



House of Representatives

General Assembly

File No. 414

February Session, 2012

Substitute House Bill No. 5487

House of Representatives, April 13, 2012

The Committee on Appropriations reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE RECOMMENDATIONS OF THE SMALL BUSINESS HEALTHCARE WORKING GROUP AND CLAIMS INFORMATION REQUIRED TO BE PROVIDED BY INSURERS.

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

1 Section 1. Section 3-123aaa of the 2012 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2012*):

4 As used in this section and sections 3-123bbb to 3-123hhh, inclusive,
5 as amended by this act:

6 (1) "Health Care Cost Containment Committee" means the
7 committee established in accordance with the ratified agreement
8 between the state and the State Employees Bargaining Agent Coalition
9 pursuant to subsection (f) of section 5-278.

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

12 (3) "Municipal-related employer" means a property management
13 business, food service business, school transportation business or
14 waste management or recycling authority or business, that is a party to
15 a contract with a nonstate public employer.

16 [(2)] (4) "Nonprofit employee" means any employee of a nonprofit
17 employer.

18 [(3)] (5) "Nonprofit employer" means (A) a nonprofit corporation,
19 organized under 26 USC 501, as amended from time to time, that (i)
20 has a purchase of service contract, as defined in section 4-70b, or (ii)
21 receives fifty per cent or more of its gross annual revenue from grants
22 or funding from the state, the federal government or a municipality or
23 any combination thereof, or (B) an organization that is tax exempt
24 pursuant to 26 USC 501(c)(5), as amended from time to time.

25 [(4)] (6) "Nonstate public employee" means any employee or elected
26 officer of a nonstate public employer.

27 [(5)] (7) "Nonstate public employer" means a municipality or other
28 political subdivision of the state, including a board of education, quasi-
29 public agency or public library. A municipality and a board of
30 education may be considered separate employers.

31 [(6)] (8) "Partnership plan" means a health care benefit plan offered
32 by the Comptroller to nonstate public employers, [or] nonprofit
33 employers, small employers or municipal-related employers under
34 section 3-123bbb, as amended by this act.

35 (9) "Small employer employee" means any employee of a small
36 employer.

37 (10) "Small employer" means a person, firm, corporation, limited
38 liability company, partnership or association actively engaged in
39 business or self-employed for at least three consecutive months that,
40 on at least fifty per cent of its working days during the preceding
41 twelve months, employed no more than fifty eligible employees, the
42 majority of whom were employed within this state. For the purposes

43 of determining the number of eligible employees under this
44 subdivision, companies that are affiliated companies, as defined in
45 section 33-840, or that are eligible to file a combined tax return for
46 purposes of taxation under chapter 208 shall be considered one
47 employer.

48 [(7)] (11) "State employee plan" means a self-insured group health
49 care benefits plan established under subsection (m) of section 5-259.

50 Sec. 2. Section 3-123bbb of the 2012 supplement to the general
51 statutes is repealed and the following is substituted in lieu thereof
52 (*Effective July 1, 2012*):

53 (a) (1) Notwithstanding the provisions of title 38a, the Comptroller
54 shall offer to nonstate public employers, [and] nonprofit employers,
55 small employers and municipal-related employers, and their
56 respective retirees, if applicable, coverage under a partnership plan or
57 plans. Such plan or plans may be offered on a fully-insured or risk-
58 pooled basis at the discretion of the Comptroller. A separate
59 prescription drug plan may be offered to small employers and
60 municipal-related employers at the discretion of the Comptroller. Any
61 health insurer, health care center or other entity that contracts with the
62 Comptroller for the purposes of this section and any fully-insured plan
63 offered by the Comptroller under such contract shall be subject to title
64 38a. Eligible employers shall submit an application to the Comptroller
65 for coverage under any such plan or plans.

66 (2) Beginning January 1, 2012, the Comptroller shall offer coverage
67 under such plan or plans to nonstate public employers. Beginning
68 January 1, 2013, the Comptroller shall offer coverage under such plan
69 or plans to nonprofit employers. Beginning on or before January 1,
70 2014, the Comptroller shall offer coverage under such plan or plans to
71 small employers and municipal-related employers.

72 (b) (1) The Comptroller shall require [nonstate public employers and
73 nonprofit] all employers that elect to obtain coverage under a
74 partnership plan to participate in such plan for not less than two-year

75 intervals. An employer may apply for renewal prior to the expiration
76 of each interval.

77 (2) The Comptroller shall develop procedures by which:

78 (A) Such employers may apply to obtain coverage under a
79 partnership plan, including procedures for nonstate public employers
80 that are currently fully insured and procedures for nonstate public
81 employers that are currently self-insured;

82 (B) Employers receiving coverage for their employees pursuant to a
83 partnership plan may (i) apply for renewal, or (ii) withdraw from such
84 coverage, including, but not limited to, the terms and conditions under
85 which such employers may withdraw prior to the expiration of the
86 interval and the procedure by which any premium payments such
87 employers may be entitled to or premium equivalent payments made
88 in excess of incurred claims shall be refunded to such employer. Any
89 such procedures shall provide that nonstate public employees covered
90 by collective bargaining shall withdraw from such coverage in
91 accordance with chapters 113 and 166; and

92 (C) The Comptroller may collect payments and fees for unreported
93 claims and expenses.

94 (c) (1) The initial open enrollment for nonstate public employers
95 shall be for coverage beginning July 1, 2012. Thereafter, open
96 enrollment for nonstate public employers shall be for coverage periods
97 beginning July first.

98 (2) The initial open enrollment for nonprofit employers shall be for
99 coverage beginning January 1, 2013. Thereafter, open enrollment for
100 nonprofit employers shall be for coverage periods beginning January
101 first and July first.

102 (3) The initial open enrollment for small employers and municipal-
103 related employers shall be for coverage beginning January 1, 2014.
104 Thereafter, open enrollment for small employers and municipal-
105 related employers shall be for coverage periods beginning July first

106 and January first.

107 (d) Nothing in this section or sections 3-123ccc and 3-123ddd, as
108 amended by this act, shall require the Comptroller to offer coverage to
109 every employer seeking coverage under sections 3-123ccc and 3-
110 123ddd, as amended by this act, from every partnership plan offered
111 by the Comptroller.

112 (e) The Comptroller shall create applications for coverage for the
113 purposes of sections 3-123ccc and 3-123ddd, as amended by this act,
114 and for renewal of a partnership plan. Such applications shall require
115 an employer to disclose whether the employer will offer any other
116 health care benefits plan to the employees who are offered a
117 partnership plan.

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

123 (g) (1) The Comptroller shall take such actions as are necessary to
124 ensure that granting coverage to an employer under sections 3-123ccc
125 and 3-123ddd, as amended by this act, will not affect the status of the
126 state employee plan as a governmental plan under the Employee
127 Retirement Income Security Act of 1974, as amended from time to
128 time. Such actions may include, but are not limited to, cancelling
129 coverage, with notice, to such employer and discontinuing the
130 acceptance of applications for coverage from nonprofit employers,
131 small employers and municipal-related employers. The Comptroller
132 shall establish the form and time frame for the notice of cancellation to
133 be provided to such employer.

134 (2) The Comptroller shall resume providing coverage for, or
135 accepting applications for coverage from, nonprofit employers, small
136 employers and municipal-related employers if the Comptroller
137 determines that granting coverage to such employers will not affect the

138 state employee plan's status as a governmental plan under the
139 Employee Retirement Income Security Act of 1974, as amended from
140 time to time.

141 (3) The Comptroller shall make a public announcement of the
142 Comptroller's decision to discontinue or resume coverage or the
143 acceptance of applications for coverage under a partnership plan or
144 plans.

