individual chooses a health
159 insurance policy under the program. The individual shall have a
160 reasonable period of time, not to exceed thirty days, after being
161 enrolled in the program to choose a health insurance policy. If the
162 individual does not choose a policy within such time, the Comptroller
163 shall select the benchmark policy for the individual. Such selection
164 shall take into account, but not be limited to, the following:

165 (1) Maximizing continuity of care for the individual;

166 (2) Keeping all family members within a single plan; and

167 (3) Supporting benchmark plans with the best performance as to
168 low premiums and high-quality care or positive outcomes for
169 individuals previously enrolled under subsection (a) of this section.

170 Sec. 8. (NEW) (*Effective July 1, 2008*) (a) The Department of Social
171 Services shall screen each eligible individual, or individual purchasing
172 coverage in the program in accordance with the provisions of section 5
173 of this act, at the time such individual applies for the program for
174 eligibility under Title XIX or Title XXI of the Social Security Act. Such
175 screening shall also determine income for purposes of establishing the
176 amount of premium payments under the program for each such
177 individual. Individuals shall be enrolled in the appropriate state
178 Medicaid program or the HUSKY Plan, unless the individual objects to
179 such enrollment. To the maximum extent feasible, relevant information
180 shall be obtained through state-maintained or state-accessible data and
181 through the self-attestation of individuals.

182 (b) Notwithstanding any provision of the general statutes, the
183 following information shall be made available to the Department of
184 Social Services and the Comptroller for the purposes of determining
185 eligibility under Title XIX or Title XXI of the Social Security Act and for
186 establishing premium payments under the program:

187 (1) Eligibility and enrollment information for individuals enrolled in
188 means tested assistance programs, other than the HUSKY Plan;

189 (2) New hire information and quarterly reports provided to the
190 Labor Department;

191 (3) Information showing United States citizenship of individuals,
192 including, but not limited to, information obtained from birth
193 certificates and other vital records; and

194 (4) Federal information about new hires, quarterly earnings, Social
195 Security numbers, immigration status and other data pertinent to
196 income or other components of eligibility for Title XIX or XXI of the
197 Social Security Act.

198 (c) The Comptroller and the Commissioner of Social Services shall
199 enter into agreements with other state agencies providing or receiving
200 information for the program. Such agreements shall require that:

201 (1) Such information be used only to verify or establish income or
202 eligibility for matching funds under Titles XIX or XXI of the Social
203 Security Act; and

204 (2) Each state agency providing information to the program train
205 and monitor all staff and contractors who have access to such
206 information and inform such staff and contractors of all applicable
207 state and federal privacy and data security requirements.

208 (d) Within available appropriations, the Commissioner of Social
209 Services shall develop and operate the information infrastructure
210 required to conduct the screening described in subsection (a) of this
211 section and shall take all feasible steps to maximize the use of federal
212 funds for developing and operating such infrastructure. The
213 Comptroller, in consultation with data privacy and security experts,
214 shall develop and implement policies and procedures that maintain
215 data security and prevent inadvertent, improper and unauthorized
216 access to or disclosure, inspection, use or modification of information.

217 (e) Any individual about whom information is provided to the
218 program shall have the right to (1) obtain, at no cost to the individual,
219 a copy of all such information, which shall identify the agency from
220 which the information was obtained, and (2) correct any
221 misinformation or complete any incomplete information. If any breach
222 of an individual's privacy occurs, such individual shall be promptly
223 informed of such breach and of any rights and remedies available to
224 the individual as a result of such breach.

225 Sec. 9. (NEW) (*Effective July 1, 2008*) (a) On or before July 1, 2009, the
226 Commissioner of Social Services shall submit to the federal Centers for
227 Medicare and Medicaid Services an amendment to the state Medicaid
228 plan required by Title XIX of the Social Security Act to extend coverage
229 to all parents, guardians and caretaker relatives with incomes at or

230 below three hundred per cent of the federal poverty level, as well as to
231 any other individuals with incomes below such level who are nineteen
232 to sixty-four years of age, inclusive, and who may be covered, at state
233 option, through the state plan amendment.

234 (b) If needed to access all federal funds allotted to the state under
235 Title XIX of the Social Security Act, the Commissioner of Social
236 Services shall cover individuals over eighteen years of age, including,
237 but not limited to, pregnant women, whether or not such individuals
238 are eligible for coverage under Title XIX of the Social Security Act.

239 (c) (1) On or before July 1, 2009, the Commissioner of Social Services
240 shall submit an application for a waiver under Section 1115 of the
241 Social Security Act, in accordance with section 17b-8 of the general
242 statutes, to authorize the use of funds received under Title XIX of the
243 Social Security Act for individuals nineteen to sixty-four years of age,
244 inclusive, with incomes at or below one hundred eighty-five per cent
245 of the federal poverty level who do not otherwise qualify under Title
246 XIX of the Social Security Act, either under mandatory eligibility or at
247 state option through state plan amendment. Federal budget neutrality
248 requirements for such waiver may be met through unused
249 uncompensated care payments to hospitals or by taking other
250 measures, provided such measures do not result in any of the
251 following for individuals who would have qualified for coverage
252 under the Medicaid program, the HUSKY Plan or state-administered
253 general assistance:

254 (A) Any reduction in covered services or access to care;

255 (B) Any increase in deductibles, premiums or other out-of-pocket
256 costs; or

257 (C) Any reduction in enforceable, individual guarantees of coverage
258 or services.

