House of Representatives

General Assembly

File No. 259

January Session, 2009

Substitute House Bill No. 6582

House of Representatives, March 26, 2009

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP.

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

Section 1. Section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group hospitalization and medical and surgical insurance plan or plans for (1) state employees, (2) members of the General Assembly who elect coverage under such plan or plans, (3) participants in an alternate retirement program who meet the service requirements of section 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits under section 5-144 or from any state-sponsored retirement system, except the teachers' retirement system and the municipal employees retirement system, (5) judges of probate and Probate Court employees, (6) the surviving spouse **[**,**]** and any dependent children **[**until they

reach the age of eighteen,**]** of a state police officer, a member of an organized local police department, a firefighter or a constable who performs criminal law enforcement duties who dies before, on or after June 26, 2003, as the result of injuries received while acting within the scope of such officer's or firefighter's or constable's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan, (7) employees of the Capital City Economic Development Authority established by section 32-601, and (8) the surviving spouse and dependent children of any employee of a municipality who dies on or after October 1, 2000, as the result of injuries received while acting within the scope of such employee's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan. For purposes of this subdivision, "employee" means any regular employee or **[**elective**]** elected officer receiving pay from a municipality, "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, flood commission or authority established by special act or regional planning agency. For purposes of subdivision (6) of this subsection, "firefighter" means any person who is regularly employed and paid by any municipality for the purpose of performing firefighting duties for a municipality on average of not less than thirty-five hours per week. The minimum benefits to be provided by such plan or plans shall be substantially equal in value to the benefits that each such employee or member of the General Assembly could secure in such plan or plans on an individual basis on the preceding first day of July. The state shall pay for each such employee and each member of the General Assembly covered by such plan or plans the portion of the premium charged for such member's or employee's individual coverage and seventy per cent of the additional cost of the form of coverage and such amount shall be credited to the total premiums owed by such employee or member of the General

Assembly for the form of such member's or employee's coverage under such plan or plans. On and after January 1, 1989, the state shall pay for anyone receiving benefits from any such state-sponsored retirement system one hundred per cent of the portion of the premium charged for such member's or employee's individual coverage and one hundred per cent of any additional cost for the form of coverage. The balance of any premiums payable by an individual employee or by a member of the General Assembly for the form of coverage shall be deducted from the payroll by the State Comptroller. The total premiums payable shall be remitted by the Comptroller to the insurance company or companies or nonprofit organization or organizations providing the coverage. The amount of the state's contribution per employee for a health maintenance organization option shall be equal, in terms of dollars and cents, to the largest amount of the contribution per employee paid for any other option that is available to all eligible state employees included in the health benefits plan, but shall not be required to exceed the amount of the health maintenance organization premium.

(b) The insurance coverage procured under subsection (a) of this section for active state employees, employees of the Connecticut Institute for Municipal Studies, anyone receiving benefits from any such state-sponsored retirement system and members of the General Assembly, who are over sixty-five years of age, may be modified to reflect benefits available to such employees or members pursuant to Social Security and medical benefits programs administered by the federal government, provided any payments required to secure such benefits administered by the federal government shall be paid by the Comptroller either directly to the employee or members or to the agency of the federal government authorized to collect such payments.

(c) On October 1, 1972, the Comptroller shall continue to afford payroll deduction services for employees participating in existing authorized plans covering state employees until such time as the employee elects in writing to be covered by the plan authorized by subsection (a) of this section.

(d) Notwithstanding the provisions of subsection (a) of this section, the state shall pay for a member of any such state-sponsored retirement system, or a participant in an alternate retirement program who meets the service requirements of section 5-162 or subsection (a) of section 5-166, and who begins receiving benefits from such system or program on or after November 1, 1989, eighty per cent of the portion of the premium charged for his individual coverage and eighty per cent of any additional cost for his form of coverage. Upon the death of any such member, any surviving spouse of such member who begins receiving benefits from such system shall be eligible for coverage under this section and the state shall pay for any such spouse eighty per cent of the portion of the premium charged for his individual coverage and eighty per cent of any additional cost for his form of coverage.

(e) Notwithstanding the provisions of subsection (a) of this section, (1) vending stand operators eligible for membership in the state employee's retirement system pursuant to section 5-175a, shall be eligible for coverage under the group hospitalization and medical and surgical insurance plans procured under this section, provided the cost for such operators' insurance coverage shall be paid by the Board of Education and Services for the Blind from vending machine income pursuant to section 10-303, and (2) blind persons employed in workshops, established pursuant to section 10-298a, on December 31, 2002, shall be eligible for coverage under the group hospitalization and medical and surgical insurance plans procured under this section, provided the cost for such persons' insurance coverage shall be paid by the Board of Education and Services for the Blind. General workers employed in positions by the Department of Developmental Services as self-advocates, not to exceed eleven employees, shall be eligible for sick leave, in accordance with section 5-247, vacation and personal leave, in accordance with section 5-250, and holidays, in accordance with section 5-254.

(f) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group

hospitalization and medical and surgical insurance plan or plans for any person who adopts a child from the state foster care system, any person who has been a foster parent for the Department of Children and Families for six months or more, a parent in a permanent family residence for six months or more, and any dependent of such adoptive parent, foster parent or parent in a permanent family residence who elects coverage under such plan or plans. The Comptroller may also arrange for inclusion of such person and any such dependent in an existing group hospitalization and medical and surgical insurance plan offered by the state. Any adoptive parent, foster parent or a parent in a permanent family residence and any dependent who elects coverage shall pay one hundred per cent of the premium charged for such coverage directly to the insurer, provided such adoptive parent, foster parent or parent and all such dependents shall be included in such group hospitalization and medical and surgical insurance plan. A person and his dependents electing coverage pursuant to this subsection shall be eligible for such coverage until no longer an adoptive parent, a foster parent or a parent in a permanent family residence. **[**An adoptive parent shall be eligible for such coverage until the adopted child reaches the age of eighteen or, if the child has not completed a secondary education program, until such child reaches the age of twenty-one.**]** As used in this section "dependent" means a spouse or natural or adopted child if such child is wholly or partially dependent for support upon the adoptive parent, foster parent or parent in a permanent family residence.

(g) Notwithstanding the provisions of subsection (a) of this section, the Probate Court Administration Fund established in accordance with section 45a-82, shall pay for each probate judge and Probate Court employee not more than one hundred per cent of the portion of the premium charged for his or her individual coverage and not more than fifty per cent of any additional cost for his or her form of coverage. The remainder of the premium for such coverage shall be paid by the probate judge or Probate Court employee to the State Treasurer. Payment shall be credited by the State Treasurer to the fund established by section 45a-82. The total premiums payable shall be

remitted by the Probate Court Administrator directly to the insurance company or companies or nonprofit organization or organizations providing the coverage. The Probate Court Administrator shall issue regulations governing group hospitalization and medical and surgical insurance pursuant to subdivision (1) of subsection (b) of section 45a-77.

(h) For the purpose of subsection (g) of this section, "Probate Court employee" means a person employed by a probate court for at least twenty hours per week.