145 (h) The Comptroller, in consultation with the Health Care Cost
146 Containment Committee, shall:

147 (1) Develop and implement patient-centered medical homes for the
148 state employee plan and partnership plans offered under this section,
149 in a manner that will reduce the costs of such plans; and

150 (2) Review claims data of the state employee plan and partnership
151 plans offered under this section, to target high-cost health care
152 providers and medical conditions and monitor costly trends.

153 (i) (1) Each insurer, health care center, hospital service corporation,
154 medical service corporation or other entity delivering, issuing for
155 delivery, renewing, amending or continuing in this state any group
156 health insurance policy providing coverage of the type specified in
157 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall:

158 (A) Upon request (i) by a nonstate public employer sponsoring such
159 policy, (ii) on or after October 1, 2012, by a nonprofit employer
160 sponsoring such policy, and (iii) on or after October 1, 2013, by a small
161 employer or a municipal-related employer sponsoring such policy,
162 provide to the Comptroller not later than thirty days after receiving
163 such request, free of charge, the following information for the most
164 recent thirty-six-month period or for the entire period of coverage,
165 whichever is shorter, in a format as set forth in subparagraph (C) of
166 this subdivision:

167 (i) Complete and accurate medical, dental and pharmaceutical
168 utilization data, as applicable;

169 (ii) Claims paid by year, aggregated by practice type and by service
170 category, each reported separately for in-network and out-of-network
171 providers, and the total number of claims paid;

172 (iii) Premiums paid by such employer by month; and

173 (iv) The number of insureds by coverage tier, including, but not
174 limited to, single, two-person and family including dependents, by
175 month;

176 (B) Include in such requested information specified in subparagraph
177 (A) of this subdivision only health information that has had identifiers
178 removed, as set forth in 45 CFR 164.514, is not individually
179 identifiable, as defined in 45 CFR 160.103, and is permitted to be
180 disclosed under the Health Insurance Portability and Accountability
181 Act of 1996, P.L. 104-191, as amended from time to time, or regulations
182 adopted thereunder; and

183 (C) Provide such requested information in a secure and
184 standardized format prescribed by the Comptroller.

185 (2) Such insurer, health care center, hospital service corporation,
186 medical service corporation or other entity shall not be required to
187 provide such information to the Comptroller more than once in any
188 twelve-month period.

189 (3) Any information provided to the Comptroller in accordance with
190 subdivision (1) of this subsection shall not be subject to disclosure
191 under section 1-210.

192 Sec. 3. Section 3-123ccc of the 2012 supplement to the general
193 statutes is repealed and the following is substituted in lieu thereof
194 (*Effective July 1, 2012*):

195 (a) Nonstate public employers, [and] nonprofit employers, small
196 employers and municipal-related employers may apply for coverage
197 under a partnership plan in accordance with this section.

198 (1) Notwithstanding any provision of the general statutes, initial
199 and continuing participation in a partnership plan by a nonstate public
200 employer shall be a permissive subject of collective bargaining and
201 shall be subject to binding interest arbitration only if the collective
202 bargaining agent and the employer mutually agree to bargain over
203 such participation.

204 (2) If [a nonstate public employer or a nonprofit] an employer
205 submits an application for coverage for all of its respective employees,
206 the Comptroller shall accept such application upon the terms and
207 conditions applicable to the partnership plan, for the next open
208 enrollment. The Comptroller shall provide written notification to such
209 employer of such acceptance and the date on which such coverage
210 shall begin, pending acceptance by such employer of the terms and
211 conditions of such plan.

212 (3) (A) Except as specified in subparagraph (D) of this subdivision, if
213 [a nonstate public employer or a nonprofit] an employer submits an
214 application for coverage for less than all of its respective employees, or
215 indicates in the application the employer will offer other health plans
216 to employees who are offered a partnership plan, the Comptroller shall
217 forward such application to a health care actuary not later than five
218 business days after receiving such application. Not later than sixty
219 days after receiving such application, such actuary shall notify the
220 Comptroller whether, as a result of the employees included in such
221 application or other factors, the application will shift a significant part
222 of such employer's employees' medical risks to the partnership plan.
223 Such actuary shall provide, in writing, to the Comptroller the specific
224 reasons for such actuary's finding, including a summary of all
225 information relied upon in making such a finding.

226 (B) If the Comptroller determines that, based on such finding, the
227 application will shift a significant part of such employer's employees'
228 medical risks to the partnership plan, the Comptroller shall not
229 provide coverage to such employer and shall provide written
230 notification and the specific reasons for such denial to such employer

231 and the Health Care Cost Containment Committee.

232 (C) If the Comptroller determines that, based on such finding, the
233 application will not shift a significant part of such employer's
234 employees' medical risks to the partnership plan, the Comptroller shall
235 accept such application for the next open enrollment. The Comptroller
236 shall provide written notification to such employer of such acceptance
237 and the date on which such coverage shall begin, pending acceptance
238 by such employer of the terms and conditions of such plan.

239 (D) If an employer included less than all of its employees in its
240 application for coverage because of (i) the decision by individual
241 employees to decline coverage from their employer for themselves or
242 their dependents, or (ii) the employer's decision not to offer coverage
243 to temporary, part-time or durational employees, the Comptroller shall
244 not be required to forward such employer's application to a health care
245 actuary.

246 (b) The Comptroller shall consult with a health care actuary who
247 shall develop:

248 (1) Actuarial standards to assess the shift in medical risks of an
249 employer's employees to a partnership plan. The Comptroller shall
250 present such standards to the Health Care Cost Containment
251 Committee for its review, evaluation and approval prior to the use of
252 such standards; and

253 (2) Actuarial standards to determine the administrative fees and
254 fluctuating reserves fees set forth in section 3-123eee, as amended by
255 this act, and the amount of premiums or premium equivalent
256 payments to cover anticipated claims and claim reserves. The
257 Comptroller shall present such standards to the Health Care Cost
258 Containment Committee for its review, evaluation and approval prior
259 to the use of such standards.

260 (c) The Comptroller may adopt regulations, in accordance with
261 chapter 54, to establish the procedures and criteria for any reviews or

262 evaluations performed by the Health Care Cost Containment
263 Committee pursuant to subsection (b) of this section or subsection (c)
264 of section 3-123ddd.

265 Sec. 4. Subdivision (2) of subsection (b) of section 3-123ddd of the
266 2012 supplement to the general statutes is repealed and the following
267 is substituted in lieu thereof (*Effective July 1, 2012*):

268 (2) Except as specified in subdivision (5) of this subsection, if [a
269 nonstate public employer or a nonprofit] an employer seeks coverage
270 for less than all of its respective retirees, regardless of whether the
271 employer is seeking coverage for all of such employer's active
272 employees, the Comptroller shall forward such application to a health
273 care actuary not later than five business days after receiving such
274 application. Not later than sixty days after receiving such application,
275 such actuary shall notify the Comptroller whether, as a result of the
276 retirees included in such application or other factors, the application
277 will shift a significant part of such employer's retirees' medical risks to
278 the partnership plan. Such actuary shall provide, in writing, to the
279 Comptroller the specific reasons for such actuary's finding, including a
280 summary of all information relied upon in making such a finding.

281 Sec. 5. Subdivision (5) of subsection (b) of section 3-123ddd of the
282 2012 supplement to the general statutes is repealed and the following
283 is substituted in lieu thereof (*Effective July 1, 2012*):

284 (5) If an employer included less than all of its retirees in its
285 application for coverage because of (A) the decision by individual
286 retirees to decline health benefits or health insurance coverage from
287 their employer for themselves or their dependents, or (B) the retiree's
288 enrollment in Medicare, the Comptroller shall not be required to
289 forward such employer's application to a health care actuary.