259 (2) If federal budget neutrality requirements do not permit
260 extending Title XIX coverage to the individuals described in

261 subdivision (1) of this subsection, such coverage shall extend to such
262 individuals with incomes under the highest possible percentage of
263 federal poverty level less than one hundred fifty per cent.

264 Sec. 10. (NEW) (*Effective July 1, 2008*) (a) Enrollees in the program
265 shall pay the amounts provided in subsection (b) of this section for the
266 health insurance policy under which they are insured.

267 (b) (1) For a health insurance policy with a premium less than or
268 equal to the premium charged by the benchmark policy:

269 (A) If the enrollee's family income is at or below one hundred fifty
270 per cent of the federal poverty level, the enrollee shall pay no
271 premium.

272 (B) If the enrollee's family income is above three hundred per cent of
273 the federal poverty level, the enrollee shall pay thirty per cent of the
274 premium.

275 (C) If the enrollee's family income is one hundred fifty-one per cent
276 to three hundred per cent of the federal poverty level, inclusive, the
277 enrollee shall pay a percentage of the premium that shall be greater
278 than zero per cent but less than thirty per cent of such premium
279 according to a schedule to be established by the Comptroller, by
280 regulations adopted in accordance with section 14 of this act.

281 (D) For an individual who would have qualified for Medicaid, the
282 HUSKY Plan or state-administered general assistance under state law
283 in effect on October 1, 2006, the premium shall not exceed the amount
284 permitted under such law for the applicable program, increased in
285 subsequent years based on changes in average per capita income
286 among state residents with incomes at or below three hundred per cent
287 of the federal poverty level, unless such averages cannot be
288 determined based on available data in which case, any increase in the
289 premium shall be based on changes in average per capita income for
290 all state residents.

291 (2) For a health insurance policy with a premium higher than the

292 premium charged by the benchmark policy, the enrollee shall pay the
293 amount specified in subdivision (1) of this subsection, plus the amount
294 of the difference between the premium for the health insurance policy
295 and the premium for the benchmark policy.

296 (c) Any amount paid by an enrollee to the program shall not be
297 included in the gross income of the enrollee for state or federal income
298 tax purposes, except as required under Section 125 of the Internal
299 Revenue Code of 1986, or any subsequent corresponding internal
300 revenue code of the United States, as from time to time amended. Each
301 employer in the state, whether or not such employer is subject to
302 payment responsibilities under sections 2 to 14, inclusive, of this act,
303 shall designate (1) the Comptroller to serve as such employer's plan
304 administrator, and (2) the program as such employer's employer-
305 sponsored group health plan, in accordance with Title 26 of the United
306 States Code, as from time to time amended.

307 (d) The Comptroller and the Commissioner of Revenue Services
308 shall establish a system for automated payments to the program
309 through payroll deductions. Automated payments shall be sent to the
310 Department of Revenue Services, which shall forward such payments
311 to the Comptroller. Enrollees participating in the program may opt out
312 of payroll deduction and establish with the Comptroller alternate
313 means of making payments to the program.

314 (e) The Comptroller shall adopt regulations, in accordance with
315 section 14 of this act, establishing when enrollee payments shall be
316 made to the Comptroller for subsequent transmittal to the health
317 insurance companies or health care centers providing health insurance
318 policies to the program and when such payments shall be made
319 directly to such health insurance companies or health care centers.

320 Sec. 11. (NEW) (*Effective July 1, 2008*) (a) (1) Each employee, and the
321 dependents of such employee, whose employer offers employer-
322 sponsored health insurance to its employees shall be deemed to be
323 insured under such insurance.

324 (2) Notwithstanding the provisions of subdivision (1) of this
325 subsection:

326 (A) If an employee or a dependent of an employee is a child who
327 qualifies for the HUSKY Plan, such child shall not be deemed to be
328 insured under employer-sponsored health insurance. Such child shall
329 be so insured only if a parent or other legal guardian of the child
330 consents to such insurance in writing.

331 (B) If an employee receives offers of employer-sponsored insurance
332 from more than one employer, such employee, or a parent or other
333 legal guardian of such employee if such employee is a child, may
334 choose which offer to accept. The Comptroller shall establish
335 guidelines, by regulations adopted in accordance with section 14 of
336 this act, to govern enrollment into employer-sponsored health
337 insurance for employees who do not accept any offer.

338 (C) Any former employee that is offered employer-sponsored health
339 insurance under the federal Consolidated Omnibus Budget
340 Reconciliation Act by the former employer shall not be deemed to be
341 insured under employer-sponsored health insurance. Such former
342 employee shall be so insured only if the former employee consents to
343 such insurance in writing.

