
OLR Bill Analysis

sSB 1204

AN ACT ESTABLISHING THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

SUMMARY:

This bill establishes the Connecticut Health Insurance Exchange, a quasi-public agency, to satisfy requirements of the federal Patient Protection and Affordable Care Act (“PPACA”). Under the bill, a 12-member board manages the exchange, including operating an online marketplace where individuals and small employers (i.e., an employer with up to 50 employees) will be able to compare and purchase insurance plans beginning in 2014.

The bill also requires the Department of Social Services (DSS) commissioner, starting January 1, 2014, to implement the “basic health program” option provided for in the PPACA. Adults under age 65 with incomes between 134% and 200% of the federal poverty level (FPL) who are ineligible for Medicaid qualify for this program, which would receive federal funding.

EFFECTIVE DATE: Upon passage

§§ 2, 14-17 – EXCHANGE CREATION

The bill creates the Connecticut Health Insurance Exchange (exchange) as a quasi-public agency and adds it to the statutes governing quasi-public agencies. It must be a solvent and self-sustaining entity by January 1, 2015. The exchange is not a state department, institution, or agency.

The purpose of the exchange is to reduce the number of people without health insurance in the state, assist small employers with purchasing and administering health insurance by offering easily comparable and understandable health insurance options to individuals and small employers, and enroll individuals in medical

assistance programs (See Section 5 below).

Board Membership

The bill vests the exchange's powers in a 12-member board of directors, which includes the public health, insurance, and social services commissioners; the Office of Policy and Management secretary; and the healthcare advocate, or their designees, as ex-officio, non-voting members. The seven voting members must be appointed by the governor and the legislative leaders by October 1, 2011. Board members are not compensated but can be reimbursed for the expenses they incur.

Board Members' Terms and Meetings

Appointed board members serve staggered four-year terms. Four are initially appointed for four years, while the governor's and Senate and House minority leaders' appointees initially serve for three years. Subsequent terms begin on October 1st of the year appointed. Directors may be reappointed. Vacancies must be filled by the appointing authority for the rest of the term. If an appointing authority does not make an appointment initially or within 90 days of a vacancy, the board must appoint a member by majority vote. Any director who fails to attend three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned.

Meetings must be held as specified in the bylaws the board adopts and at other times as the chairperson deems necessary.

The board must elect a chairperson every two years from among its members. The chairperson must schedule the board's first meeting by October 1, 2011.

Board Members' Qualifications

Each appointee must have demonstrated expertise in at least two of the following areas:

1. individual or small employer health insurance coverage,
2. health benefits plan administration,

3. health care finance,
4. public or private health care delivery system administration, or
5. health insurance plan purchase.

Each appointing authority must consider the other appointees' expertise when making an appointment to ensure the board reflects a diversity of expertise and the state's cultural, ethnic, and geographical communities.

Exchange directors and staff members cannot be employed by or affiliated with (1) an insurer, insurance producer or broker, health care provider, health care facility, or health or medical clinic while serving as an exchange director or staff member or (2) a trade association of insurers, insurance producers or brokers, health care providers, health care facilities, or health or medical clinics. Nor can they be health care providers, unless they receive no compensation as a provider and do not have an ownership interest in a professional health care practice.

As a condition of qualifying for the board of directors, an appointee must take and subscribe the state Constitutional oath or affirmation. A record of the oath must be filed in the secretary of state's office.

Quorum; Transacting Business

Four of the 12 directors constitute a quorum for the board to transact business. The board may act by a majority vote at any meeting where there is a quorum. The bill specifies that a board vacancy does not impair the board's authority to exercise its rights and perform its duties. Any actions it takes may be authorized by resolution, which takes effect immediately unless it provides otherwise.

Chief Executive Officer

The bill requires the board to select and appoint a chief executive officer (CEO) who serves at its pleasure and receives compensation the board sets. The CEO administers the exchange's programs and activities in accordance with the board's established policies and objectives. He or she may hire other employees as designated by the

board.

Consultation

The bill allows the board to consult with public or private parties it deems necessary or desirable in performing its duties.

Advisory Committees

The bill authorizes the board to create advisory committees it deems necessary to represent key stakeholders, including consumers, small employers, the insurance industry, and health care providers.