290 Sec. 6. Subdivision (1) of subsection (d) of section 3-123eee of the
291 2012 supplement to the general statutes is repealed and the following
292 is substituted in lieu thereof (*Effective July 1, 2012*):

293 (1) The Comptroller may terminate participation in the partnership
294 plan by a nonprofit employer, small employer or municipal-related
295 employer on the basis of nonpayment of premium or premium
296 equivalent, provided at least ten days' advance notice is given to such
297 employer, which may continue the coverage and avoid the effect of the
298 termination by remitting payment in full at any time prior to the
299 effective date of termination.

300 Sec. 7. Section 3-123fff of the 2012 supplement to the general statutes
301 is amended by adding subsection (c) as follows (*Effective July 1, 2012*):

302 (NEW) (c) There is established a Private Sector Health Care
303 Advisory Committee. The committee shall make advisory
304 recommendations to the Health Care Cost Containment Committee
305 concerning health care coverage for small employer employees and
306 municipal-related employees. The advisory committee shall consist of
307 small employers and municipal-related employers and their respective
308 employees participating in a partnership plan and shall include the
309 following members appointed by the Comptroller: (1) Two small
310 employer representatives; (2) two small employer employee
311 representatives; (3) two municipal-related employer representatives;
312 and (4) two municipal-related employee representatives.

313 Sec. 8. Section 38a-567 of the 2012 supplement to the general statutes
314 is repealed and the following is substituted in lieu thereof (*Effective July*
315 *1, 2012*):

316 Health insurance plans and insurance arrangements covering small
317 employers and insurers and producers marketing such plans and
318 arrangements shall be subject to the following provisions:

319 (1) (A) (i) Any such insurer or producer marketing such plans or
320 arrangements shall offer premium quotes to small employers upon
321 request for coverage for employees who work a normal work week of
322 thirty or more hours. Upon request by a small employer, such insurer
323 or producer shall offer premium quotes for coverage for employees
324 that include those who work a normal work week of at least twenty

325 hours.

326 (ii) No small employer that has requested premium quotes for
327 coverage for employees that include those who work a normal work
328 week of less than thirty hours shall be required to accept such quotes
329 or coverage in lieu of premium quotes or coverage for only those
330 employees who work a normal work week of thirty or more hours.

331 (iii) Nothing in this subparagraph shall require a small employer
332 that offers coverage to its employees who work a normal work week of
333 thirty hours or more to offer coverage to its employees who work a
334 normal work week of less than thirty hours.

335 (B) Any such plan or arrangement shall be renewable with respect
336 to all eligible employees or dependents at the option of the small
337 employer, policyholder or contractholder, as the case may be, except:
338 (i) For nonpayment of the required premiums by the small employer,
339 policyholder or contractholder; (ii) for fraud or misrepresentation of
340 the small employer, policyholder or contractholder or, with respect to
341 coverage of individual insured, the insureds or their representatives;
342 (iii) for noncompliance with plan or arrangement provisions; (iv) when
343 the number of insureds covered under the plan or arrangement is less
344 than the number of insureds or percentage of insureds required by
345 participation requirements under the plan or arrangement; or (v) when
346 the small employer, policyholder or contractholder is no longer
347 actively engaged in the business in which it was engaged on the
348 effective date of the plan or arrangement.

349 (C) Renewability of coverage may be effected by either continuing
350 in effect a plan or arrangement covering a small employer or by
351 substituting upon renewal for the prior plan or arrangement the plan
352 or arrangement then offered by the carrier that most closely
353 corresponds to the prior plan or arrangement and is available to other
354 small employers. Such substitution shall only be made under
355 conditions approved by the commissioner. A carrier may substitute a
356 plan or arrangement as stated above only if the carrier effects the same
357 substitution upon renewal for all small employers previously covered

358 under the particular plan or arrangement, unless otherwise approved
359 by the commissioner. The substitute plan or arrangement shall be
360 subject to the rating restrictions specified in this section on the same
361 basis as if no substitution had occurred, except for an adjustment
362 based on coverage differences.

363 (D) Notwithstanding the provisions of this subdivision, any such
364 plan or arrangement, or any coverage provided under such plan or
365 arrangement may be rescinded for fraud, intentional material
366 misrepresentation or concealment by an applicant, employee,
367 dependent or small employer.

368 [(E) Any individual who was not a late enrollee at the time of his or
369 her enrollment and whose coverage is subsequently rescinded shall be
370 allowed to reenroll as of a current date in such plan or arrangement
371 subject to any preexisting condition or other provisions applicable to
372 new enrollees without previous coverage. On and after the effective
373 date of such individual's reenrollment, the small employer carrier may
374 modify the premium rates charged to the small employer for the
375 balance of the current rating period and for future rating periods, to
376 the level determined by the carrier as applicable under the carrier's
377 established rating practices had full, accurate and timely underwriting
378 information been supplied when such individual initially enrolled in
379 the plan. The increase in premium rates allowed by this provision for
380 the balance of the current rating period shall not exceed twenty-five
381 per cent of the small employer's current premium rates. Any such
382 increase for the balance of said current rating period shall not be
383 subject to the rate limitation specified in subdivision (6) of this section.
384 The rate limitation specified in this section shall otherwise be fully
385 applicable for the current and future rating periods. The modification
386 of premium rates allowed by this subdivision shall cease to be
387 permitted for all plans and arrangements on the first rating period
388 commencing on or after July 1, 1995.]

389 (2) Except in the case of a late enrollee who has failed to provide
390 evidence of insurability satisfactory to the insurer, the plan or

391 arrangement may not exclude any eligible employee or dependent
392 who would otherwise be covered under such plan or arrangement on
393 the basis of an actual or expected health condition of such person. No
394 plan or arrangement may exclude an eligible employee or eligible
395 dependent who, on the day prior to the initial effective date of the plan
396 or arrangement, was covered under the small employer's prior health
397 insurance plan or arrangement pursuant to workers' compensation,
398 continuation of benefits pursuant to section 38a-554 or other applicable
399 laws. The employee or dependent must request coverage under the
400 new plan or arrangement on a timely basis and such coverage shall
401 terminate in accordance with the provisions of the applicable law.

402 [(3) (A) For rating periods commencing on or after October 1, 1993,
403 and prior to July 1, 1994, the premium rates charged or offered for a
404 rating period for all plans and arrangements may not exceed one
405 hundred thirty-five per cent of the base premium rate for all plans or
406 arrangements.

407 (B) For rating periods commencing on or after July 1, 1994, and prior
408 to July 1, 1995, the premium rates charged or offered for a rating
409 period for all plans or arrangements may not exceed one hundred
410 twenty per cent of the base premium rate for such rating period. The
411 provisions of this subdivision shall not apply to any small employer
412 who employs more than twenty-five eligible employees.

413 (4) For rating periods commencing on or after October 1, 1993, and
414 prior to July 1, 1995, the percentage increase in the premium rate
415 charged to a small employer, who employs not more than twenty-five
416 eligible employees, for a new rating period may not exceed the sum of:

417 (A) The percentage change in the base premium rate measured from
418 the first day of the prior rating period to the first day of the new rating
419 period;

420 (B) An adjustment of the small employer's premium rates for the
421 prior rating period, and adjusted pro rata for rating periods of less
422 than one year, due to the claim experience, health status or duration of

423 coverage of the employees or dependents of the small employer, such
424 adjustment (i) not to exceed ten per cent annually for the rating
425 periods commencing on or after October 1, 1993, and prior to July 1,
426 1994, and (ii) not to exceed five per cent annually for the rating periods
427 commencing on or after July 1, 1994, and prior to July 1, 1995; and

428 (C) Any adjustments due to change in coverage or change in the
429 case characteristics of the small employer, as determined from the
430 small employer carrier's applicable rate manual.]