(i) The Comptroller may provide for coverage of employees of municipalities, nonprofit corporations, community action agencies and small employers and individuals eligible for a health coverage tax credit, retired members or members of an association for personal care assistants under the plan or plans procured under subsection (a) of this section, provided: (1) Participation by each municipality, nonprofit corporation, community action agency, small employer, eligible individual, retired member or association for personal care assistants shall be on a voluntary basis; (2) where an employee organization represents employees of a municipality, nonprofit corporation, community action agency or small employer, participation in a plan or plans to be procured under subsection (a) of this section shall be by mutual agreement of the municipality, nonprofit corporation, community action agency or small employer and the employee organization only and neither party may submit the issue of participation to binding arbitration except by mutual agreement if such binding arbitration is available; (3) no group of employees shall be refused entry into the plan by reason of past or future health care costs or claim experience; (4) rates paid by the state for its employees under subsection (a) of this section are not adversely affected by this subsection; (5) administrative costs to the plan or plans provided under this subsection shall not be paid by the state; (6) participation in the plan or plans in an amount determined by the state shall be for the duration of the period of the plan or plans, or for such other period as mutually agreed by the municipality, nonprofit corporation,

community action agency, small employer, retired member or association for personal care assistants and the Comptroller; and (7) nothing in this section or section 12-202a, 38a-551, 38a-553 or 38a-556 shall be construed as requiring a participating insurer or health care center to issue individual policies to individuals eligible for a health coverage tax credit. The coverage provided under this section may be referred to as the "Municipal Employee Health Insurance Plan". The Comptroller may arrange and procure for the employees and eligible individuals under this subsection health benefit plans that vary from the plan or plans procured under subsection (a) of this section. Notwithstanding any provision of part V of chapter 700c, the coverage provided under this subsection may be offered on either a fully underwritten or risk-pooled basis at the discretion of the Comptroller. For the purposes of this subsection, (A) "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, regional emergency telecommunications center, tourism district established under section 32-302, flood commission or authority established by special act, regional planning agency, transit district formed under chapter 103a, or the Children's Center established by number 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a nonprofit corporation organized under 26 USC 501 that has a contract with the state or receives a portion of its funding from a municipality, the state or the federal government, or (ii) an organization that is tax exempt pursuant to 26 USC 501(c)(5); (C) "community action agency" means a community action agency, as defined in section 17b-885; (D) "small employer" means a small employer, as defined in subparagraph (A) of subdivision (4) of section 38a-564; (E) "eligible individuals" or "individuals eligible for a health coverage tax credit" means individuals who are eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment

Assistance programs of the Trade Act of 2002, [(P.L. 107-210)] P.L. 107-210; (F) "association for personal care assistants" means an organization composed of personal care attendants who are employed by recipients of service (i) under the home-care program for the elderly under section 17b-342, (ii) under the personal care assistance program under section 17b-605a, (iii) in an independent living center pursuant to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for individuals with acquired brain injury as described in section 17b-260a; and (G) "retired members" means individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system.

(j) (1) Notwithstanding any provision of law, [to the contrary,] the existing rights and obligations of state employee organizations and the state employer under current law and contract shall not be impaired by the provisions of this section. (2) Other conditions of entry for any group into the plan or plans procured under subsection (a) of this section shall be determined by the Comptroller upon the recommendation of a coalition committee established pursuant to subsection (f) of section 5-278, except for such conditions referenced in subsection (g) of this section. (3) Additional determinations by the Comptroller on (A) issues generated by any group's actual or contemplated participation in the plan or plans, (B) modifications to the terms and conditions of any group's continued participation, (C) related matters shall be made upon the recommendation of such committee. (4) Notwithstanding any provision of law to the contrary, a municipal employer and an employee organization may upon mutual agreement reopen a collective bargaining agreement for the exclusive purpose of negotiating on the participation by such municipal employer or employee organization in the plan or plans offered under the provisions of this section.

(k) The Comptroller shall submit annually to the General Assembly a review of the coverage of employees of municipalities, nonprofit corporations, community action agencies, small employers under subsection (i) of this section and eligible individuals under subsection

(i) of this section beginning February 1, 2004.

(l) (1) Effective July 1, 1996, any deputies or special deputies appointed pursuant to section 6-37 of the general statutes, revision of 1958, revised to 1999, or section 6-43, shall be allowed to participate in the plan or plans procured by the Comptroller pursuant to subsection (a) of this section. Such participation shall be voluntary and the participant shall pay the full cost of the coverage under such plan.

(2) Effective December 1, 2000, any state marshal shall be allowed to participate in the plan or plans procured by the Comptroller pursuant to subsection (a) of this section. Such participation shall be voluntary and the participant shall pay the full cost of the coverage under such plan.

(3) Effective December 1, 2000, any judicial marshal shall be allowed to participate in the plan or plans procured by the Comptroller pursuant to subsection (a) of this section. Such participation shall be voluntary and the participant shall pay the full cost of the coverage under such plan unless and until the judicial marshals participate in the plan or plans procured by the Comptroller under this section **[**5-259**]** through collective bargaining negotiations pursuant to subsection (f) of section 5-278.

(m) (1) Notwithstanding any provision of the general statutes, the Comptroller shall begin procedures to convert the group hospitalization and medical and surgical insurance plans set forth in subsection (a) of this section, including any prescription drug plan offered in connection with or in addition to such insurance plans, to self-insured plans for benefit periods beginning on or after July 1, 2009, except that any dental plan offered in connection with or in addition to such insurance plans may be fully insured.

(2) On or after January 1, 2010, the Comptroller may merge any other insurance plans procured by the Comptroller into the self-insured plans established pursuant to subdivision (1) of this subsection.

(3) Any company that provides administrative services for the self-insured plans set forth in subdivision (1) of this subsection shall be required under its administrative services only contract to charge such company's lowest available rate for such services.

Sec. 2. (NEW) (*Effective July 1, 2009*) As used in this section and sections 3 to 7, inclusive, of this act:

(1) "Health Care Costs Containment Committee" means the committee established pursuant to the ratified agreement between the state and state employees' Bargaining Agent Coalition pursuant to subsection (f) of section 5-278 of the general statutes.

(2) "Municipal-related employee" means any employee of a municipal-related employer.

(3) "Municipal-related employer" means any property management business, food service business or school transportation business that is a party to a contract with a nonstate public employer. "Municipal-related employer" does not include a nonprofit employer, a nonstate public employer or a small employer.

(4) "Nonprofit employee" means any employee of a nonprofit employer.

(5) "Nonprofit employer" means a nonprofit corporation, as defined in subparagraph (B) of subdivision (7) of subsection (i) of section 5-259 of the general statutes, as amended by this act. "Nonprofit employer" does not include a municipal-related employer, a nonstate public employer or a small employer.

(6) "Nonstate public employee" means any employee or elected officer of a nonstate public employer.

(7) "Nonstate public employer" means a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library. "Nonstate public employer" does not include a municipal-related employer, a nonprofit employer or a small

employer.

(8) "Small employer employee" means any employee of a small employer.

(9) "Small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months that, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty employees, the majority of whom were employed within this state. "Small employer" does not include a municipal-related employer, a nonprofit employer or a nonstate public employer. In determining the number of eligible employees, companies that are affiliates, as defined in section 33-840 of the general statutes, or that are eligible to file a combined tax return under chapter 208 of the general statutes shall be considered one employer.

(10) "State employee plan" or "state plan" means a self-insured group health care benefits plan established under subsection (m) of section 5-259 of the general statutes, as amended by this act.

Sec. 3. (NEW) (*Effective July 1, 2009*) (a) (1) Notwithstanding the provisions of title 38a of the general statutes, the Comptroller shall offer coverage under the state employee plan to nonstate public employers, municipal-related employers, small employers and nonprofit employers and their respective retirees, if applicable, in accordance with subdivision (2) of this subsection, and provided the Comptroller receives an application from any such employer and the application is approved in accordance with sections 4 and 5 of this act.

(2) The Comptroller shall offer coverage under the state employee plan: (A) To nonstate public employers beginning January 1, 2010; (B) to municipal-related employers and nonprofit employers beginning July 1, 2010; and (C) to small employers beginning January 1, 2011.