§ 3 – WRITTEN PROCEDURES

The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement for board approval before either may take effect;
2. hiring, dismissing, promoting, and compensating exchange employees, including an affirmative action policy and a requirement for board approval before a position may be created or a vacancy filled;
3. acquiring real and personal property and personal services, including a requirement for board approval for any nonbudgeted expenditure over \$5,000;
4. contracting for financial, legal, bond, underwriting, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses;
5. issuing and retiring bonds, bond anticipation notes, and other obligations of the exchange;
6. establishing requirements for certifying qualified health plans including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms

and coverage descriptions, and quality measures for health benefit plan performance; and

7. implementing the bill or other provisions of state law, provided they do not conflict with U.S. Health and Human Services (HHS) regulations.

§ 4 – AUDIT

The bill requires the board to require that the exchange be annually audited by HHS. It must submit to the Insurance and Real Estate Committee a copy of each audit conducted by HHS or any independent auditing firm within seven days of receiving the audit.

§ 5 – PURPOSES OF THE EXCHANGE

The bill specifies the purposes of the exchange and permits public funds to be spent to carry them out. Under the bill, the exchange can:

1. employ assistants, agents, and other employees as necessary who are exempt from classified service unless they are not managers;
2. engage consultants, attorneys, and other experts as necessary;
3. acquire, own, manage, hold, or dispose of real and personal property and lease, convey, deal, or enter into agreements concerning its property on any terms necessary to carry out these purposes;
4. receive and accept aid or contributions of any type from any source;
5. charge assessments or user fees to health carriers or otherwise generate funds to support exchange operations and navigator grants (see below);
6. obtain insurance against loss of property and other assets;
7. invest funds not needed for immediate use or disbursement in U.S.- or state-issued or -guaranteed obligations and in

obligations that are legal investments for savings banks in Connecticut;

8. issue, fund, or refund bonds, notes, and other obligations of the exchange for any of its corporate purposes and provide for and secure bondholders' rights;
9. borrow money to obtain working capital;
10. account for and audit its funds and those of any entity that receives funds from the exchange;
11. enter into contracts or agreements necessary to perform its duties, including agreements with the departments of Revenue Services, Social Services, Insurance, Labor, and any other state agency;
12. if permitted under its contracts, agree to any termination, modification, forgiveness, or other change of any term of any contractual right, payment, royalty, contract, or agreement; and
13. award grants to navigators (see below).

§ 5 – FREEDOM OF INFORMATION

The exchange is subject to the Freedom of Information Act, except the following information is not subject to disclosure:

1. the names and applications of individuals and employers seeking coverage through the exchange;
2. individuals' health information; and
3. information exchanged between the exchange and the departments of Social Services, Public Health, Revenue Services, and Insurance, the Comptroller's Office, or any other state agency that is subject to confidentiality agreements under contracts with the exchange.

§ 6 – DUTIES OF THE EXCHANGE

Under the bill, the exchange must:

1. implement procedures for certifying, recertifying, and decertifying health benefit plans as qualified health plans, consistent with HHS guidelines;
2. use selective criteria to limit the number of plans offered through the exchange, provided consumers have an adequate selection of plans;
3. operate a toll-free consumer assistance hotline;
4. provide for enrollment periods as provided in the PPACA;
5. maintain an Internet website through which people may obtain (a) standardized comparative information on qualified health plans, (b) quality and price rating information developed by HHS for qualified health plans, and (c) transparent, contractually binding information about a qualified health plan's premiums and cost-sharing requirements, including deductibles, copayments, and coinsurance and coverage limitations;
6. publish on its website the average costs of licensing, regulatory fees, and any other payments the exchange requires and the exchange's administrative costs, including information on amounts lost to waste, fraud, and abuse;
7. rate each qualified health plan offered through the exchange and determine each plan's level of coverage, in accordance with criteria and regulations developed by HHS;
8. use a standardized format for presenting health benefit options in the exchange;
9. determine if an applicant is eligible for Medicaid, the State Children's Health Insurance Program, or other state public programs and enroll an eligible applicant in the program;
10. establish and make available electronically a calculator that

allows individuals to determine the actual cost of coverage, taking into consideration any applicable premium tax credit and cost-sharing reduction;