431 [(5)] (3) (A) With respect to plans or arrangements issued on or after
432 July 1, 1995, the premium rates charged or offered to small employers
433 shall be established on the basis of a community rate, adjusted to
434 reflect one or more of the following classifications:

435 (i) Age, provided age brackets of less than five years shall not be
436 utilized;

437 (ii) Gender;

438 (iii) Geographic area, provided an area smaller than a county shall
439 not be utilized;

440 (iv) Industry, provided the rate factor associated with any industry
441 classification shall not vary from the arithmetic average of the highest
442 and lowest rate factors associated with all industry classifications by
443 greater than fifteen per cent of such average, and provided further, the
444 rate factors associated with any industry shall not be increased by
445 more than five per cent per year;

446 (v) Group size, provided the highest rate factor associated with
447 group size shall not vary from the lowest rate factor associated with
448 group size by a ratio of greater than 1.25 to 1.0;

449 (vi) Administrative cost savings resulting from the administration of
450 an association group plan or a plan written pursuant to section 5-259,
451 provided the savings reflect a reduction to the small employer carrier's
452 overall retention that is measurable and specifically realized on items

453 such as marketing, billing or claims paying functions taken on directly
454 by the plan administrator or association, except that such savings may
455 not reflect a reduction realized on commissions;

456 (vii) Savings resulting from a reduction in the profit of a carrier who
457 writes small business plans or arrangements for an association group
458 plan or a plan written pursuant to section 5-259 provided any loss in
459 overall revenue due to a reduction in profit is not shifted to other small
460 employers; and

461 (viii) Family composition, provided the small employer carrier shall
462 utilize [only] one or more of the following billing classifications only:
463 (I) Employee; (II) employee plus family; (III) employee and spouse;
464 (IV) employee and child; (V) employee plus one dependent; and (VI)
465 employee plus two or more dependents.

466 (B) The small employer carrier shall quote premium rates to small
467 employers after receipt of all demographic rating classifications of the
468 small employer group. No small employer carrier may inquire
469 regarding health status or claims experience of the small employer or
470 its employees or dependents prior to the quoting of a premium rate.

471 (C) The provisions of subparagraphs (A) and (B) of this subdivision
472 shall apply to plans or arrangements issued on or after July 1, 1995.
473 [The provisions of subparagraphs (A) and (B) of this subdivision shall
474 apply to plans or arrangements issued prior to July 1, 1995, as of the
475 date of the first rating period commencing on or after that date, but no
476 later than July 1, 1996.]

477 [(6)] (4) For any small employer plan or arrangement on which the
478 premium rates for employee and dependent coverage or both, vary
479 among employees, such variations shall be based solely on age and
480 other demographic factors permitted under subparagraph (A) of
481 subdivision [(5)] (3) of this section and such variations may not be
482 based on health status, claim experience [,] or duration of coverage of
483 specific enrollees. Except as otherwise provided in subdivision (1) of
484 this section, any adjustment in premium rates charged for a small

485 employer plan or arrangement to reflect changes in case characteristics
486 prior to the end of a rating period shall not include any adjustment to
487 reflect the health status, medical history or medical underwriting
488 classification of any new enrollee for whom coverage begins during
489 the rating period.

490 [(7) For rating periods commencing prior to July 1, 1995, in any case
491 where a small employer carrier utilized industry classification as a case
492 characteristic in establishing premium rates, the rate factor associated
493 with any industry classification shall not vary from the arithmetical
494 average of the highest and lowest rate factors associated with all
495 industry classifications by greater than fifteen per cent of such
496 average.]

497 [(8)] (5) Differences in base premium rates charged for health benefit
498 plans by a small employer carrier shall be reasonable and reflect
499 objective differences in plan design, not including differences due to
500 the nature of the groups assumed to select particular health benefit
501 plans.

502 [(9) For rating periods commencing prior to July 1, 1995, in any case
503 where an insurer issues or offers a policy or contract under which
504 premium rates for a specific small employer are established or
505 adjusted in part based upon the actual or expected variation in claim
506 costs or actual or expected variation in health conditions of the
507 employees or dependents of such small employer, the insurer shall
508 make reasonable disclosure of such rating practices in solicitation and
509 sales materials utilized with respect to such policy or contract.]

510 [(10)] (6) If a small employer carrier denies coverage or a small
511 employer carrier or any producer representing that carrier fails, for
512 any reason, to offer coverage, as requested to a small employer that is
513 self-employed, the small employer carrier shall promptly offer such
514 small employer the opportunity to purchase a small employer health
515 care plan. [If a small employer carrier or any producer representing
516 that carrier fails, for any reason, to offer coverage as requested by a
517 small employer that is self-employed, that small employer carrier shall

518 promptly offer such small employer an opportunity to purchase a
519 small employer health care plan.]

520 [(11)] (7) No small employer carrier or producer shall, directly or
521 indirectly, engage in the following activities:

522 (A) Encouraging or directing small employers to refrain from filing
523 an application for coverage with the small employer carrier because of
524 the health status, claims experience, industry, occupation or
525 geographic location of the small employer, except the provisions of
526 this subparagraph shall not apply to information provided by a small
527 employer carrier or producer to a small employer regarding the
528 carrier's established geographic service area or a restricted network
529 provision of a small employer carrier; or

530 (B) Encouraging or directing small employers to seek coverage from
531 another carrier because of the health status, claims experience,
532 industry, occupation or geographic location of the small employer.

533 [(12)] (8) No small employer carrier shall, directly or indirectly,
534 enter into any contract, agreement or arrangement with a producer
535 that provides for or results in the compensation paid to a producer for
536 the sale of a health benefit plan to be varied because of the health
537 status, claims experience, industry, occupation or geographic area of
538 the small employer. A small employer carrier shall provide reasonable
539 compensation, as provided under the plan of operation of the
540 program, to a producer, if any, for the sale of a special or a small
541 employer health care plan. No small employer carrier shall terminate,
542 fail to renew or limit its contract or agreement of representation with a
543 producer for any reason related to the health status, claims experience,
544 occupation, or geographic location of the small employers placed by
545 the producer with the small employer carrier.

546 [(13)] (9) No small employer carrier or producer shall induce or
547 otherwise encourage a small employer to separate or otherwise
548 exclude an employee from health coverage or benefits provided in
549 connection with the employee's employment.

550 [(14)] (10) Denial by a small employer carrier of an application for
551 coverage from a small employer shall be in writing and shall state the
552 reasons for the denial.

553 [(15)] (11) No small employer carrier or producer shall disclose (A)
554 to a small employer the fact that any or all of the eligible employees of
555 such small employer have been or will be reinsured with the pool, or
556 (B) to any eligible employee or dependent the fact that he has been or
557 will be reinsured with the pool.

558 [(16)] (12) If a small employer carrier enters into a contract,
559 agreement or other arrangement with another party to provide
560 administrative, marketing or other services related to the offering of
561 health benefit plans to small employers in this state, the other party
562 shall be subject to the provisions of this section.

563 [(17)] (13) The commissioner may adopt regulations, in accordance
564 with the provisions of chapter 54, setting forth additional standards to
565 provide for the fair marketing and broad availability of health benefit
566 plans to small employers.

567 [(18)] (14) Each small employer carrier shall maintain at its principal
568 place of business a complete and detailed description of its rating
569 practices and renewal underwriting practices, including information
570 and documentation that demonstrates that its rating methods and
571 practices are based upon commonly accepted actuarial assumptions
572 and are in accordance with sound actuarial principles. Each small
573 employer carrier shall file with the commissioner annually, on or
574 before March fifteenth, an actuarial certification certifying that the
575 carrier is in compliance with this part and that the rating methods have
576 been derived using recognized actuarial principles consistent with the
577 provisions of sections 38a-564 to 38a-573, inclusive, as amended by this
578 act. Such certification shall be in a form and manner and shall contain
579 such information as determined by the commissioner. A copy of the
580 certification shall be retained by the small employer carrier at its
581 principal place of business. Any information and documentation
582 described in this subdivision but not subject to the filing requirement

583 shall be made available to the commissioner upon his request. Except
584 in cases of violations of sections 38a-564 to 38a-573, inclusive, as
585 amended by this act, the information shall be considered proprietary
586 and trade secret information and shall not be subject to disclosure by
587 the commissioner to persons outside of the department except as
588 agreed to by the small employer carrier or as ordered by a court of
589 competent jurisdiction.