(b) The Comptroller shall offer participation in such plan to nonstate

public employers, municipal-related employers, small employers and nonprofit employers for not less than two-year intervals. An employer may apply for renewal prior to the expiration of each interval. The Comptroller shall develop procedures by which employers receiving coverage for their employees pursuant to the state plan may (1) apply for renewal, or (2) withdraw from such coverage, including, but not limited to, the terms and conditions under which such employers may withdraw prior to the expiration of the interval and the procedure by which any premium payments such employers may be entitled to shall be refunded. Any such procedures shall provide that nonstate public employees covered by collective bargaining shall withdraw from such coverage in accordance with chapters 68, 113 and 166 of the general statutes.

(c) Open enrollment for nonstate public employees, municipal-related employees, small employer employees and nonprofit employees shall be for coverage periods beginning January first and July first.

(d) Nothing in this section and sections 4 to 6, inclusive, of this act shall require the Comptroller to offer coverage to every employer seeking coverage under sections 4 and 5 of this act from every plan offered under the state employee plan.

(e) The Comptroller shall create applications for coverage for the purposes of this section and sections 4 and 5 of this act. Such applications shall require an employer to disclose whether the employer will offer any other health plan to the employees who are offered the state plan.

(f) No employee shall be enrolled in the state plan if such employee is covered through such employee's employer by health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

Sec. 4. (NEW) (*Effective July 1, 2009*) (a) Nonstate public employers

may join the state employee plan in accordance with this subsection.

(1) Notwithstanding any other provision of the general statutes, initial participation in the state employee plan by a nonstate public employer shall be a permissive subject of collective bargaining and shall be subject to binding interest arbitration only if the collective bargaining agent and the employer mutually agree to bargain over such initial participation. Such mutual agreement shall be in writing and signed by authorized representatives of the collective bargaining agent and the employer. Continuation in the state employee plan, after initial participation, shall be a mandatory subject of bargaining and shall be subject to binding interest arbitration in accordance with the same procedures and standards that apply to any other mandatory subject of bargaining pursuant to chapters 68, 113 and 166 of the general statutes. For purposes of this section, a board of education and a municipality shall be considered separate employers and shall submit separate applications.

(2) (A) If a nonstate public employer submits an application in accordance with this subsection for all of its employees, the Comptroller shall accept such application for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin.

(B) If a nonstate public employer submits an application for less than all of its employees, or indicates in the application the employer will offer other health plans to employees who are offered the state health plan, the Comptroller shall forward such application to the Health Care Costs Containment Committee not later than five business days after receiving such application. Said committee may, not later than thirty days after receiving such application, certify to the Comptroller that the application will shift a significantly disproportional part of such employer's medical risks to the state employee plan, and shall provide in writing the specific reasons for its finding, including a summary of all information replied upon in making such a finding. If the Comptroller receives such certification,

the Comptroller shall not provide coverage to such employer and shall provide written notification to such employer and the specific reasons for such denial. If the Comptroller does not receive such certification, the Comptroller shall accept such application for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin.

(b) Municipal-related employers, small employers and nonprofit employers may join the state employee plan in accordance with this subsection.

(1) If a municipal-related employer, small employer or nonprofit employer submits an application for all of its employees, the Comptroller shall accept such application for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin.

(2) If a municipal-related employer, small employer or nonprofit employer submits an application for less than all of its employees, or indicates in the application the employer will offer other health plans to employees who are offered the state health plan, the Comptroller shall forward such application to the Health Care Costs Containment Committee not later than five business days after receiving such application. Said committee may, not later than thirty days after receiving such application, certify to the Comptroller that the application will shift a significantly disproportional part of such employer's medical risks to the state employee plan, and shall provide in writing the specific reasons for its finding, including a summary of all information replied upon in making such a finding. If the Comptroller receives such certification, the Comptroller shall not provide coverage to such employer and shall provide written notification to such employer and the specific reasons for such denial. If the Comptroller receives such certification, the Comptroller shall not provide coverage to such employer. If the Comptroller does not receive such certification, the Comptroller shall accept such application

for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin.

(c) The Comptroller shall not forward an employer's application for coverage for review by the Health Care Costs Containment Committee, pursuant to this section, if such employer included less them all of its employees in its application because of (1) the decision by individual employees to decline coverage from their employer for themselves or their dependents, or (2) the employer's decision to not offer coverage to temporary, part-time or durational employees.

(d) The Comptroller may adopt regulations, in accordance with chapter 54 of the general statutes, to establish the procedures and criteria for any reviews or evaluations performed by the Health Care Costs Containment Committee pursuant to subparagraph (B) of subdivision (2) of subsection (a) of this section, subdivision (2) of subsection (b) of this section and subdivision (2) of subsection (b) of section 5 of this act.

(e) Notwithstanding any provision of the general statutes, the state employee plan shall not be deemed (1) an unauthorized insurer, or (2) a multiple employer welfare arrangement. Any licensed insurer in this state may conduct business with the state employee plan.

Sec. 5. (NEW) (*Effective July 1, 2009*) (a) Employers eligible to seek coverage for their employees under the state employee plan, pursuant to sections 3 and 4 of this act, may seek such coverage for their retirees in accordance with this section, except that any retirees eligible for Medicare benefits shall not be eligible for the state plan. Premium payments for such coverage shall be remitted by the employer to the Comptroller in accordance with section 6 of this act and shall be the same as those paid by the state, inclusive of any premiums paid by retired state employees.

(b) (1) If an employer seeks coverage for all of such employer's retirees in accordance with this section and all of such employer's

employees in accordance with section 3 of this act, the Comptroller shall accept such application for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin.

(2) If an employer seeks coverage for less than all of such employer's retirees, regardless of whether the employer is seeking coverage for all of such employer's active employees, the Comptroller shall forward such application to the Health Care Costs Containment Committee not later than five business days after receiving such application. Said committee may, not later than thirty days after receiving such application, certify to the Comptroller that, with respect to such retirees, the application will shift a significantly disproportional part of an employer's medical risks to the state employee plan, and shall provide in writing the specific reasons for its finding, including a summary of all information replied upon in making such a finding. If the Comptroller receives such certification, the Comptroller shall not provide coverage to such employer for such employer's retirees and shall provide written notification to such employer and the specific reasons for such denial. If the Comptroller does not receive such certification, the Comptroller shall accept such application for the next open enrollment. The Comptroller shall provide written notification to such employer of such acceptance and the date on which such coverage shall begin.

(3) The Comptroller shall not forward an employer's application for coverage for review by the Health Care Costs Containment Committee, pursuant to this section, if such employer included less than all of its retirees in its application because of (1) the decision by individual retirees to decline coverage from their employer for themselves or their dependents, or (2) retirees' enrollment in Medicare.

(c) Nothing in sections 2 to 7, inclusive, of this act shall diminish any right to retiree health insurance pursuant to a collective bargaining agreement or any other provision of the general statutes.

Sec. 6. (NEW) (*Effective July 1, 2009*) (a) There is established a

restricted grant fund that is a separate, nonlapsing account to be known as the state plan premium account. All premiums paid by employers and employees pursuant to this section shall be deposited into said account. The account shall be administered by the Comptroller, with the advice of the Health Care Costs Containment Committee, for payment of claims.

(b) Premium payments shall be remitted by the employer to the Comptroller and shall be the same as those paid by the state, inclusive of any premiums paid by state employees and retired state employees, if applicable, except as otherwise provided in this section or section 5 of this act. The Comptroller may charge each employer participating in the state plan an administrative fee calculated on a per member per month basis.

(c) Premium rates for small employers shall be the total premium rate paid by the state, inclusive of any premiums paid by state employees for a particular health care product offered by the Comptroller, except that an insurance carrier offering coverage under the state plan may adjust such rate to reflect one or more of the characteristics set forth in subparagraph (A) of subdivision (5) of section 38a-567 of the general statutes.