11. ensure a qualified employer is allowed to make defined contributions to a health carrier on behalf of an employee enrolling in a qualified health plan;
12. certify if an individual is exempt from the PPACA requirement to carry health insurance or from the penalty for not doing so;
13. provide to the U.S. treasury secretary the name and taxpayer identification number of each individual (a) granted an exemption from PPACA requirements, (b) who was an employee eligible for the premium tax credit because his or her employer did not provide minimum essential health benefits coverage or provided coverage that was unaffordable or did not meet the required actuarial value, (c) who notifies the exchange he or she has changed employers, and (d) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;
14. give each employer the name of each employee who was eligible for a premium tax credit and ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
15. determine eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions as required by HHS or the Treasury department;
16. select entities qualified to serve as navigators under the PPACA and award grants to them (see below);
17. review the rate of premium growth within and outside the exchange and consider that information when developing recommendations on whether to continue limiting qualified employer status to small employers;

18. develop ways to independently evaluate consumers' experiences with the exchange, including hiring consultants to act as secret shoppers;
19. establish (a) rating systems that allow individuals and small employers to compare the value of competing qualified health plans and (b) plan member satisfaction surveys that emphasize soliciting comment from members with serious health conditions or financial difficulties resulting from serious health conditions; and
20. credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer. (A free choice voucher is an option that allows employees with incomes up to 400% of the FPL to apply the amount their employer contributes for insurance to buy a plan on the exchange if the amount they must pay for employer-sponsored insurance is unaffordable.)

Stakeholders

The exchange must consult with stakeholders relevant to implementing the bill, including:

1. people who are knowledgeable about the health care system, have experience in making informed decisions regarding health, medical, and scientific matters, and are enrolled in qualified health plans;
2. people and entities with experience in facilitating enrollment in qualified health plans;
3. representatives of small employers and self-employed individuals;
4. the DSS; and
5. advocates for enrolling hard-to-reach populations.

Financial Integrity

The exchange must meet the following financial integrity requirements:

1. keep an accurate accounting of all activities, receipts, and expenditures and annually report about these to HHS and the governor, insurance commissioner, and legislature;
2. fully cooperate with any HHS investigation and allow HHS to (a) investigate its affairs, (b) examine its properties and records, and (c) require periodic reports of its activities; and
3. ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or lobbying state or federal governments.

§ 7 – NAVIGATOR GRANT PROGRAM

The bill requires the exchange to establish a “navigator” grant program to award grants to certain entities to market the exchange. The exchange must establish performance standards, accountability requirements, and maximum grant amounts.

Purpose

Under the bill, a navigator must:

1. conduct public education activities to raise awareness of the availability of qualified health plans sold through the exchange;
2. distribute fair and impartial information about enrollment in qualified health plans and the availability of federal premium tax credits and cost-sharing reductions under the PPACA;
3. facilitate enrollment in qualified health plans;
4. refer individuals with a grievance, complaint, or question about a plan, a plan’s coverage, or a determination under a plan’s coverage to the healthcare advocate or any customer relations unit the exchange establishes; and

5. provide information in a manner that is culturally and linguistically appropriate.

Entities Allowed as Navigators

The bill requires the exchange to award navigator grants at the board's sole discretion to any of the following entities:

1. a trade, industry, or professional association;
2. a community and consumer-focused nonprofit group;
3. a chamber of commerce;
4. a labor union;
5. a small business development center; or
6. a Connecticut-licensed insurance producer or broker.

Under the bill, a navigator cannot (1) be an insurer or (2) receive any direct or indirect consideration from an insurer for enrolling people in a qualified health plan.

To receive a navigator award, an entity must demonstrate to the board's satisfaction that it has (1) relationships, or could develop relationships, with small employers, their employees, and individuals, including those who are underinsured, uninsured, or self-insured, who are likely to qualify to enroll in a qualified health plan or (2) particular expertise or experience in meeting the health insurance needs of small employers, minorities, seniors, and young adults.

Miscellaneous

The bill requires a navigator to comply with the PPACA and related federal regulations and guidance. It also requires the exchange to collaborate with HHS to develop standards that ensure the information navigators provide is fair and accurate.

§§ 8, 9 – QUALIFIED HEALTH PLANS

The bill requires the exchange to make qualified health plans

available to qualified individuals and employers by January 1, 2014. The exchange cannot make plans available unless they are qualified health plans.