344 (D) If an employer offered employer-sponsored health insurance to
345 its employees on or before October 1, 2006, and the amount of such
346 employer's current premium payments per insured employee are not
347 less than the amount of such employer's premium payments per
348 insured employee on or before October 1, 2006, adjusted for the
349 medical care component of the consumer price index, an employee or
350 dependent of such employee may decline an offer of employer-
351 sponsored health insurance and shall not be deemed to be insured
352 under such insurance.

353 (b) Any employee who qualifies under the Title XIX Medicaid
354 program and is enrolled in an employer-sponsored health insurance
355 policy shall receive supplemental coverage as provided in section 11 of

356 this act.

357 (c) Nothing in sections 2 to 14, inclusive, of this act shall prohibit an
358 employer or an individual from purchasing or providing health
359 insurance or health care services in addition to those provided under
360 the program.

361 Sec. 12. (NEW) (*Effective from passage*) Any enrollee in the program
362 who is eligible for supplemental coverage under Medicaid or the
363 HUSKY Plan shall receive such supplemental coverage. The
364 Comptroller, in cooperation with the Commissioner of Social Services,
365 shall develop integrated, seamless procedures to ensure that such
366 enrollees receive such coverage.

367 Sec. 13. (NEW) (*Effective from passage*) (a) The Comptroller shall
368 prospectively adjust payments for each health insurance policy under
369 the program to compensate fully for any differences between the
370 average risk levels of the policy's enrollees and the state's nonelderly
371 population.

372 (b) Within available appropriations, during the first three years of
373 implementation of the program, the Comptroller may subsidize the
374 cost of reinsurance premiums related to the program. The remainder of
375 the cost of such premiums shall be paid from payments made to the
376 program by or on behalf of enrollees.

377 (c) The Comptroller shall establish risk corridors and coinsurance
378 percentages for subsidized reinsurance based on best practices from
379 other states.

380 (d) On or before January 1, 2011, the Comptroller shall submit a
381 report, in accordance with the provisions of section 11-4a of the general
382 statutes, to the joint standing committee of the General Assembly
383 having cognizance of matters relating to insurance and real estate,
384 containing recommendations about future financing for reinsurance. If
385 the General Assembly does not take action to the contrary before the
386 end of the January, 2011 regular session, reinsurance premiums shall,

387 for the third and each subsequent year, be paid entirely by payments
388 made to the program by or on behalf of enrollees.

389 Sec. 14. (NEW) (*Effective from passage*) The Comptroller shall adopt
390 regulations, in accordance with chapter 54 of the general statutes, to
391 implement and administer the State Health Insurance Purchasing Pool
392 program pursuant to sections 1 to 13, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2008</i>	New section
Sec. 2	<i>July 1, 2008</i>	New section
Sec. 3	<i>July 1, 2008</i>	New section
Sec. 4	<i>July 1, 2008</i>	New section
Sec. 5	<i>July 1, 2008</i>	New section
Sec. 6	<i>July 1, 2008</i>	New section
Sec. 7	<i>July 1, 2008</i>	New section
Sec. 8	<i>July 1, 2008</i>	New section
Sec. 9	<i>July 1, 2008</i>	New section
Sec. 10	<i>July 1, 2008</i>	New section
Sec. 11	<i>July 1, 2008</i>	New section
Sec. 12	<i>from passage</i>	New section
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>from passage</i>	New section

FIN *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Various State Agencies	GF - See Below

Municipal Impact: None

Explanation

This bill creates the State Health Insurance Purchasing Pool (SHIPP). All state residents under the age of 65 who do not have employer sponsored health insurance are required to enroll.

Population

According to the Office of Health Care Access (OHCA) 2006 Household Survey, 222,700 Connecticut residents were uninsured at the time of the survey. However, the survey also found that 346,700 had been uninsured at some point in the previous year. For the sake of this analysis, it is assumed that these 346,700 individuals who did not have a stable source of health insurance would enroll in the SHIPP program.

The bill does not exempt individuals currently eligible for Medicaid and SAGA benefits from this default enrollment, as these programs are not considered employer sponsored insurance. As federal law requires that Medicaid be the payer of last resort, SHIPP would thus pick up the cost of services for all SAGA, HUSKY A and B members, as well as those Medicaid fee-for-service enrollees under the age of 65. This would add approximately 388,000 additional individuals to SHIPP, for a total eligible population of 734,700.

Cost Impact

The bill requires the state Comptroller to contract with insurance companies and HMO's to provide insurance policies for SHIPP. The Comptroller must make available a choice of health insurance policies that meet certain requirements. Assuming that health insurance policies procured under the terms of the bill would cost between \$4,000 and \$6,000 per person annually, the total cost of the policies would be between \$2,938,800,000 and \$4,408,200,000. The bill establishes a sliding scale of premium contributions based on federal poverty level. Based on data from the OHCA survey, it is estimated that enrolled individuals would contribute between \$171,300,000 and \$257,000,000. Although the bill is not specific as to who is responsible to pay for the balance of these costs, it is assumed that the state would incur a net premium cost of \$2,767,500,000 to \$4,151,200,000.