(d) Each employer shall pay monthly the amount determined by the Comptroller, pursuant to this section, for coverage of its employees or its employees and retirees, as appropriate, under the state employee plan. An employer may require each covered employee to contribute a portion of the cost of such employee's coverage under the plan, subject to any collective bargaining obligation applicable to such employer.

(e) If any payment due by an employer under this section is not submitted to the Comptroller by the tenth day after the date such payment is due, interest to be paid by such employer shall be added, retroactive to the date such payment was due, at the prevailing rate of interest as determined by the Comptroller.

(1) The Comptroller may terminate participation in the state

employee plan by a municipal-related employer, small employer or nonprofit employer on the basis of nonpayment of premium, provided at least ten days' advance notice is given to such employer, which may continue the coverage and avoid the effect of the termination by remitting payment in full at any time prior to the effective date of termination.

(2) (A) If a nonstate public employer fails to make premium payments as required by this section, the Comptroller may direct the State Treasurer, or any other officer of the state who is the custodian of any moneys made available by grant, allocation or appropriation payable to such nonstate public employer, to withhold the payment of such moneys until the amount of the premium or interest due has been paid to the Comptroller, or until the State Treasurer or such custodial officer determines that arrangements have been made, to the satisfaction of the State Treasurer, for the payment of such premium and interest. Such moneys shall not be withheld if such withholding will adversely affect the receipt of any federal grant or aid in connection with such moneys.

(B) If no grant, allocation or appropriation is payable to such nonstate public employer or is not withheld, pursuant to subparagraph (A) of this subdivision, the Comptroller may terminate participation in the state employee plan by a nonstate public employer on the basis of nonpayment of premium, provided at least ten days' advance notice is given to such employer, which may continue the coverage and avoid the effect of the termination by remitting payment in full at any time prior to the effective date of termination.

(3) The Comptroller may request the Attorney General to recover any premium and interest costs from a terminated employer.

Sec. 7. (NEW) (*Effective July 1, 2009*) (a) There is established a Nonstate Public Health Care Advisory Committee. The committee shall make advisory recommendations to the Health Care Costs Containment Committee concerning health care coverage for nonstate public employees. The advisory committee shall consist of nonstate

public employers and employees participating in the state plan and shall include the following members appointed by the Comptroller: (1) Three municipal employer representatives, one of whom represents towns with populations of one hundred thousand or more, one of whom represents towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents towns with populations under twenty thousand; (2) three municipal employee representatives, one of whom represents employees in towns with populations of one hundred thousand or more, one of whom represents employees in towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents employees in towns with populations under twenty thousand; (3) three board of education employers, one of whom represents towns with populations of one hundred thousand or more, one of whom represents towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents towns with populations under twenty thousand; (4) three board of education employee representatives, one of whom represents towns with populations of one hundred thousand or more, one of whom represents towns with populations of at least twenty thousand but under one hundred thousand, and one of whom represents towns with populations under twenty thousand; and (5) one neutral chairperson, who shall be a member of the National Academy of Arbitrators or an arbitrator authorized by the American Arbitration Association or the Federal Mediation and Conciliation Service to serve as a neutral arbitrator in labor relations cases.

(b) There is established a Private Sector Health Care Advisory Committee. The committee shall make advisory recommendations to the Health Care Costs Containment Committee concerning health care coverage for private sector employees. The advisory committee shall consist of municipal-related employers, small employers and nonprofit employers and their respective employees participating in the state plan and shall include the following members appointed by the Comptroller: (1) Two municipal-related employer representatives; (2) two municipal-related employee representatives; (3) two small

employer representatives; (4) two small employee representatives; (5) two nonprofit employer representatives; (6) two nonprofit employee representatives; and (7) one neutral chairperson, who shall be a member of the National Academy of Arbitrators or an arbitrator authorized by the American Arbitration Association or the Federal Mediation and Conciliation Service to serve as a neutral arbitrator in labor relations cases.

Sec. 8. (NEW) (*Effective July 1, 2009*) The Comptroller may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 2 to 7, inclusive, of this act.

Sec. 9. (NEW) (*Effective from passage*) The Comptroller shall not offer coverage under the state employee plan pursuant to sections 3 to 6, inclusive, of this act until the State Employees' Bargaining Agent Coalition has provided its written consent to the clerks of both houses of the General Assembly to incorporate the terms of sections 2 to 7, inclusive, of this act into its collective bargaining agreement.

Sec. 10. (NEW) (*Effective from passage*) Notwithstanding the provisions of title 38a of the general statutes, two or more municipalities may join together by written agreement as a single entity for the purpose of procuring health insurance for their employees. Any such group shall be approved by the commissioner and shall be on a fully underwritten basis. Such written agreement shall establish the membership of such group, the duration of such health insurance coverage, requirements regarding the payment of premiums for such health insurance coverage and the procedures for a municipality to withdraw from such group and terminate such health insurance coverage. Any group established pursuant to this section shall not be deemed a fictitious group.

Sec. 11. Subparagraph (B) of subdivision (4) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(B) "Small employer" does not include (i) a municipality procuring

health insurance or health care pursuant to section 5-259, as amended by this act, or sections 3 to 5, inclusive, of this act, (ii) a private school in this state procuring health insurance through a health insurance plan or an insurance arrangement sponsored by an association of such private schools, (iii) a nonprofit organization procuring health insurance pursuant to section 5-259, as amended by this act, unless the Secretary of the Office of Policy and Management and the State Comptroller make a request in writing to the Insurance Commissioner that such nonprofit organization be deemed a small employer for the purposes of this chapter, (iv) an association for personal care assistants procuring health insurance pursuant to section 5-259, as amended by this act, or (v) a community action agency procuring health insurance pursuant to section 5-259, as amended by this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	5-259
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*July 1, 2009*	New section
Sec. 8	*July 1, 2009*	New section
Sec. 9	*from passage*	New section
Sec. 10	*from passage*	New section
Sec. 11	*July 1, 2009*	38a-564(4)(B)

INS *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 House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 10 $	FY 11 $
Comptroller	GF - Cost	$245,600	$245,600
State Comptroller - Fringe Benefits[1]	All Funds – See Below	See Below	See Below
Department of Revenue Services	GF - See Below	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 10 $	FY 11 $
Various Municipalities	Savings	Potential	Potential

Explanation

Section 1: Self-Insuring

This bill would require the Comptroller to begin to convert the state health plans (dental may be excluded) to self-insured plans beginning on or after July 1, 2009. This would require: 1) written consent from the State Employees' Bargaining Agent Coalition (SEBAC); 2) cancelling the current fully-insured contract which is not set to expire until July 1, 2011; and 3) negotiating an administrative services only (ASO) contract for the self-insured plans.

As a self-insured employer, the state would pay directly for participant claims on an incurred-and-reported basis. When an entity

[1] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller on an actual cost basis. The following is provided for estimated costs associated with additional personnel. The estimated non-pension fringe benefit rate as a percentage of payroll is 25.43%. Fringe benefit costs for new positions do not initially include pension costs as the state's pension contribution is based upon the 6/30/08 actuarial valuation for the State Employees Retirement System (SERS) which certifies the contribution for FY 10 and

moves from fully-insured plans to a self-insured mechanism, the premiums paid to a health insurer cease and claims begin to be paid directly from a self-insured pool, in this case appropriated by the legislature. There is a potential one-time savings due to the typical 30 to 60 day lag in the payment of provider health claims after services are rendered.