The bill defines a “qualified health plan” as a health benefit plan that is certified as meeting criteria outlined in the PPACA and this bill. A “qualified individual” is a state resident seeking to enroll in a qualified health plan offered to individuals through the exchange. A “qualified employer” is a small employer that elects to make its full-time employees eligible for at least one qualified health plan offered through the exchange, and if it chooses, make some or all part-time employees eligible. The employer must either (1) have its principal place of business in Connecticut and provide coverage through the exchange to all its eligible employees wherever located or (2) provide coverage through the exchange to all its eligible employees employed in Connecticut.

The exchange must allow a health carrier to offer a limited scope dental plan, either separately or as part of a plan that covers pediatric dental benefits.

Under the bill, the exchange or a health carrier offering plans through the exchange cannot charge an individual a coverage termination fee or penalty if the individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual’s employer-sponsored coverage has become affordable under federal standards.

Employer Requirements

To participate in the exchange, a qualified employer must:

1. not offer to its employees coverage outside the exchange under a competing health benefit plan that offers the same, or substantially the same, benefits provided through the exchange;
2. participate in a “cafeteria plan” that allows employees to get federal tax benefits for their health insurance premium payments; and

3. make available in a timely manner, for confidential review by the exchange's CEO, employer documents, records, or other information the CEO determines are necessary to verify that (a) the employer is in compliance with state and federal law relating to providing group health plans, especially nondiscrimination in coverage, and (b) enrollees' eligibility under the health benefit plan's terms.

The bill also requires the employer to reserve the right to determine, subject to state and federal law, employer eligibility, enrollment, and participation criteria and the amount of any employer contributions to a qualified health plan to cover its employees. (It appears to give the employer the responsibility to determine its own eligibility to participate in the exchange but requires the exchange to determine whether the employer is allowed to make defined contributions to a health carrier on behalf of an employee enrolling in a qualified health plan.)

Certifying Qualified Health Plans

The bill authorizes the exchange to certify a health benefit plan as a qualified health plan if:

1. the plan covers the state's insurance benefit mandates and the federally designated essential health benefits (but a plan does not have to contain all essential health benefits if it is a qualified dental plan and the health carrier prominently discloses that (1) the plan does not provide all essential pediatric benefits and (2) qualified dental plans with those and other dental benefits are offered through the exchange);
2. the insurance commissioner has approved the premium rates and contract language;
3. the plan provides at least a bronze level of coverage (covering 60% of the cost of essential health benefits) unless it is certified as meeting federal catastrophic plan requirements and is offered only to people eligible for such plans (e.g., under age 30 or

exempt from the PPACA's requirement to carry health insurance);

4. the plan complies with federal limits on out-of-pocket costs;
5. the plan meets the requirements for certification in accordance with the exchange's adopted written procedures and HHS regulations; and
6. the exchange determines that making the plan available is in the interests of qualified individuals and employers in the state.

Under the bill, the exchange cannot refuse to certify a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it provides treatments to prevent patients' deaths in circumstances the exchange believes are too costly or inappropriate.

The exchange cannot exempt any health carrier from state licensure or reserve requirements and must apply the certification criteria in a way that assures a level playing field among health carriers participating in the exchange.

Health Carrier Requirements

To be eligible to offer qualified health plans through the exchange, a health carrier must:

1. be licensed and in good standing to offer health insurance in Connecticut;
2. offer through the exchange one catastrophic plan and at least one plan each at the (a) bronze coverage level (covering 60% of the cost of essential health benefits), (b) silver coverage level (covering 70% of the cost of essential health benefits), (c) gold coverage level (covering 80% of the cost of essential health benefits), and (d) platinum coverage level (covering 90% of the cost of essential health benefits);
3. offer an identical plan outside the exchange at the same

premium rate (presumably for each of the five plans above);

4. charge the same premium rate for each qualified health plan whether offered (a) through the exchange or outside the exchange or (b) directly by the carrier or through an insurance producer;
5. not charge a coverage termination fee or penalty to an individual who enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards;
6. ensure that commissions or financial incentives paid to an insurance producer or broker in connection with an insurance plan's sale are comparable whether the plan is sold within or outside the exchange; and
7. comply with HHS regulations and any other requirements the exchange may establish.