As stated above, the bill does not exempt individuals with government sponsored insurance from the automatic enrollment in SHIPP. The state would therefore lose the 50% federal match (65% for HUSKY B) for the cost of the services that are now covered under SHIPP. Medicaid and SAGA may then serve as a wrap around policy for services available under the government programs but which are not included in the SHIPP plan.

The bill requires various duties related to plan administration, client screening, enrollment, counseling, revenue collection, education, electronic health records, and reinsurance. These duties will result in increased costs to the Office of the State Comptroller as well as the Departments of Revenue Services and Social Services. Assuming an administrative overhead of 5% to 15% for these functions, annual increased costs of \$146,900,000 to \$661,230,000 will result.

The effect of the implementation of the SHIPP plan on the current employer based health insurance system is not known. It is possible that a government subsidized health system will incent employers to drop coverage if their employees can get coverage under SHIPP for comparable cost sharing. Section 11(d) further allows employees to drop their employer sponsored insurance and enroll in SHIPP if their

employer effectively lowers its premium payments. Any such migration from employer sponsored insurance to SHIPP will increase the costs detailed above.

Section 9 of the bill implements expansions of eligibility for the HUSKY and Medicaid programs. Given the default enrollment in SHIPP implemented in section 7 of this bill, the implications of these expansions are not clear.

Revenue Impact

The bill could also significantly affect personal income tax and insurance premiums tax revenues as a result of establishing SHIPP, in addition to the impact on the federal Medicaid reimbursement noted above.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 7314

***AN ACT ESTABLISHING THE STATE HEALTH INSURANCE
PURCHASING POOL PROGRAM.***

SUMMARY:

This bill establishes the State Health Insurance Purchasing Pool (SHIPP) program and requires state residents to enroll in it if they are under 65 and do not have employer-sponsored health insurance coverage.

The bill requires the state comptroller to contract with insurance companies and health care centers (HMOs) to provide insurance policies for SHIPP. The comptroller must administer all aspects of the program including:

1. making available a choice of health insurance policies that meet the requirements under the bill and are affordable to most state residents,
2. enrolling eligible residents in an insurance plan if the individual does not select one,
3. implementing a health consumer assistance program to counsel people about SHIPP health insurance options, and
4. paying for the cost of SHIPP program reinsurance premiums.

The bill creates a sliding scale of premium contributions for enrollees. The poorest enrollees make no contribution and those with incomes above 300% of the federal poverty level pay 30% of the premium. It is not clear who pays the balance of the insurance premium.

The bill specifies that the comptroller must pay the costs of reinsurance premiums related to the program. Reinsurance costs are a portion of the premium that the insured pays.

The bill does not create or indicate into what fund the comptroller will deposit employee premium contributions (see COMMENT).

It also requires the comptroller to require each insurance company providing SHIPP health insurance to operate an electronic health record system to make information available to SHIPP enrollees, insurance companies, and others.

It requires the comptroller to adopt regulations to implement and administer SHIPP.

It requires the Department of Social Services (DSS) commissioner to (1) screen every SHIPP-eligible person for HUSKY eligibility and (2) apply for a Medicaid waiver to use federal funds for certain individuals not currently HUSKY eligible. The bill increases HUSKY income eligibility limits.

EFFECTIVE DATE: July 1, 2008 for the comptroller to procure health insurance policies, voluntary and mandatory enrollment, the consumer assistance program, reinsurance payments, Medicaid and HUSKY eligibility screening and income limit provisions, and upon passage for the comptroller to adopt regulations implementing the bill.

COMPTROLLER'S SHIPP DUTIES

Overview (§§ 1, 2, 5, 6 & 13 (c))

The bill requires the comptroller to establish SHIPP within her office to provide health insurance policies that ensure affordable health care for eligible individuals. "Eligible individuals" are state residents, as defined in federal regulation, who are under 65 and are not covered by employer-sponsored insurance. An individual is not eligible if he or she (1) has been a state resident for less than six months and (2) lives in a household that does not have any family member who is employed full-time.

The comptroller must make available to each eligible individual seeking to enroll in SHIPP a choice of health policies that are affordable to most state residents and offer a wide range of benefit options. The policies must include at least one “benchmark policy” (see below). The bill does not define “affordable to most residents.”

It does not prohibit an employer or an individual from purchasing or providing health coverage in addition to that provided through SHIPP.

Procuring Insurance

The comptroller must:

1. arrange and procure health insurance policies for SHIPP enrollees,
2. negotiate and contract with insurance companies and HMOs authorized under state law to engage in insurance business in the state to provide SHIPP health insurance policies, and
3. approve these policies in accordance with state insurance law. (It is unclear whether the bill gives the comptroller authority to approve the policies, as only the insurance commissioner can do currently, or if it means the comptroller must seek approval under state law, i.e., from the insurance commissioner.)

The provision authorizing the comptroller to procure insurance policies is not effective until July 1, 2008, and the bill requires that SHIPP be available for enrollees on that same date (see COMMENT).

Public Education

The bill requires the comptroller to provide education on SHIPP to all state residents and create a health consumer assistance office to counsel individuals and enroll them in SHIPP.