Currently, the Comptroller pays approximately $70 million in fully-insured health care premiums each month for active and retired state employees. One-time savings will result from the lag in claims incurred but not yet reported to the new self-insured in the first two months of the transition. Assuming that half of the claims incurred are paid in the first two months, the state would obtain a one-time savings of $70 million in FY 10.

The current fully-insured contract for state employee and retiree health insurance includes an average rate cap of 10% per year across all health care plans to hold down costs in FY 10 and in FY 11. The state's premium rates in FY 10 and FY 11 will be determined from the past year's average monthly claims per employee. For example, if the average FY 09 trend increase is 5%, then premiums would similarly increase by 5% in FY 10. If instead the average FY 09 claims were 13%, premiums would only increase 10% due to the rate cap. Other administrative charges would only increase according to the CPI index. By going self-insured, these rate caps become obsolete and the state assumes direct financial responsibility for all costs of enrollees' medical claims.

The first quarter of FY 09 had an average claims loss ratio of 97 percent (versus an average rate of 88% last year).[2] As a result, savings over the FY 10 - FY 11 period may be minimal or non-existent should

FY 11. Therefore, new positions will not impact the state's pension contribution until FY 12 after the next scheduled certification on 6/30/2010.

[2] Health insurance costs are attributed primarily to claims experience. These "loss costs" for state employees and retirees are generally in the range of 80 percent of the premium paid to health plans, but can vary from year to year based upon the health experience of the pool of covered lives.

loss ratios remain at current levels or continue to increase. Based on information obtained from the Comptroller's Office, switching to a self-insured plan could result in FY 10 rates that are 5.9% higher than the maximum rate under the existing fully-insured contract, which equates to an additional $69 million in health costs for the state plan.

The estimated savings from eliminating the risk charge for claims fluctuations currently paid under a fully insured plan would be $20 million annually. The State may wish to budget for the purchase of stop-loss insurance for individual claims exceeding a set dollar amount to cover fluctuations in claims from year to year. This stop-loss insurance would cost the state approximately $10 million annually.

The Comptroller's Office indicates the need for three additional staff positions, consisting of two (2) Retirement and Benefit Officer positions and one (1) Retirement and Benefits Coordinator with a July 1, 2009 start date to work on the transition to an ASO plan and to prepare to open the plan to additional groups. The salaries and fringe benefits associated with these three positions total $245,600.

To the extent that the state of Connecticut can provide ongoing health coverage at a lower cost than private health plans, additional annual savings could be achieved. While the bill does not require the state to provide for reserves to cover claims, it is a common practice to establish a rate stabilization reserve consisting of approximately 2 months worth of anticipated claims.

Sections 2 – 11: Pooling

By permitting the Comptroller to offer coverage under the state employee health plan the bill provides an additional health insurance option to non-state public employers beginning January 1, 2010; municipal-related and non-profit employers beginning July 1, 2010; and to small employers (defined as 50 employees or less) as of January 1, 2011. The bill requires that the total premium the newly enrolled employers pay be the same as those the state pays for the same coverage except it may adjust the rate for a small employer to reflect its

group characteristics. It specifies that employers may require an employee contribution toward the premium, subject to any collective bargaining agreement. It also permits the Comptroller to charge participating employers an administrative fee on a per member per month basis.

Participation in the state plan would be voluntary but will require a minimum of two years participation. The bill proposes immediate acceptance of any employer group that applies in its entirety for coverage. Partial groups applying for coverage are to be reviewed by a health care actuary which will increase the cost to the current health care actuarial services agreement. If it is determined that the group would adversely affect the state pool, the partial group shall be denied coverage. In doing so, the bill seeks to address a potentially negative impact to the state employee pool by preventing an employer from shifting a significantly disproportional share of its medical risks to the state employee plan.

Permitting additional participants to join the current state employee health plan could potentially impact the existing pool. The cost of the state employee health plans is based upon the demographics and claims experience of the existing composition of state employees and retirees. To the extent that additional covered lives affect the claims loss ratio, costs of the state will be directly impacted. While at least 22 other states allow municipalities to participate in their state employee health plans by pooling together (11 states) or in a separate pool like the Municipal Employee Health Insurance Plan (11 states), there are currently no states offering this coverage to small businesses or to non-profits in general.

Municipalities, non-state public employers, non-profit organizations and small employers currently offering health coverage through private health insurers are required to pay an Insurance Premiums Tax to the state of Connecticut. To the degree that this bill results in these groups shifting their participation in fully-insured health plans to procure coverage under Connecticut General Statute 5-259(i) the state

would experience a revenue loss to the Insurance Premiums Tax. Current law exempts new or renewal contracts or policies written to provide health care coverage to municipal employees under a plan procured pursuant to Connecticut General Statute 5-259(i) from the Insurance Premiums Tax. In other words, MEHIP participants are currently exempted from the premiums tax. As a result, there would not be a loss to the premiums tax should MEHIP participants shift to coverage under the pooled state health plan.

There are approximately 110,000 municipal employees (including boards of education). It is anticipated that certain municipalities (particularly smaller towns and non-state public groups) small non-profit organizations and small employers will achieve savings from the state's large-group purchasing power, pooled risk and administrative economies of scale. In order for these groups to determine if they can achieve a savings under the state plan, employers must examine not only the rates and plan design but also 2 to 3 years of its utilization data. The table below provides a comparison of current average annual premium rates within various public and private sectors.

		Average Annual Premium Rates			
	Employer	**Single Coverage**	**Employee Share**	**Family Coverage**	**Employee Share**
National*	Small Firms	$4,826	12%	$12,508	34%
	Large Firms	$4,793	16%	$13,096	23%
Regional*	Northeast	$5,033	17%	$13,740	21%
State+	State of Connecticut	$5,844	3%	$15,778	12%
Industry*	State/Local Government	$5,547	12%	$12,843	22%
Local**	CT Cities & Towns	$6,828	10%	$18,660	10%
	CT Boards of Education	$5,400	16%	$18,936	13%

**National, Regional, and Industry PPO plan data obtained from 2008 Employer Health Benefit Survey. + State POE health plan data obtained from Office of the State Comptroller. ** Local data obtained from CT Public Sector*

Background

Health insurance costs are attributed primarily to claims experience. These "loss costs" for state employees and retirees are generally in the range of 80 percent of the premium paid to health plans, but can vary from year to year based upon the health experience of the pool of covered lives. The cost of plan administration includes the processing of claims, establishing provider networks, negotiating provider payments, and providing utilization review and disease management services. In addition, under a fully insured plan there is a risk charge to cover the potential fluctuations in claims from year to year. Private health insurers are also required to maintain minimum reserve requirements based upon Connecticut insurance law.

The benefits provided under the state employee health plans are established in a collectively bargained agreement between the State of Connecticut and the State Employees Bargaining Agent Coalition (SEBAC). The current 20-year agreement expires in 2017. Currently, the state plan is provided on a fully-insured basis through 4 vendors (Anthem Blue Cross and Blue Shield, Health Net, Oxford/United Health and Caremark) offering 12 plans for active and retired employees. It covers approximately 57,000 employees, 37,000 retirees and their dependents.

As a result of the recent negotiation with the state's health care vendors, the state employee health plan premiums for FY 09 did not contain a rate increase. The finalized FY 10 premium rates will be published in a Comptroller's Numbered Memorandum expected before the end of April. The FY 09 premiums rates for the state employee plans are published with the Comptroller's Numbered Memorandum 2008-16 and can be found using the link: http://www.osc.state.ct.us/2008memos/attachments/att200816.htm

Beginning in FY 09, the state's prescription drug plan became funded on a self-insured basis (Memorandum of Understanding dated

3/20/08 between the state and SEBAC). The savings associated with this change is estimated to be $14.5 million. Per the agreement, this savings will be deposited in the state's Other Post Employment Benefits (OPEB) trust fund which was established to begin to address the state's unfunded retiree health liability estimated at $21.7 billion. An established rate stabilization reserve has not been created for the state's self-insured prescription drug plan.