590 [(19)] (15) The commissioner may suspend all or any part of this
591 section relating to the premium rates applicable to one or more small
592 employers for one or more rating periods upon a filing by the small
593 employer carrier and a finding by the commissioner that either the
594 suspension is reasonable in light of the financial condition of the
595 carrier or that the suspension would enhance the efficiency and
596 fairness of the marketplace for small employer health insurance.

597 [(20) For rating periods commencing prior to July 1, 1995, a small
598 employer carrier shall quote premium rates to any small employer
599 within thirty days after receipt by the carrier of such employer's
600 completed application.]

601 [(21)] (16) Any violation of subdivisions [(10)] (6) to [(16)] (12),
602 inclusive, of this section and of any regulations established under
603 subdivision [(17)] (13) of this section shall be an unfair and prohibited
604 practice under sections 38a-815 to 38a-830, inclusive.

605 [(22) (A)] (17) With respect to plans or arrangements issued
606 pursuant to subsection (i) of section 5-259, at the option of the
607 Comptroller, the premium rates charged or offered to small employers
608 purchasing health insurance shall not be subject to this section,
609 provided [(i)] (A) the plan or plans offered or issued cover such small
610 employers as a single entity and cover not less than three thousand
611 employees on the date issued, [(ii)] (B) each small employer is charged
612 or offered the same premium rate with respect to each employee and
613 dependent, and [(iii)] (C) the plan or plans are written on a guaranteed
614 issue basis.

615 [(B)] (18) (A) With respect to plans or arrangements [issued] offered
616 by an association, [group plan, at the option of the administrator of the
617 association group plan,] an insurer issuing health insurance plans and
618 insurance arrangements covering employers in this state shall offer
619 premium quotes upon request by an association that meets the
620 provisions of this subdivision for an association group plan under
621 which the premium rates charged or offered to small employers
622 purchasing health insurance under this subdivision shall not be subject
623 to this section, provided (i) the plan or plans offered or issued cover
624 such small employers as a single entity and cover not less than three
625 thousand employees on the date issued, (ii) each small employer is
626 charged or offered the same premium rate with respect to each
627 employee and dependent, and (iii) the plan or plans are written on a
628 guaranteed issue basis. In addition, such association [group (I)] shall
629 be a bona fide group as set forth in the Employee Retirement and
630 Security Act of 1974 [, (II)] and shall not be formed for the purposes of
631 fictitious grouping, as defined in section 38a-827. [, and (III)] shall not
632 issue any plan that shall cause undue disruption in the insurance
633 marketplace, as determined by the commissioner.]

634 (B) No association that requests premium quotes for an association
635 group plan shall be required to accept such premium quotes or
636 association group plan. An insurer shall not issue any plan that shall
637 cause undue disruption in the insurance marketplace, as determined
638 by the commissioner.

639 Sec. 9. Subdivision (28) of section 38a-564 of the 2012 supplement to
640 the general statutes is repealed and the following is substituted in lieu
641 thereof (*Effective July 1, 2012*):

642 (28) "Actuarial certification" means a written statement by a member
643 of the American Academy of Actuaries or other individual acceptable
644 to the commissioner that a small employer carrier is in compliance
645 with the provisions of [subdivisions] subdivision (4) [, (6), (7) and (9)]
646 of section 38a-567, as amended by this act, and the regulations
647 promulgated by the commissioner pursuant to section 38a-567, as

648 amended by this act, based upon the person's examination, including a
649 review of the appropriate records and of the actuarial assumptions and
650 methods used by the small employer carrier in establishing premium
651 rates for applicable health benefit plans.

652 Sec. 10. Subsection (b) of section 38a-569 of the general statutes is
653 repealed and the following is substituted in lieu thereof (*Effective July*
654 *1, 2012*):

655 (b) Any member may reinsure with the pool coverage of an eligible
656 employee of a small employer, or any dependent of such an employee,
657 except that no member may reinsure with the pool coverage of an
658 eligible employee of a small employer, or any dependent of such an
659 employee, whose premium rates are not subject to section 38a-567, as
660 amended by this act, pursuant to subdivision [(22)] (17) or (18) of
661 section 38a-567, as amended by this act. Any reinsurance placed with
662 the pool from the date of the establishment of the pool regarding the
663 coverage of an eligible employee of a small employer, or any
664 dependent of such an employee shall be provided as follows:

665 (1) (A) With respect to a special health care plan or a small employer
666 health care plan, the pool shall reinsure the level of coverage provided;
667 (B) with respect to other plans, the pool shall reinsure the level of
668 coverage provided up to, but not exceeding, the level of coverage
669 provided in a small employer health care plan or the actuarial
670 equivalent thereof as defined and authorized by the board; and (C) in
671 either case, no reinsurance may be provided in any calendar year for a
672 reinsured employee or dependent until five thousand dollars in benefit
673 payments have been made for services provided during that calendar
674 year for that reinsured employee or dependent, which payments
675 would have been reimbursed through said reinsurance in the absence
676 of the annual five-thousand-dollar deductible. The amount of the
677 deductible shall be periodically reviewed by the board and may be
678 adjusted for appropriate factors as determined by the board;

679 (2) With respect to eligible employees, and their dependents,
680 coverage may be reinsured: (A) Within such period of time after the

681 commencement of their coverage under the plan as may be authorized
682 by the board, or (B) commencing January 1, 1992, on the first plan
683 anniversary after the employer's coverage has been in effect with the
684 small employer carrier for a period of three years, and every third plan
685 anniversary thereafter, provided, commencing May 1, 1994,
686 reinsurance pursuant to this subparagraph shall only be permitted
687 with respect to eligible employees and their dependents of a small
688 employer which has no more than two eligible employees as of the
689 applicable anniversary;

690 (3) Reinsurance coverage may be terminated for each reinsured
691 employee or dependent on any plan anniversary;

692 (4) Reinsurance of newborn dependents shall be allowed only if the
693 mother of any such dependent is reinsured as of the date of birth of
694 such child, and all newborn dependents of reinsured persons shall be
695 automatically reinsured as of their date of birth; and

696 (5) Notwithstanding the provisions of subparagraph (A) of
697 subdivision (2) of this subsection: (A) Coverage for eligible employees
698 and their dependents provided under a group policy covering two or
699 more small employers shall not be eligible for reinsurance when such
700 coverage is discontinued and replaced by a group policy of another
701 carrier covering two or more small employers, unless coverage for
702 such eligible employees or dependents was reinsured by the prior
703 carrier; and (B) at the time coverage is assumed for such group by a
704 succeeding carrier, such carrier shall notify the pool of its intention to
705 provide coverage for such group and shall identify the employees and
706 dependents whose coverage will continue to be reinsured. The time
707 limitations for providing such notice shall be established by the pool.

708 Sec. 11. Section 38a-513 of the 2012 supplement to the general
709 statutes is amended by adding subsection (e) as follows (*Effective July 1,*
710 *2012*):

711 (NEW) (e) An insurance company or health care center that delivers
712 or issues for delivery a group health insurance policy or plan in this

713 state shall offer premium quotes to a large employer upon request for
714 coverage for its employees. No such employer that requests premium
715 quotes for such coverage shall be required to accept such premium
716 quotes or coverage.