The comptroller is authorized to educate state residents about the policies available through SHIPP by:

1. preparing educational materials and conducting information sessions and workshops,
2. contracting with nonprofits and community-based organizations for outreach to hard-to-reach populations, and
3. consulting with, and reimbursing, licensed health insurance brokers for help in educating residents.

Health Consumer Assistance Program

A separate provision requires her to establish a health consumer assistance program to counsel potential enrollees and enroll them in SHIPP. It authorizes her to establish the consumer assistance program within her office or contract with a nonprofit organization to operate the program. The nonprofit organization must (1) be financially independent from all insurance companies and HMOs providing SHIPP policies and (2) not receive any financial benefit, direct or indirect, from an enrollee's choice of any insurance policy under the program.

SHIPP POLICY REQUIREMENTS***All Health Policies (§ 4)***

The bill establishes a number of requirements for each health policy under SHIPP.

Each policy must:

1. be in compliance with the provisions of state insurance law governing health insurance (CGS Chapter 700);
2. cover preexisting conditions (this may conflict with provisions of Chapter 700c, which requires such coverage but allows for a 12-month waiting period before coverage kicks in);
3. guarantee issue;
4. require payment of the same premium for each "class of coverage";

5. cover, without cost-sharing, examinations for every adult and child, including all screenings and immunizations that are appropriate to the individual's age, gender, culture, race and ethnicity; and
6. treat each designated provider (see below) as a preferred provider to which the insurance policy's lowest schedule of primary care copayments or coinsurance applies, except that an insurance policy need not extend this status to a designated provider if the Public Health Department (DPH) certifies that the policy provides alternate arrangements for primary care that do not reduce primary care access for the policy's enrollees living in the provider's service area.

The bill defines class of coverage to mean single adult coverage, two adult coverage, and variations of coverage with children as approved by the comptroller. This apparently means that the premium would be the same under a given policy whether an enrollee is seeking coverage for a single adult, a couple, or a family.

Designated Providers

All policies must treat designated providers as preferred health care providers. It defines designated provider as a:

1. federally qualified health center (FQHC);
2. health center the comptroller, in conjunction with the public health commissioner, determines to be substantially similar to an FQHC;
3. school-based health clinic; or
4. primary care clinic or other primary care provider DPH designates as comprising such an essential part of a local community's available primary care that, without it, members of the community would not have sufficient access to primary care.

Benchmark Policies (§ 3)

The comptroller must make available at least one benchmark policy which meets specific requirements set in the bill in addition to the requirements stated above.

The benchmark policy must have an actuarial value that at least equals the sum of the actuarial value of (1) all coverage, excluding dental coverage, for average New England enrollees in employer-based insurance during the previous year, and (2) dental coverage for average New England enrollees in employer-based insurance during the previous year. The commissioner must survey employer-based health insurance coverage in New England to determine the actuarial value of benchmark policies and must annually adjust the actuarial value to reflect increases in health care. The bill does not define "average New England enrollee."

The benchmark policy must also include coverage for the following: office visits; inpatient and outpatient hospital care; mental and behavioral health care, including substance abuse treatment; prescription drugs, including brand name and generic drugs; maternity care, including prenatal and postpartum care; oral contraceptives; durable medical equipment; speech, physical and occupational therapy; home health care; hospice services and extended care as alternatives to institutionalization; preventive and restorative dental care; basic vision care; and, as prescribed by a physician, personalized nutrition and exercise plans and smoking cessation services.

REQUIRED ELECTRONIC HEALTH RECORD SYSTEM (§ 2(D))

The comptroller must require each insurance company and HMO providing SHIPP health insurance to operate an electronic health record system, certified by the comptroller, no later than October 1, 2008. She must promote the use of information technology by these insurance providers, and by individuals applying to, enrolled in, or seeking information about SHIPP; and she must arrange for training, assistance, and technical support to assure the effective use of such a system.

The bill states that the comptroller must certify that the electronic record systems meet the interoperability standards she establishes by regulations adopted under the bill for such systems. But the rest of the bill, including the regulations section to which this provision refers, does not include anything about interoperability standards.

SHIPP PROGRAM ENROLLMENT (§ 5 & 6)

Voluntary (§§ 5 & 6)

Eligible individuals can enroll in SHIPP starting on July 1, 2008 with their premium contribution established on a sliding scale based on income level. Those who do not meet the definition of eligible individuals may also enroll starting on that date, but they must pay 100% of the premium. It is unclear if those who are not eligible for the program, due to living in the state for less than six months must still pay 100% of the premium once their state residency passes the six-month mark.

Under the bill, a person may enroll through the comptroller's office or DSS.

Mandatory (§ 7)

Any eligible individual who is not enrolled in SHIPP on or after July 1, 2008 will be enrolled by default when:

1. either the revenue services or labor department receives a report of the person's income,
2. a state income tax form is filed and the person is listed as a member of the household, or
3. the person seeks health care.

The bill does not indicate how revenue services or labor department officials will determine if a person is already in SHIPP and what means they must use to contact the comptroller regarding a person's SHIPP status. When an uninsured person seeks health care, it is also unclear how that will be communicated to the comptroller.