The Out Years

The future cost of the state employee health plan will be based upon the demographics and claims experience of the future composition of state employees and retirees. To the extent that additional covered lives impact the loss ratio of the plans, a resulting impact may be experienced on the plan's cost to the state. The annualized ongoing fiscal impact identified would continue into the future subject to inflation.

Sources: Public Hearing Testimony 3/2/09, Employer Health Benefits 2008 Annual Survey, The Kaiser Family Foundation & Health Research & Educational Trust, 2008 Connecticut Public Sector Healthcare Cost and Benefit Survey, OLR Research Reports, Office of the State Comptroller, State Health Plan Subscriber Agreement.

OLR Bill Analysis

sHB 6582

AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP.

SUMMARY:

This bill requires the comptroller to convert the state employee health insurance plan, excluding dental, to a self-insured arrangement for benefit periods effective July 1, 2009 and later. (Pharmacy benefits are already self-insured.) It authorizes her to merge, on or after January 1, 2010, any health benefit plans she arranges into the self-insured state plan. The bill requires that a company contracting with the state to provide administrative services for the self-insured state plan must charge the state its lowest available rate.

The bill requires the comptroller to offer coverage under the self-insured state plan, for certain employees and retirees, to (1) nonstate public employers beginning January 1, 2010; (2) municipal-related and nonprofit employers beginning July 1, 2010; and (3) small employers beginning January 1, 2011. She must do this (1) after the General Assembly receives written consent from the State Employees' Bargaining Agent Coalition (SEBAC) and (2) subject to specified requirements and conditions. Employers that apply and are approved for coverage must agree to benefit periods of at least two years. The bill authorizes the comptroller to adopt regulations related to opening the state plan to these other groups.

The bill requires the Health Care Costs Containment Committee (HCCCC), a state labor and management committee that exists under agreement with SEBAC, to (1) review certain employer applications for coverage under the state plan and (2) certify to the comptroller in writing if the group will shift a significantly disproportionate share of

its employees' medical risks to the state plan. If so, the bill requires the comptroller to decline the group coverage.

The bill:

1. requires the state to charge employers participating in the state plan the same premium rates the state pays, except it may adjust the rate for a small employer to reflect its group characteristics;

2. allows the comptroller to have state money withheld from a municipality participating in the state plan that fails to pay premiums and, with 10-days' notice, terminate any participating employer group that does not pay its premiums;

3. establishes a "state plan premium account" as a restricted grant fund, into which employer groups' premiums must be deposited and from which claims must be paid;

4. establishes two advisory committees to make recommendations to the HCCCC about coverage for nonstate public employees and private sector employees;

5. permits two or more municipalities to enter into a written agreement to act as a single entity to obtain health insurance for their employees, subject to specified conditions, including insurance commissioner approval; and

6. excludes from the state insurance law definition of "small employer" a municipality obtaining health care benefits through the self-insured state plan or the Municipal Employee Health Insurance Plan (MEHIP).

The bill eliminates the dependent age limitation for certain children eligible for coverage under the state plan or a state-arranged plan.

The bill also makes conforming and technical changes.

EFFECTIVE DATE: July 1, 2009; except for the provisions about (1)

self-insuring the state plan, (2) needing SEBAC's agreement before opening the state plan to other groups, (3) municipalities acting as a single entity to obtain employee health insurance, and (4) covering dependents to age 26 under the state plan, which are effective upon passage.

§ 1 — CONVERT STATE PLAN TO SELF-INSURANCE

By law, the comptroller solicits bids and enters into contracts with insurance carriers to provide health insurance for state employees and retirees. The bill requires the comptroller to begin the process of converting the state employee health insurance plans, including pharmacy benefits but excluding dental benefits, to a self-insured arrangement for benefit periods effective July 1, 2009 and later. The state began self-insuring pharmacy benefits July 1, 2008.

In 1997, the state and SEBAC reached a 20-year agreement regarding state employee health insurance and retirement benefits. That agreement called for fully-insured health insurance. Last year, the state and SEBAC entered into a memorandum of understanding (MOU) concerning certain health care issues. Among other things, the MOU (1) permitted the state to self-insure pharmacy benefits effective July 1, 2008 and (2) gives the state sole discretion to provide pharmacy benefits in the future on a fully-insured, self-insured, or other appropriate basis. It specifies that such a decision "shall not be appealed or arbitrated in any forum by SEBAC, any constituent union or state employee" (Section 2(A), MOU dated March 20, 2008).

Insurer Administering Self-Insured State Plan

The bill permits any licensed insurer in Connecticut to conduct business with the state with respect to the self-insured plan. Under the bill, that the state's contract with an insurer for administrative services must require the insurer to charge the state its lowest rate available.

Merging State-Arranged Plans

The bill permits the comptroller to merge, on or after January 1, 2010, any benefit plans she arranges into the self-insured state plan.

Under the law's authority, she arranges hospital, medical, and surgical insurance for a person who (1) adopts a child from the state foster care system, (2) has been a foster parent for the Department of Children and Families for at least six months, or (3) is a parent in a permanent family residence for at least six months, and the person's dependent child (see BACKGROUND). The law permits her to provide these people coverage through the state employee insurance plan.

The law also authorizes her to arrange coverage under MEHIP, on a fully-insured or risk-pooled (e.g., self-insured) basis, for (1) employees of municipalities, nonprofit corporations, community action agencies, and small employers; (2) people eligible for a health coverage tax credit under federal law; (3) members of an association of personal care assistants; and (4) people eligible for a retirement benefit from the Connecticut municipal employees' retirement system. The comptroller currently offers a fully-insured MEHIP plan for these groups and a self-insured "enhanced MEHIP" plan for municipalities.

§ 1 — COVERAGE FOR CERTAIN DEPENDENT CHILDREN

The bill eliminates the dependent age limitation for a child, who is eligible for coverage under the state plan or a state-arranged plan, of (1) a state or local police officer, firefighter, or constable with criminal law enforcement duties who dies from injuries received on the job and (2) an adoptive or foster parent or a parent in a permanent family residence for at least six months. Current law ends dependent coverage at age 18 and, for a child of an adoptive or foster child or parent in a permanent family residence that has not finished college, age 21. (State insurance law requires coverage for a child until age 26, subject to certain criteria.)

§ 2 — DEFINITIONS

The bill defines "nonstate public employer" as a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library. It does not include a municipal-related, nonprofit, or small employer. A "nonstate public employee" is an employee or elected officer of a nonstate public employer.

A "municipal-related employer" is a property management, food service, or school transportation business that contracts with a nonstate public employer. It does not include a nonstate public, nonprofit, or small employer.

A "nonprofit employer" is (1) a nonprofit corporation organized under federal law (26 USC 501) that contracts with the state or receives a portion of its funding from a local, state, or federal government or (2) a tax-exempt organization under federal law (26 USC 501(c)(5)). It does not include a nonstate public, municipal-related, or small employer.

A "small employer" is a person, firm, corporation, limited liability company, partnership, or association actively engaged in business or self-employed for at least three consecutive months that, on at least 50% of its working days during the preceding 12 months, employed 50 or fewer employees and the majority of them in Connecticut. When counting the number of employees, companies that are affiliates under state law or eligible to file a combined tax return are considered one employer. A "small employer" does not include a nonstate public, municipal-related, or nonprofit employer.