717 Sec. 12. Section 38a-591 of the 2012 supplement to the general
718 statutes is repealed and the following is substituted in lieu thereof
719 (*Effective July 1, 2012*):

720 (a) For purposes of this section, "Affordable Care Act" means the
721 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
722 from time to time, and regulations adopted thereunder.

723 (b) Each insurance company, fraternal benefit society, hospital
724 service corporation, medical service corporation and health care center
725 licensed to do business in the state shall comply with Sections 1251,
726 1252 and 1304 of the Affordable Care Act and the following Sections of
727 the Public Health Service Act, as amended by the Affordable Care Act:
728 (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A,
729 inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.

730 (c) This section shall apply, on and after the effective dates specified
731 in the Affordable Care Act, to insurance companies, fraternal benefit
732 societies, hospital service corporations, medical service corporations
733 and health care centers licensed to do business in the state.

734 (d) No provision of the general statutes concerning a requirement of
735 the Affordable Care Act shall be construed to supersede a provision of
736 the general statutes that provides greater protection to an insured,
737 except to the extent the latter prevents the application of a requirement
738 of the Affordable Care Act.

739 (e) Not later than sixty days after the Secretary of the United States
740 Department of Health and Human Services (1) issues final regulations
741 for the methodology for calculating the actuarial value of individual
742 and small employer health insurance policies and health care plans, or
743 (2) makes publicly available any applicable calculator or applicable

744 data necessary to perform such calculations, each insurance company,
745 fraternal benefit society, hospital service corporation, medical service
746 corporation and health care center that delivers, issues for delivery,
747 renews, amends or continues a health plan of the type specified in
748 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall disclose
749 to each policyholder or subscriber, in writing, the actuarial value of the
750 health insurance policy or health care plan under which such
751 policyholder or subscriber is insured or enrolled.

752 [(e)] (f) The Insurance Commissioner may adopt regulations, in
753 accordance with the provisions of chapter 54, to implement the
754 provisions of this section.

755 Sec. 13. Section 38a-513f of the 2012 supplement to the general
756 statutes is repealed and the following is substituted in lieu thereof
757 (*Effective July 1, 2012*):

758 (a) As used in this section:

759 (1) "Claims paid" means the amounts paid for the covered
760 employees of an employer by an insurer, health care center, hospital
761 service corporation, medical service corporation or other entity as
762 specified in subsection (b) of this section for medical services and
763 supplies and for prescriptions filled, but does not include expenses for
764 stop-loss coverage, reinsurance, enrollee educational programs or
765 other cost containment programs or features, administrative costs or
766 profit.

767 (2) "Employer" means any [town, city, borough, school district,
768 taxing district or fire district] employer employing more than fifty
769 employees.

770 (3) "Utilization data" means (A) the aggregate number of procedures
771 or services performed for the covered employees of the employer, by
772 practice type and by service category, or (B) the aggregate number of
773 prescriptions filled for the covered employees of the employer, by
774 prescription drug name.

775 (b) Each insurer, health care center, hospital service corporation,
776 medical service corporation or other entity delivering, issuing for
777 delivery, renewing, amending or continuing in this state any group
778 health insurance policy providing coverage of the type specified in
779 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall:

780 (1) Not later than October first, annually, provide to an employer
781 sponsoring such policy, free of charge, the following information for
782 the most recent thirty-six-month period or for the entire period of
783 coverage, whichever is shorter, and ending not [more than sixty days
784 prior to the date of the request] earlier than the preceding August first,
785 in a format as set forth in subdivision (3) of this subsection:

786 (A) Complete and accurate medical, dental and pharmaceutical
787 utilization data, as applicable;

788 (B) Claims paid by year, aggregated by practice type and by service
789 category, each reported separately for in-network and out-of-network
790 providers, and the total number of claims paid;

791 (C) Premiums paid by such employer by month; and

792 (D) The number of insureds by coverage tier, including, but not
793 limited to, single, two-person and family including dependents, by
794 month;

795 (2) Include in such [requested] information specified in subdivision
796 (1) of this subsection only health information that has had identifiers
797 removed, as set forth in 45 CFR 164.514, is not individually
798 identifiable, as defined in 45 CFR 160.103, and is permitted to be
799 disclosed under the Health Insurance Portability and Accountability
800 Act of 1996, P.L. 104-191, as amended from time to time, or regulations
801 adopted thereunder; and

802 (3) Provide such [requested] information [(A) in a written report, (B)
803 through an electronic file transmitted by secure electronic mail or a file
804 transfer protocol site, or (C) through a secure web site or web site
805 portal that is accessible by such employer] in a secure and

806 standardized format prescribed by the Comptroller.

807 (c) Such insurer, health care center, hospital service corporation,
808 medical service corporation or other entity shall not be required to
809 provide such information to the employer more than once in any
810 twelve-month period.

811 (d) (1) Except as provided in subdivision (2) of this subsection,
812 information provided to an employer pursuant to subsection (b) of this
813 section shall be used by such employer only for the purposes of
814 obtaining competitive quotes for group health insurance or to promote
815 wellness initiatives for the employees of such employer.

816 (2) Any employer may provide to the Comptroller upon request the
817 information disclosed to such employer pursuant to subsection (b) of
818 this section. The Comptroller shall maintain as confidential any such
819 information.

820 (e) Any information provided to an employer in accordance with
821 subsection (b) of this section or to the Comptroller in accordance with
822 subdivision (2) of subsection (d) of this section shall not be subject to
823 disclosure under section 1-210. An employee organization, as defined
824 in section 7-467, that is the exclusive bargaining representative of the
825 employees of such employer shall be entitled to receive claim
826 information from such employer in order to fulfill its duties to bargain
827 collectively pursuant to section 7-469.

828 (f) If a subpoena or other similar demand related to information
829 provided pursuant to subsection (b) of this section is issued in
830 connection with a judicial proceeding to an employer that receives
831 such information, such employer shall immediately notify the insurer,
832 health care center, hospital service corporation, medical service
833 corporation or other entity that provided such information to such
834 employer of such subpoena or demand. Such insurer, health care
835 center, hospital service corporation, medical service corporation or
836 other entity shall have standing to file an application or motion with
837 the court of competent jurisdiction to quash or modify such subpoena.

838 Upon the filing of such application or motion by such insurer, health
 839 care center, hospital service corporation, medical service corporation
 840 or other entity, the subpoena or similar demand shall be stayed
 841 without penalty to the parties, pending a hearing on such application
 842 or motion and until the court enters an order sustaining, quashing or
 843 modifying such subpoena or demand.

844 Sec. 14. Section 38a-513g of the 2012 supplement to the general
 845 statutes is repealed and the following is substituted in lieu thereof
 846 (*Effective July 1, 2012*):

847 (a) For the purposes of this section, "employer" [has the same
 848 meaning as provided in section 38a-513f] means any town, city,
 849 borough, school district, taxing district or fire district employing more
 850 than fifty employees.

851 (b) Not later than October first, annually, each employer that
 852 sponsors a fully insured group health insurance policy for its active
 853 employees, early retirees and retirees that provides coverage of the
 854 type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section
 855 38a-469 shall submit electronically to the Comptroller, in a form
 856 prescribed by the Comptroller, the following information: For the two
 857 policy years immediately preceding, the percentage increase or
 858 decrease in the policy or plan costs, calculated as the total premium
 859 costs, inclusive of any premiums or contributions paid by active
 860 employees, early retirees and retirees, divided by the total number of
 861 active employees, early retirees and retirees covered by such policy.