Eligible individuals enrolled by default are issued a fee-for-service insurance policy until the individual chooses a health policy offered under SHIPP. Once enrolled, the bill gives such enrollees a reasonable amount of time, not to exceed 30 days, to choose a SHIPP plan. If the person does not make a choice within that time, the comptroller must select a SHIPP benchmark policy for him or her.

In making this decision the comptroller must consider at least the following:

1. maximizing the enrollee's continuity of care;
2. keeping family members within a single plan; and
3. supporting benchmark plans with the best performance as determined by low premiums and high-quality care or positive outcomes for individuals who were mandatory enrollees.

Open Enrollment and Changing Health Policies (§ 6)

SHIPP enrollees may change policies during any open enrollment period the comptroller establishes. She must establish at least one open enrollment period a year. Enrollees may change policies at other times for good cause, consistent with regulations the comptroller establishes under the bill.

ENROLLEE PREMIUMS (§ 10)

Premium Sliding Scale

The bill establishes a sliding scale of premium contributions for policies with premiums that are less than or equal to the benchmark policy premium. For these policies enrollees will make the following contributions (see Table 1).

Table 1: Enrollee's Insurance Premium Contribution

Enrollee's Family Income Level	Premium Contribution (based on benchmark policy premiums)
At or below 150% of	No contribution

federal poverty level (FPL)*	
At or above 150% to 300% of FPL*	Between 0% and 30% of the premium as listed on comptroller's schedule
Above 300% of FPL	30% of the premium
*These two tiers overlap in the bill as those whose earnings are equal to 150% of FPL are in both tiers.	
FPL: 100% of FPL for 2007 is \$10,210 for an individual and \$20,650 for a family of four.	

For individuals who would qualify for Medicaid, HUSKY, or state administered general assistance (SAGA) under state law in effect October 1, 2006, the bill requires that the premium not exceed the amount permitted in the particular law. The bill permits increases in the following years based on changes in the per capita income among state residents with incomes at or below 300% of FPL (unless such averages are not available, in which case any increase in premium must be based on average per capita income changes for all state residents). Under current state law, there is no premium for HUSKY A or for SAGA. Under HUSKY B, premiums are permitted only for recipients who earn at least 235% of the FPL.

Policies With Premiums Higher Than The Benchmark Premium

The bill provides that, for a SHIPP policy with a premium higher than the benchmark policy premium, the enrollee must pay what would be due under the applicable formula already described plus the difference between the benchmark premium and the higher premium.

Premium Contributions & Income Tax

Under the bill, enrollee contributions will be deducted from the enrollee's gross income for state and federal income tax purposes, except as required under Section 125 of the IRS Code (which allows employees to place pre-tax dollars into certain types of health plans).

COMPTROLLER AND DRS DUTIES RELATED TO EMPLOYEE CONTRIBUTIONS AND TRANSMITTAL TO POLICY PROVIDERS (§ 10 (D) & (E))

The comptroller and the revenue services commissioner must establish an automated payroll deduction system for enrollee payments to SHIPP. Automated payments must be sent to DRS, which must forward them to the comptroller. Enrollees participating in the program may opt out of payroll deduction and establish with the comptroller an alternate means of making payments to SHIPP.

The comptroller must adopt regulations establishing when (1) enrollee payments must be made to the comptroller for transmittal to the health insurance companies or HMOs providing SHIPP insurance policies and (2) enrollee payments must be made directly to such insurance companies or health centers.

MANDATORY EMPLOYER DESIGNATION OF THE STATE AS PLAN ADMINISTRATOR (§ 10)

The bill requires each employer in the state to designate (1) the comptroller as the employer's health plan administrator and (2) SHIPP as the employer's employer-sponsored group health plan, in accordance with federal tax law.

WHEN AN EMPLOYEE IS NOT CONSIDERED COVERED UNDER AN EMPLOYER'S HEALTH PLAN (§ 11)

Under the bill, each employee who works for an employer who offers employer-sponsored health insurance, and his or her dependents, will be deemed to be covered under that insurance except in the following situations:

1. If the employee, or his or her dependent, is a child who qualifies for HUSKY, the child will not be considered covered under the employer's plan. The child will be considered insured if his parent or legal guardian consents in writing to the employer-sponsored insurance.
2. If the employee receives offers of employer insurance from more than one employer, the employee (or the parent or guardian if

the employee is a child) may choose to accept one of the offers. In cases where the employee does not accept either offer, the comptroller must establish guidelines, adopted in regulations, to govern enrollment into employer-sponsored plans for such employees.

3. Any former employee offered employer-sponsored health insurance under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) by a former employer will not be deemed insured under employer-sponsored health insurance. The former employee is considered so insured only if he or she consents in writing to the COBRA insurance.
4. If an employer offered health insurance to its employees on or before October 1, 2006 and the per-employee cost of the current insurance is at least equal to the employer's per-employee cost on or before October 1, 2006 (adjusted for the medical care component of the CPI), an employee or dependent of such employee can decline an offer of employer-sponsored health insurance and will not be deemed to be insured under such insurance. This provision appears to allow insured employees to compare the cost of their employer plan to what they would pay in a SHIPP plan and choose the less expensive plan.