§ 3 — OPEN STATE EMPLOYEE PLAN TO OTHERS

The bill requires the comptroller to offer coverage under the self-insured state plan to certain employer groups that submit an application that is approved under the bill's provisions. She must offer coverage to:

1. nonstate public employers beginning January 1, 2010;

2. municipal-related and nonprofit employers beginning July 1, 2010; and

3. small employers beginning January 1, 2011.

It is unclear whether opening the state plan to private sector employers jeopardizes the plan's status as a "governmental plan" for purposes of federal law (see BACKGROUND).

The bill specifies that the comptroller does not have to offer coverage from every plan offered under the state plan to every employer.

Open Enrollment

Under the bill, open enrollment for nonstate public, municipal-related, nonprofit, and small employers' employees must be for coverage periods that begin January 1 and July 1.

Coverage Term, Renewal, and Withdrawal

In order for an employer group to participate in the self-insured state employee plan, the group must agree to benefit periods lasting at least two years. An employer may apply for renewal before the end of each benefit period.

The bill requires the comptroller to develop procedures for an employer group to (1) apply for renewal or (2) withdraw from participation in the state plan. The procedures must include the terms and conditions under which a group can withdraw before the benefit period ends and how to obtain a refund for any unearned premiums paid. The procedures must provide that nonstate public employees covered under a collective bargaining agreement must withdraw in accordance with applicable state collective bargaining laws for municipal employees and teachers.

Application Form

The bill requires the comptroller to create an application for employer groups seeking coverage under the state plan. In the application, the employer must disclose whether it will offer any other plan to the employees offered the state plan.

Taft-Hartley Exception

The bill prohibits an employee from enrolling in the state plan if he or she is covered through his or her employer under a health insurance plan or arrangement issued to, or in accordance with, a trust established through collective bargaining under the federal Labor

Management Relations Act (i.e., the Taft-Hartley Act).

§ 4 — EMPLOYER GROUP PARTICIPATION

Permissive and Mandatory Collective Bargaining for Nonstate Public Employers

The bill makes a nonstate public employer group's initial participation in the state employee plan a permissive subject of collective bargaining. If the union and the employer agree in writing to bargain over the initial participation, then the decision to join the plan is subject to binding arbitration. Authorized union and employer representatives must sign the agreement.

The bill makes a nonstate public employer group's continuation in the state plan a mandatory subject of collective bargaining, subject to binding interest arbitration in accordance with applicable state collective bargaining laws for municipal employees and teachers.

The bill specifies that a board of education and a municipality are considered separate employers and must apply for coverage under the state plan separately.

Application and Decision Process for All Eligible Employers

The bill establishes two different processes for determining whether a nonstate public, municipal-related, nonprofit, or small employer group's application for coverage will be accepted, depending on whether the application covers all or some of the employees.

If the application covers all of an employer's employees, the bill requires the comptroller to accept the application for the next open enrollment and give the employer written notice of when coverage begins. But if the application covers only some of an employer's employees or it indicates the employer will offer other health plans to employees offered the state health plan, the comptroller must forward the application to the HCCCC within five days of receiving it.

Within 30 days of receiving an application from the comptroller, the HCCCC must determine whether it will shift a significantly

disproportional part of the employer group's medical risks to the state plan. If so, HCCCC must certify this in writing to the comptroller and include the specific reasons for the decision and the information relied upon in making it. (The bill does not specify what criteria HCCCC is to use to make such decisions. It is also unclear whether HCCCC has the actuarial expertise to complete such underwriting reviews.)

Under the bill, if the comptroller receives a disproportional risk shift certification from HCCCC, she must deny the application and give the employer written notice that includes specific reasons for denial. If the comptroller does not receive such a certification from the HCCCC, she must accept the application and give the employer written notice of when coverage begins.

Exceptions to HCCCC Review

The bill prohibits the comptroller from forwarding to HCCCC an application that proposes to cover fewer than all of its employees because (1) the employer decides not to cover temporary, part-time, or durational employees or (2) individual employees decline coverage.

Regulations Regarding HCCCC Review

The bill authorizes the comptroller to adopt regulations in accordance with law to establish procedures for HCCCC's application reviews.

Self-Insured Plan is Not Unauthorized Insurer or MEWA

The bill specifies that the self-insured state employee plan is not an unauthorized insurer or a "multiple employer welfare arrangement" (see BACKGROUND).

Licensed Insurers May Do Business with State Plan

The bill permits any licensed insurer in Connecticut to conduct business with the state plan.

§ 5 — RETIREES

Employer groups eligible to cover employees under the state plan also may seek coverage for their retirees who are not eligible for

Medicare. The bill states that it does not diminish any right to retiree health insurance under a collective bargaining agreement or state law.

The bill requires the employer to remit premiums for retirees' coverage to the comptroller in accordance with the bill's provisions. It specifies that a retiree's premiums for coverage under the state plan must be the same as those the state pays, including premiums retired state employees pay.

Application and Decision Process

The application process and decision notice requirements with respect to covering an employer's retirees, including HCCCC review if the employer's application proposes to cover fewer than all retirees, is the same as for employees (described in § 4 above).

Exceptions to HCCCC Review

The bill prohibits the comptroller from forwarding an application to HCCCC when the only retirees an employer excludes from the proposed coverage are those who (1) decline coverage or (2) are Medicare enrollees.

§ 6 — PREMIUMS, FEES, COST SHARING, AND STATE ACCOUNT

Premiums

The bill requires, with exception, that the premiums an employer group pays to participate in the state plan must be the same as those the state pays, including any premiums state employees and retirees pay. The bill requires an employer to pay premiums to the comptroller monthly in an amount she determines for providing coverage for the group's employees and retirees, if any.

Small Employer Premiums. It permits adjustments to the premiums charged a small employer that reflect one or more group characteristics specified in state insurance law. These include:

1. age, but age brackets of fewer than five years are not permitted;

2. gender;

3. geographic area, but one smaller than county is not permitted;

4. industry, within certain variation limits;

5. group size, within certain variation limits;

6. administrative costs saved by participating in the state plan, as long as they are measurable and realized on items such as marketing, billing, or claims paying functions, but not commissions;

7. savings realized by not paying a profit margin to an insurance carrier by participating in the state plan; and

8. family composition, including employee, employee plus family, employee and spouse, employee and child, employee plus one dependent, and employee plus two or more dependents.

(The bill indicates that "an insurance carrier offering coverage under the state plan" may adjust a small employer's premium, but since the state plan will be self-insured, the state offers coverage, not an insurer. Perhaps the bill means to refer to an insurer contracted to administer the state plan.)

Administrative Fee and Employee Contribution

The bill authorizes the comptroller to charge employers an administrative fee calculated on a per member, per month basis.

It permits an employer to require a covered employee or retiree to pay part of the coverage cost, subject to any applicable collective bargaining agreement.

Penalties for Late Payment of Premiums

Interest. If an employer does not pay its premiums by the 10th day after the due date, the bill requires the group to also pay interest, retroactive to the due date, at the prevailing rate, as the comptroller determines.

State Money Withheld. If a nonstate public employer fails to make premium payments, the bill authorizes the comptroller to direct the state treasurer, or any state officer who is the custodian of state money (i.e., grant, allocation, or appropriation) owed the group, to withhold payment. The money must be withheld until (1) the group pays the comptroller the past due premiums or interest or (2) the treasurer or state officer determines that arrangements, satisfactory to the treasurer, have been made for paying the premiums and interest.

The bill prohibits the treasurer or state officer from withholding state money from the group if doing so impedes receiving any federal grant or aid in connection with it.