A health carrier seeking exchange certification for a qualified health plan must agree to submit (presumably to the exchange) and prominently post on the carrier's website, justification for any premium increase (and any related information) before it is implemented (the bill does not give a specific timeframe). The exchange must consider this justification, along with any additional information and recommendations from the insurance commissioner, when determining whether to allow the carrier to continue making the plan available through the exchange.

A health carrier must disclose information in plain language to the public regarding claims, finances, enrollment and disenrollment, rating practices, out-of-network payments and cost sharing, enrollee rights under the PPACA, and other information HHS requires. It must also submit this information to the exchange, insurance commissioner and HHS.

A health carrier must also inform individuals, upon request, of the amount of cost sharing (e.g., deductibles, copayments, and coinsurance) they are responsible for under their plans for specific services. The information must be provided through an Internet website and through other means (which the bill does not specify) for individuals without Internet access.

Qualified Dental Plans

The bill applies, to the extent applicable, to qualified dental plans, except as modified by written procedures adopted by the exchange and the following:

1. a health carrier seeking certification of a dental plan as a qualified dental plan must be licensed in Connecticut to offer dental coverage but does not need to be licensed to offer other health benefits;
2. qualified dental plans are limited to dental and oral health benefits, cannot duplicate benefits typically offered by non-dental plans, and must include, at a minimum, the essential pediatric dental benefits defined by HHS and other dental benefits as the exchange or HHS may specify; and
3. health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by one carrier and health benefits by another carrier, as long as the plans are priced and made available for purchase separately.

§ 10 – STATE PLEDGE REGARDING CONTRACTUAL OBLIGATIONS

Under the bill, the state pledges and agrees with any person the exchange contracts with that the state will not limit or alter the rights vested in the exchange until the exchange's contractual obligations are fully met and performed. But the bill does not preclude limitation or alteration if the law makes adequate provision to protect those with contracts with the exchange.

§ 11 – EXCHANGE TAX EXEMPTIONS

The bill exempts the exchange from all state and local franchise, corporate business, property, and income taxes except for those levied for or in connection with (1) the manufacture or sale of products subject to an agreement made by the exchange or (2) any person contracting with the exchange.

§ 12 – REPORTING REQUIREMENTS

The bill requires the exchange’s board to report to the governor and Insurance, Public Health and Finance Committees by January 1, 2013 on the following:

1. the potential effect of adverse selection on the exchange (see below);
2. recommendations to promote transparency in the exchange, including whether contracts between health carriers and the exchange should be subject to disclosure under the Freedom of Information Act;
3. an initial methodology for imposing assessments or user fees on health carriers that are reasonably likely to (a) collect sufficient funds for the exchange, including start-up, operating, and administrative costs, and money for navigator grants and (b) achieve financial sustainability for the exchange by January 1, 2015;
4. any funds the exchange has or is attempting to procure;
5. recommendations to ensure (a) maximum participation in the exchange by individuals and small employers to optimally pool risks, (b) the exchange is a viable and competitive alternative for individuals and small employers to procure health benefit plans, (c) that administrative costs relating to procuring health benefit plans are reduced for small employers participating in the exchange, and (d) that an employee uses a qualified employer’s defined contributions to purchase a health benefit plan;
6. whether the expand the definition of “small employer” to

- include employers with up to 100 employees;
7. whether to allow employers with more than 100 employees to participate in the exchange starting in 2017;
 8. whether to continue to require qualified health plans to provide benefits beyond those included in the federal essential health benefits package;
 9. any administrative role the exchange should have in collecting and paying premiums due to health carriers from individuals and small employers purchasing health benefit plans on the exchange;
 10. the relationship of the exchange to insurance producers and agents;
 11. recommendations to ensure that transitions between state health care programs (including Medicaid, HUSKY A and B, and the Charter Oak Plan) and federally subsidized and private pay health care coverage are centralized, seamless, and preserve continuity of coverage and care; and
 12. the exchange's capacity to award navigator grants.

Report on Adverse Selection

The above report must include (1) the effect of adverse selection on the exchange's operation and (2) any recommendations to reduce the potential negative effect of any such adverse selection. The report must include recommendations to ensure that regulation of health benefit plans is similar for qualified health plans offered through the exchange and health benefit plans offered outside it. It must also include recommendations on whether the exchange should require health carriers, as a condition of participating in the exchange, to (1) offer health benefit plans outside the exchange at silver and gold coverage levels, (2) not offer only catastrophic or bronze coverage level plans outside the exchange, or (3) not offer within or outside the exchange through affiliates, the same health benefit plans at different premium

rates.