If an employee is not considered covered under his or her employer's plan, then the employee is eligible to join SHIPP.

ADDITIONAL INSURANCE (§ 11(C))

The bill permits an individual or an employer to purchase or provide health insurance or health care services in addition to those provided through SHIPP.

COMPENSATING FOR VARYING RISK LEVELS (§ 13(A))

In order to compensate for varying risk levels for enrollees under different policies, the comptroller must prospectively adjust payments to each SHIPP health insurance policy. The payments will compensate for any difference between the average risk level of a policy's enrollees

and the state's nonelderly population.

REINSURANCE PREMIUMS AND REINSURANCE REPORT (§ 13(B) & (C))

The bill requires that payments made to SHIPP be used to pay for the reinsurance costs of the insurance providers. (Reinsurance is insurance for insurance companies, i.e., it helps spread the risk, thus lessening the liability for the primary insurer.)

The bill permits the comptroller to subsidize, during the first three years SHIPP is implemented and within available appropriations, the cost of reinsurance for the insurers. Any reinsurance cost not covered by appropriations will be paid for by payments made to the program on behalf of enrollees. For subsidized reinsurance, the comptroller must establish risk corridors and coinsurance percentages based on best practices in other states (i.e., terms of reinsurance).

The comptroller is required to issue a report, by January 1, 2011, containing recommendations on the future financing for reinsurance to the Insurance and Real Estate Committee. This provision also requires that, if the General Assembly does not take action to the contrary by the end of the 2011 regular session, reinsurance premiums must, for the third and each subsequent year, be paid entirely by payments made to the program by or on behalf of enrollees. But this appears to have incorrect timing as the bill requires SHIPP to be available for enrollees (and therefore fully implemented) by July 1, 2008. This makes the report from the comptroller (due January 1, 2011) arrive at the legislature during SHIPP's third year, and the legislature has until the end of the session to act on the report. At that time, the third year of the program is nearly over. It is unclear how the comptroller could delay paying for reinsurance costs until the year is almost over.

HUSKY AND MEDICAID CHANGES

DSS Screening for Medicaid or HUSKY Eligibility (§ 8)

The bill requires DSS to screen each person eligible for or purchasing coverage in SHIPP for Medicaid or State Children's Health

Insurance Program (SCHIP) eligibility. The screening must also determine income for establishing premium payments under SHIPP. It requires individuals (presumably only those who qualify) to be enrolled in one or the other public program, unless he or she objects to doing so.

The bill requires relevant information to be obtained through state-maintained or state-accessible data and through the individual's self-attestation to the maximum extent feasible.

The bill requires the appropriate state agencies to provide the following information to DSS and the comptroller for purposes of Medicaid or SCHIP eligibility and establishing SHIPP's premium payment:

1. eligibility and enrollment information for individuals enrolled in means-tested assistance programs other than HUSKY;
2. new hire information and quarterly reports provided to the Labor Department;
3. information showing individuals' U.S. citizenship, including information obtained from birth certificates and other vital records; and
4. federal information about new hires, quarterly earnings, Social Security numbers, immigration status, and other data pertinent to income or other components of Medicaid and SCHIP eligibility.

The bill requires the comptroller and DSS commissioner to enter into agreements with other state agencies providing or receiving information for the SHIPP program. The agreements must require that:

1. the information is used only to verify or establish income or eligibility for matching federal Medicaid or SCHIP funds and
2. each agency providing information train and monitor staff and

contractors who have access to the information and inform them of all applicable state and federal privacy and data security requirements.

The bill requires the DSS commissioner, within available appropriations, to develop and operate the information infrastructure needed to conduct the screenings, and take all feasible steps to maximize federal funds for this purpose. The comptroller, in consultation with data privacy and security experts, must develop and implement policies and procedures that maintain data security and prevent inadvertent, improper, and unauthorized access to or disclosure, inspection, use, or modification of the information.

The bill gives individuals about whom information is provided the right to (1) obtain, at no cost, copies of all information identifying the agency that released the information and (2) correct any misinformation or complete any incomplete information. Individuals must be promptly informed (it is not clear by whom) if any breach of privacy occurs including any rights and remedies available as a result of the breach.

Increase in Income Limits for Medicaid Eligibility (§ 9)

By July 1, 2009, the bill requires the DSS commissioner to submit to the federal Centers for Medicare and Medicaid Services a Medicaid State Plan amendment to increase the income limits for Medicaid coverage for adults. DSS must extend coverage to parents, guardians, and caretaker relatives with incomes up to 300% of the FPL. Currently, parents and caretaker relatives of children receiving HUSKY A (Medicaid) qualify for Medicaid with income up to 150% of the FPL. (The bill does not specify that these adults must be caretaker relatives of HUSKY A children.)