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

Section 1	<i>July 1, 2012</i>	3-123aaa
Sec. 2	<i>July 1, 2012</i>	3-123bbb
Sec. 3	<i>July 1, 2012</i>	3-123ccc
Sec. 4	<i>July 1, 2012</i>	3-123ddd(b)(2)
Sec. 5	<i>July 1, 2012</i>	3-123ddd(b)(5)
Sec. 6	<i>July 1, 2012</i>	3-123eee(d)(1)
Sec. 7	<i>July 1, 2012</i>	3-123fff

Sec. 8	<i>July 1, 2012</i>	38a-567
Sec. 9	<i>July 1, 2012</i>	38a-564(28)
Sec. 10	<i>July 1, 2012</i>	38a-569(b)
Sec. 11	<i>July 1, 2012</i>	38a-513
Sec. 12	<i>July 1, 2012</i>	38a-591
Sec. 13	<i>July 1, 2012</i>	38a-513f
Sec. 14	<i>July 1, 2012</i>	38a-513g

INS *Joint Favorable Subst. C/R* PD

PD *Joint Favorable C/R* APP

APP *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 13 \$	FY 14 \$
State Comptroller - Fringe Benefits ¹	GF & TF- Potential Cost	See Below	See Below
Comptroller	GF - Cost	See Below	See Below
Department of Revenue Services	GF - Revenue Loss	None	\$8.4 - \$21.0 million

Note: GF=General Fund and TF = Transportation Fund

Municipal Impact: None

Explanation

The bill makes various changes which result in the following fiscal impacts:

Sections 1 through 6 of the bill require the Comptroller (OSC), beginning January 1, 2014, to offer coverage under the Partnership Plan² to 1) municipal-related employers, their employees, and retirees³ and 2) small employers, their employees, and retirees.⁴ In addition, the bill allows the OSC to offer a separate prescription drug plan to municipal-related employers and small employers.

Participation is voluntary, with a two year minimum term. There

¹ The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated non-pension fringe benefit cost associated with most personnel changes is 29.22% of payroll in FY 13 and FY 14.

² PA 11-58 established the Partnership Plan.

³ Municipal related employers are defined in the bill as a property management business, food service business, school transportation business or waste management or recycling authority or business that is a party to a contract with a non-state public employer (municipality).

⁴ Small employers are those with 50 or less employees.

are approximately 610,160 employees of small employers.⁵ It is currently unknown how many municipal-related employees there are and what if any proportion of small employers are municipal-related employers. It has been estimated that in FY 14 approximately 173,200 employees of small businesses will be insured in health plans outside of the exchange, for whom the Partnership Plan would be an option.^{6 7} It is currently unknown the number of dependents who will be enrolled in plans outside of the exchange.

Sections 1 through 6 result in the fiscal impact to the state and the state employee health plan as a result of the following factors, as described below: 1) the potential impact to the existing pool, 2) federal Employee Retirement Income Security Act (ERISA), administrative, and personnel related costs, 3) actuarial costs, and lastly, 4) loss of revenue.

Impact to the Existing Pool

The Partnership Plan is currently permitted to be offered on a fully-insured (separate pool) or risk-pooled basis, whereby joining entities are pooled with the state employee health plan. If the joining entities are pooled with the state health plan there may be a cost to the plan. The cost would not accrue to the state until the second half of FY 14 at the earliest. The impact to the state from a fully insured plan is discussed in the subsequent section (See: *ERISA, Administrative, and Personnel Costs*).

The current cost of the state health plan is based on the demographics and claims experience of the existing pool. To the extent that additional lives affect the claims loss ratio, the cost of the state health plan will be directly impacted. The bill maintains current

⁵ This figure may or may not include employees of municipal-related employers as defined by the bill. (Source: CT Department of Labor).

⁶Source: Mercer, *Health Insurance Exchange Planning Report: The State of Connecticut*. January 19, 2012.

⁷ The Patient Protection and Affordable Care Act (PPACA) requires the state to establish the following as of January 1, 2014: 1) a health insurance exchange and 2) a Small Business Health Options Program (or "SHOP Exchange").

practice and requires immediate acceptance of any employer group that applies in its entirety for coverage. Partial groups applying for coverage are required to be reviewed by a health care actuary, with few exceptions. If it is determined that the partial group will adversely affect the state pool, the group shall be denied coverage. This requirement is intended to safeguard the state from an employer shifting a significantly disproportionate share of its medical risk to the state employee plan. If the Partnership Plan is established as a separate, fully-insured plan, there will be no similar impact on the existing pool.

As of July 1, 2010, the state employee health plan converted from fully insured to self-insured and now pays the total cost of claims on an incurred basis. Therefore, a monthly premium equivalent is estimated based on the anticipated annual claims expenditures including administrative costs. The state health plan will incur a cost to the extent that actual claims costs are more than the premium equivalent being charged to employers in a given year. It is assumed any surplus (premiums in excess of claims expenditures) for employers will be used in two ways: 1) to build a reserve pool for those employers or 2) repay the state for any costs incurred for claim overages in the prior year. This is the current rule for municipalities covered by the Partnership Plan.⁸ To the extent that the rules for small employers differ from those for municipalities, the impact and liability for the state will be different.

The state spent approximately \$1.0 billion in FY 11 on state employee and retiree health costs. Based on the FY 12 estimated requirements a 1% change in claims cost equals approximately \$11.9 million; a 5% change in claims costs equals approximately \$59.3 million. The Plan currently covers 201,426 lives.

It should be noted that the state does not currently have stop loss insurance. Any additional costs may be mitigated by the following: 1)

⁸ *Source:* State of Connecticut PA 11-58, Partnership Plan Rules of Operation. February 21, 2012.

a fluctuating reserve fee, 2) annual rate renewal adjustments and 2) administrative fees the OSC may charge employers.⁹

ERISA, Administrative, and Personnel Costs

It is currently unknown what the additional administrative expenses or other potential financial liability there will be to the OSC under ERISA or as a result of expanding the Partnership Plan to municipal-related and small business employers. As previously mentioned the OSC has the authority to charge an administrative fee to participating employers. The cost to the state may be mitigated to the extent that administrative costs are recouped from employers through such a fee.

In addition, the OSC will need a minimum of two additional staff to fulfill the ERISA requirements and manage the expansion of the Partnership Plan to an unknown number of employers. The associated salary and fringe benefit cost for two employees is approximately, \$193,830 annually. It is anticipated additional staff will be required starting in FY 13.

Current law requires the OSC to take appropriate steps to safeguard the state health plan's designation as a "governmental plan" under ERISA. It is currently unclear if allowing municipal-related and small business employers to join the state health plan will impact the state's designation as a governmental plan.¹⁰ In addition, if the Partnership Plan is offered to small employers as a separate plan the State will be responsible for administering the plan or plans pursuant to ERISA

⁹ The Partnership Plan has established the following rates for municipalities: 1) fluctuating reserve fee (risk charge) for municipalities equal to 3.5% of expected claims costs for the group, 2) renewal rate equal to the state plan percentage change plus or minus 3%, and 3) administrative fee is equal to that of the state employee health plan of \$4 per employee per month. It is uncertain to what extent this is representative of what the rates will be for other employer groups who join the Partnership Plan. (*Id*)

¹⁰ There is currently a rulemaking proceeding among the U.S. Department of Labor, Internal Revenue Service, and the Pension Benefit Guaranty Corporation (a US government agency) regarding the definition of a "governmental plan" for purposes of ERISA exemption. A final rule has not yet been issued.

regulations. If the inclusion of municipal-related employers and small business employers changes the state plans' status and exemption under ERISA or the state offers the plan to employers as a separate pool there will be administrative and personnel expenses for the OSC.¹¹

By way of background, US Department of Labor outlines, in summary, the nature of the plan's responsibilities under ERISA:

plans to provide participants with plan	ERISA requires
including important information about plan	information
funding; provides fiduciary responsibilities for	features and
manage and control plan assets; requires plans to	those who
grievance and appeals process for participants to get	establish a
their plans; and gives participants the right to sue	benefits from
breaches of fiduciary duty. ¹²	for benefits and

In addition, ERISA requires a financial audit to be conducted by an independent auditor.