Within one year of the exchange's implementation, the board must also annually evaluate and report to the governor and Insurance, Public Health, and Finance committees on whether adverse selection is occurring with respect to self-insured plans and plans sold outside the exchange.

Initial Assessment Methodology

The bill requires the exchange's board of directors to file the initial assessment methodology for imposing user fees or assessments required above with the clerks of the House of Representatives and Senate within 10 days after the date it submits its initial report to the governor and legislative committees. The methodology is deemed approved if the legislature does not vote to approve or reject it within 30 days of its filing. If the legislature rejects the methodology, the board of directors must refile a revised methodology within 15 days of the vote. It specifies that these requirements apply only to the board's initial assessment methodology as long as the board provides reasonable notice to carriers of any subsequent changes to the approved initial methodology.

§ 13 – INSURANCE COMMISSIONER'S AUTHORITY

The bill and the exchange's actions do not preempt or supersede the insurance commissioner's authority to regulate insurance in Connecticut. Unless the bill expressly provides to the contrary, all health carriers offering qualified health plans in Connecticut must comply with all applicable state health insurance laws and regulations and insurance commissioner's orders.

§§ 18 & 19 – MEDICAID INCOME LIMITS; NEW BASIC HEALTH PROGRAM FOR ADULTS UNDER AGE 65

Changes in Medicaid Income Limits

The bill requires that, starting January 1, 2014, Medicaid must be provided to all adults ages 18 to 64, including childless adults, parents, and needy caretaker relatives, (1) who qualify for coverage under PPACA's provisions extending Medicaid to low-income adults

(Section 1902 (a)(10)(A)(i)(VIII) of the Social Security Act) and (2) whose family income is up to 133% of the FPL, regardless of assets. Currently, 133% of the FPL for one person is \$14,483 annually.

Under current law, these adults are eligible for Medicaid but at different income levels, and they do not have to meet an asset test. Parents and caretaker relatives receive HUSKY A coverage under a different provision of the Social Security Act (Section 1931) if their income is up to 185% of the FPL (currently \$20,146 annually for one person). The state also offers Medicaid coverage to childless adults if their income is up to 60% of the FPL. This latter coverage is authorized under the above PPACA provision.

Under the bill, starting January 1, 2014, children are still covered if their family income is up to 185% of the FPL. But parents and caretaker relatives of these children, and childless adults are covered only up to 133% of the FPL.

New Basic Health Program for Adults under Age 65

Starting January 1, 2014, the bill requires the DSS commissioner to implement a “basic health program” (BHP) option provided for in the PPACA. The BHP must provide medical benefits to Medicaid ineligible adults under age 65 with family income between 134% and 200% of the FPL. The bill explicitly includes in the program (1) parents and other caretaker relatives of HUSKY A children whose family income exceeds 133% of the FPL and (2) certain legal immigrants.

The program must include the same benefits, cost-sharing limits, and other consumer safeguards that apply to Medicaid beneficiaries. If federal funds the state receives for the basic health program exceed its costs, the excess funds must be used to increase reimbursement rates of participating Medicaid or BHP providers. The commissioner must take all necessary actions to maximize available federal funds to establish the program.

Under the BHP, the federal government pays 95% of the amount it would pay in subsidies and tax credits if BHP enrollees were in the

health insurance exchange.

The bill establishes a separate, non-lapsing “Basic Health Plan Program Account” in the General Fund to hold any money required by law to be deposited into it. The DSS commissioner must spend the funds to operate the BHP in conformance with federal law.

BACKGROUND

Related Bills

The Insurance and Real Estate Committee favorably reported SB 921 and HB 6323, both of which similarly create an exchange as a quasi-public agency.

The Public Health Committee favorably reported HB 6305 which also requires the DSS commissioner to establish a Basic Health Program for certain Medicaid-ineligible adults starting January 1, 2014.

HB 6587, favorably reported by the Human Services Committee to the Appropriations Committee on March 22, also requires DSS to establish a Basic Health Program starting January 1, 2014.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 18 Nay 10 (03/30/2011)