The bill also requires DSS, as part of the State Plan amendment, to extend Medicaid coverage to any other individuals between the ages of 19 and 64 up to this same income level who can be covered, at state option, through the amendment. Currently, only a limited number of

non-elderly adults can receive Medicaid coverage, and the income limit is far below 300% of the FPL (about 56%).

Also by July 1, 2009, the bill requires the commissioner to apply for a Section 1115 Medicaid waiver to authorize the use of Medicaid funds for individuals between ages 19 and 64 with incomes at or below 185% of the FPL who are not otherwise eligible for Medicaid, either “under mandatory eligibility or at state option through state plan amendment.”

The bill allows the state to meet federal budget neutrality requirements (necessary for all Section 1115 waivers) by claiming unspent uncompensated care payments to hospitals or taking other measures. But these measures may not result in the following for individuals who would have qualified for Medicaid, HUSKY, or State-Administered General Assistance (SAGA):

1. a reduction in covered services or access to care;
2. an increase in deductibles, premiums, or other out-of-pocket costs; or
3. a reduction in enforceable individual coverage guarantees.

The bill provides that if budget neutrality prevents the bill’s coverage up to 185% of FPL, the coverage must be available at income at the highest percentage under 150% of FPL.

Using SCHIP to Expand Coverage (§ 9)

The bill requires the DSS commissioner to cover individuals over age 18, including pregnant women, if necessary to access all Medicaid funds allotted to the state. He must do this even if these individuals are not eligible for Medicaid. (Federal Medicaid funds are not allotted to the state. Rather, the federal government reimburses the state for 50% of what it spends on Medicaid recipients.)

Currently, the state uses SCHIP funds to cover children in families with incomes between 185% and 300% of the FPL (HUSKY B), as well

as 18- and 19-year-old children (HUSKY A, which is part of the Medicaid program) with incomes up to 185% of the FPL. Younger children in families with incomes below 185% are eligible for HUSKY A, and their parents or caretaker relatives qualify for HUSKY A if their income is less than 150% of the FPL. Likewise, pregnant women with incomes up to 185% of the FPL are eligible for HUSKY A coverage.

It appears that the bill would require DSS to cover pregnant women with higher incomes under the HUSKY B program using SCHIP funds, which federal law allows. It is not clear how high the federal government would allow the state to set the income limit for this group.

SUPPLEMENT COVERAGE FOR MEDICAID- AND HUSKY-ELIGIBLE INDIVIDUALS (§§ 11 (B) & 12)

The bill provides that employees who qualify for Medicaid and are in an employer-sponsored health insurance plan must receive “supplemental” coverage under Medicaid. Likewise, it requires employees who are eligible for supplemental coverage under Medicaid or HUSKY (it does not specify whether it is HUSKY A (Medicaid) or HUSKY B (SCHIP)) to receive it.

Under the Medicaid program, enrollees who have employer-sponsored coverage can get help paying the premiums for that coverage, as well as supplemental coverage for any gaps in the employer plan.

Since the HUSKY B program is available only to children whose parents are not enrolled in an employer plan (federal SCHIP law prohibition), the bill’s provision could not be implemented unless DSS received a federal waiver. The bill does not direct DSS to seek this waiver.

The bill requires the comptroller, in cooperation with the DSS commissioner to develop integrated procedures to ensure enrollees receive this coverage.

Section 11 refers to a provision in Section 11, which appears to be a mistake. Section 12 is the correct reference.

REGULATIONS (§§ 10 & 14)

The comptroller must adopt regulations to implement and administer SHIPP, including addressing how enrollee payments will be made to the comptroller for transmittal to insurance companies.

COMMENT

No Fund Named or Established for Premium Contributions (§ 11)

The bill does not create a new fund or account or indicate what established fund into which the comptroller must deposit employee premium contributions.

The bill specifies that the comptroller must adopt regulations that “specify procedures and standards for the collection and deposit of contributions” by employers in the state. Usually, when any funds are raised for a specific reason, the legislation either creates a specific account or fund for it or directs what existing fund the money will be deposited in.

Required SHIPP Availability Date and Comptroller’s Authority to Procure Insurance (§§ 2, 6 &7)

The bill requires that SHIPP be available for voluntary and mandatory enrollees on July 1, 2008. Yet the provision authorizing the comptroller to procure insurance policies for SHIPP does not take effect until July 1, 2008.

BACKGROUND

Legislative History

The House referred the bill (File 264) to the Finance, Revenue and Bonding Committee, which voted out substitute language that deletes the mandate on employers to pay 11% of their payroll to the comptroller.

Related Bills

Several legislative committees have favorably reported bills broadly

addressing health care access that contain provisions similar to those in HB 7314. They are:

Bill Number	Committee
SB 1	Public Health
SB 3	Human Services
SB 70	Insurance
SB 1127	Human Services
HB 6158	Children
HB 6652	Insurance

COMMITTEE ACTION

Labor and Public Employees Committee

Joint Favorable Substitute

Yea 8 Nay 2 (03/15/2007)

Human Services Committee

Joint Favorable

Yea 10 Nay 7 (04/26/2007)

Finance, Revenue and Bonding Committee

Joint Favorable Substitute

Yea 34 Nay 16 (05/08/2007)