Terminate Plan Participation. With respect to a (1) nonstate public employer that is not owed state money or from which money is not withheld and (2) municipal-related, nonprofit, or small employer, the bill allows the comptroller to terminate the group's participation in the state plan for failure to pay premiums if she gives the group at least 10-days notice. The group can avoid termination by paying premiums and interest due in full before the termination effective date.

The bill allows the comptroller to ask the attorney general to recover any premiums and interest owed from a terminated group.

State Plan Premium Account

The bill establishes a separate, nonlapsing state plan premium account as a restricted grant fund. The comptroller, to whom employer groups remit premiums, must (1) deposit the premiums collected into this account and (2) with HCCCC's advice, administer the account to pay claims.

§ 7 — ADVISORY COMMITTEES

Nonstate Public Health Care Advisory Committee

The bill establishes a 13-member Nonstate Public Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for nonstate public employees.

The committee consists of (1) one neutral chairperson, who must be a member of the National Academy of Arbitrators or an arbitrator the American Arbitration Association or Federal Mediation and Conciliation Service authorizes to serve as a neutral arbitrator in labor relations cases and (2) members representing the nonstate public employers and employees participating in the state plan.

The members include three representatives of (1) municipal employers, (2) municipal employees, (3) board of education employers, and (4) board of education employees. Of the three representatives for each category, one must represent a town with (1) 100,000 or more people, (2) at least 20,000 but under 100,000 people, and (3) under 20,000 people. The comptroller appoints the committee members.

Private Sector Health Care Advisory Committee

The bill establishes a 13-member Private Sector Health Care Advisory Committee, which must make recommendations to the HCCCC regarding health care coverage for private sector employees.

The committee consists of (1) one neutral chairperson, who must be a member of the National Academy of Arbitrators or an arbitrator the American Arbitration Association or Federal Mediation and Conciliation Service authorizes to serve as a neutral arbitrator in labor relations cases and (2) members representing the municipal-related, nonprofit, and small employers and their employees participating in the state plan.

The members include two representatives of (1) municipal-related employers, (2) employees of municipal-related employers, (3) nonprofit employers, (4) employees of nonprofit employers, (5) small employers, and (6) employees of small employers. The comptroller appoints the committee members.

§ 8 — REGULATIONS

The bill authorizes the comptroller to adopt regulations in accordance with law to implement its provisions regarding opening the state employee plan to the specified employer groups.

§ 9 — SEBAC CONSENT

The bill prohibits the comptroller from opening the state employee plan to the specified employer groups until SEBAC provides the House and Senate clerks written consent to incorporate the bill's terms into its collective bargaining agreement. (Presumably, SEBAC's written consent goes to the clerks for legislative action. By law, if the legislature does not take action within 30 days, the agreement is deemed approved (CGS § 5-278(b).)

§ 10 — JOINT MUNICIPAL HEALTH INSURANCE PURCHASES

The bill permits two or more municipalities to enter into a written agreement to act as a single entity to obtain health insurance for their employees. It specifies that such a group is not a fictitious group.

The bill requires the insurance commissioner to approve any such group, which must be fully insured (i.e., not self-insured or using alternative financing methods). The municipalities' agreement must establish:

1. the group's membership,
2. the insurance coverage duration,
3. premium payment requirements,
4. procedures for a municipality to withdraw from the agreement, and
5. procedures for terminating the insurance coverage.

Related Law

By law, municipalities may jointly perform any function that each can perform separately under any law or special act, charter, or home rule ordinance (CGS § 7-148cc). Each participating municipality must approve a joint agreement in the same manner as it approves an ordinance or, if it does not approve ordinances, the budget. Any such agreement must establish a withdrawal process and require the body that approved it to review the agreement at least once every five years.

§ 11 — MUNICIPAL GROUP IS NOT A SMALL EMPLOYER

The bill excludes a municipality obtaining health care benefits through MEHIP or the self-insured state plan from the state insurance law definition of "small employer."

The law defines a "small employer" as a person, firm, corporation, limited liability company, partnership, or association that (1) is actively engaged in business or self-employed for at least three consecutive months and (2) on at least 50% of its working days during the preceding 12 months, employed no more than 50 eligible employees, the majority of whom were employed within Connecticut.

By law, "small employer" does not include a:

1. municipality, association of personal care assistants, or community action agency obtaining health insurance through MEHIP;

2. nonprofit organization purchasing health insurance through MEHIP, unless the secretary of the Office of Policy and Management and the comptroller ask the insurance commissioner in writing to deem the nonprofit organization a small employer for the purposes of the health insurance statutes; or

3. private school in Connecticut obtaining health insurance through a health insurance plan or an insurance arrangement that an association of private schools sponsors.

BACKGROUND

Permanent Family Residence

The bill does not define "a parent in a permanent family residence." However, the child welfare statutes define "permanent family residence" as a child care facility the Department of Children and Families licenses, subject to specified criteria, to provide permanent care to handicapped children (CGS § 17a-154). The law requires parents who intend to provide permanent foster care to a handicapped

child to occupy, as their principal residence, a residential one- or two-family home that either the parents or a nonstock corporation that seeks to protect handicapped children owns or leases. At least one parent must, as his or her principal occupation, provide direct and regular care to the foster children placed in the residence.

ERISA

The federal Employee Retirement Income Security Act (ERISA, U.S. Code Title 29) governs certain activities of most private employers who maintain employee welfare benefit plans and preempts many state laws in this area.

ERISA-covered welfare benefit plans must meet a wide range of (1) fiduciary, reporting, and disclosure requirements and (2) benefit requirements (including benefits required under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability and Accountability Act (HIPAA), Mental Health Parity Act, Newborns' and Mothers' Health Protection Act, and Women's Health and Cancer Rights Act).

ERISA does not apply to a "governmental plan," which it defines as "a plan established or maintained for its employees by the government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing." If the state plan permits private sector employers join, it may lose its status as a governmental plan, thereby subjecting itself to the full requirements of ERISA, including federal oversight.

U.S. DOL Opinion Concerning ERISA Applicability. In 1999, the California School and Legal College Services of the Sonoma County Office of Education (the office) requested an advisory opinion from the U.S. Department of Labor (DOL) concerning the applicability of ERISA. Specifically, it asked if allowing 28 private sector employees to participate in the California Public Employees' Retirement System (CalPERS) would adversely affect CalPERS' status as a "governmental plan" within the meaning of ERISA.

In its opinion, DOL stated that "governmental plan status is not affected by participation of a de minimis number of private sector employees. However, if a benefit arrangement is extended to cover more than a de minimis number of private sector employees, the Department may not consider it a governmental plan" under ERISA (U.S. DOL Advisory Opinion 1999-10A, July 26, 1999). DOL further noted that its opinion related solely to the application of ERISA's provisions and "is not determinative of any particular tax treatment under the Internal Revenue Code." It advised the office to contact the IRS to clarify tax treatment of the proposed arrangement.

Multiple Employer Welfare Arrangement (MEWA)

An employer that self-insures a health benefit plan for its employees is generally not subject to state insurance laws because of federal pre-emption under ERISA. But a multiple employer plan may not have the same result.

ERISA defines "multiple employer welfare arrangement" as an employee welfare benefit plan, or any other arrangement that is established or maintained for the purpose of offering or providing benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that it does not include a plan or arrangement established or maintained by a collective bargaining agreement, rural electrical cooperative, or rural telephone cooperative association (29 U.S.C. § 1002(40)).

Congress amended ERISA in 1983 to provide an exception to ERISA's preemption provisions for the regulation of MEWAs under state insurance laws (P.L. 97-473). As a result, if an ERISA-covered employee welfare benefit plan is a MEWA, states may apply and enforce state insurance laws with respect to it.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 14 Nay 5 (03/10/2009)