Actuarial Costs

Additional funding may be required to expand the current actuarial services provided to the state in support of the Partnership Plan. The additional cost will depend on the scope of additional services required of the actuary, which is largely dependent on the number of firms who request quotes and the complexity of the analysis. These costs may be mitigated to the extent they are passed through to employers. However, it is unlikely all of the costs will be able to be passed along. The OSC's current contract calls for services not to exceed approximately \$1.0 million for the contracted year.

As previously discussed, under current law the Comptroller is

¹¹ Public hearing testimony of the OSC.

¹² Source: US Department of Labor: <http://www.dol.gov/dol/topic/health-plans/erisa.htm>

required to forward the application to a health care actuary in the event an employer wishes to enroll part of their group, with the exception of certain circumstances. In addition, health care actuaries provide the following support:

- 1) establish actuarial standards to assess:
 - a) the shift in medical risk,
 - b) administrative fees,
 - c) fluctuating reserve fees, and
- 2) establish premium equivalents.

Loss of Revenue

Pursuant to CGS Sec. 12-202a(a) insurers who provide coverage for small employers are required to pay an Insurance Premium Tax to the state of 1.75% of total net direct premiums written. To the degree that the bill results in small employers shifting their participation in fully-insured health plans to the Partnership Plan, the state will experience a revenue loss from the Insurance Premiums Tax.

Assuming all of the estimated 173,200 employees of small businesses who will be insured in health plans outside of the exchange in FY 14¹³ shift from commercial coverage to the Partnership Plan, there will be a revenue loss of \$8.4 - \$21.0 million in FY 14.¹⁴ The estimated annualized revenue loss beginning in FY 15 is \$16.8 - \$42.0 million. The actual revenue loss is dependent upon the number of employers utilizing the Partnership Plan and the actual premium costs of associated employees in the commercial market.

Section 2 also requires insurers, at the request of a non-state public employer, nonprofit employer, small employer, or municipal-related

¹³ Mercer Report.

¹⁴ It is currently unknown what level of coverage potential participating employees have, i.e. individual coverage versus family coverage.

employer sponsoring a health policy to provide claims, premium, and enrollment information to the OSC at no charge. This provision does not result in a fiscal impact.

Section 7 establishes the Private Sector Health Care Advisory Committee. This provision does not result in a fiscal impact.

Section 8 makes the following changes: 1) various technical and conforming changes which do not result in a fiscal impact, and 2) requires an insurer to offer a premium quote to an association upon request. There is not anticipated to be a fiscal impact as a result of this provision.

Sections 9 and 10 make technical and conforming changes which do not result in a fiscal impact.

Section 11 is not anticipated to result in a fiscal impact. The section requires an insurer to offer a premium quote to a larger employer upon request of the employer.

Section 12 does not result in a fiscal impact. The section requires an insurer to provide written disclosure to all policyholders or subscribers on the actuarial value (AV)¹⁵ of the health insurance policy or plan no later than sixty days after the Secretary of the United States Department of Health and Human Services issues regulations and tools for the calculation of the AV.

Section 13 does not result in a fiscal impact. The section makes the following changes: 1) modifies the period of time insurers are required to provide claims information on to requesting employers, and 2) modifies the method in which claims information is provided to the OSC from email to a secure and standardized format required by the OSC.

¹⁵ The AV is the “percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.” (Source: www.healthcare.gov)

Section 14 makes technical changes which do not result in a fiscal impact

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation. In addition, normal annual pension costs (currently estimated at 7.7% of payroll) attributable to the identified personnel changes will be recognized in the state's annual required pension contribution in future actuarial valuations.

OLR Bill Analysis**sHB 5487*****AN ACT CONCERNING THE RECOMMENDATIONS OF THE SMALL BUSINESS HEALTHCARE WORKING GROUP AND CLAIMS INFORMATION REQUIRED TO BE PROVIDED BY INSURERS.*****SUMMARY:**

This bill requires:

1. the comptroller to offer employee and retiree coverage under “partnership plans” to (a) small employers (i.e., those with 50 or fewer employees) and (b) “municipal-related employers” as defined by the bill (§§ 1-7);
2. health insurers, HMOs, and similar entities to give certain utilization, claim, and premiums data to (a) the comptroller upon the request of employers eligible to participate in the partnership plans (§ 2) and (b) all employers, instead of just municipal employers, with more than 50 employees (§ 13);
3. health insurers to offer premium quotes to certain association group plans (§ 8);
4. health insurers and HMOs to offer premium quotes to large employers (presumably employers with more than 50 employees) (§ 11); and
5. health insurers, HMOs, and similar entities to disclose to policyholders and plan subscribers the actuarial value of their health care insurance policies and plans (§ 12).

The bill also makes technical and conforming changes and deletes obsolete language (§§ 8-10 & 14).

EFFECTIVE DATE: July 1, 2012

§§ 1-7 – CONNECTICUT PARTNERSHIP PLAN

By law, the comptroller must offer a health care benefit plan (i.e., a partnership plan) to certain employer groups that apply for coverage and are approved in accordance with the law. He must offer coverage to nonstate public employers beginning January 1, 2012 and nonprofit employers beginning January 1, 2013. Coverage is for the benefit of their employees and retirees.

The bill requires the comptroller, beginning by January 1, 2014, also to offer coverage to small employers and municipal-related employers, for the benefit of their employees and retirees. The initial open enrollment must be for coverage that begins January 1, 2014; subsequent enrollment periods must be for coverage periods beginning July 1 and January 1. The bill extends the same partnership plan requirements and processes as exist in current law to these two new employer groups.

By law, the comptroller may offer partnership plans on a fully-insured or risk-pooled basis at his discretion. Any insurer, HMO, or entity with which he contracts and any fully insured plan offered is subject to state insurance laws. The bill specifies that the comptroller has discretion to offer a separate prescription drug plan to small and municipal-related employers.

Definitions

The bill defines a “small employer” as 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 in the last 12 months, employed 50 or fewer eligible employees, the majority of whom were employed in Connecticut. For the purposes of determining the employer’s number of eligible employees, affiliated companies and companies that can file a combined tax return are considered one employer.

The bill defines a “municipal-related employer” as a specified type

of business that has a contract with a nonstate public employer (i.e., a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library). The business must be a (1) property management business, (2) food service business, (3) school transportation business, or (4) waste management or recycling authority or business.

Coverage Term

By law, in order for an employer group to participate in a partnership 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.

Taft-Hartley Exception

By law, an employee cannot enroll in a partnership 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).

Status as a Governmental Health Plan Under Federal ERISA

By law, the comptroller must take any necessary actions to ensure that providing coverage to an employer group under a partnership plan will not affect the state employee health plan's status as a "governmental plan" under the federal Employee Retirement Income Security Act (ERISA) (see BACKGROUND). ERISA sets certain fiduciary and disclosure standards for private-sector health plans and exempts governmental plans from these requirements.

If the comptroller determines that providing coverage affects the state plan's ERISA status, he may cancel an employer's coverage with notice and stop accepting applications. He must resume accepting applications if he determines that granting the coverage will not affect the state plan's ERISA status. He must publicly announce any decision to discontinue or resume coverage or accepting applications for coverage.

Application and Decision Process for Eligible Employers

The bill extends the application and decision process applicable to nonstate public and nonprofit employers to small and municipal-related employers. There are two different processes for determining whether an 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 employees, the comptroller must accept the application for the next enrollment period. He must give the employer written notice of when coverage begins, pending the employer's acceptance of the plan's terms and conditions.

But if the application covers only some employees or it indicates that the employer will offer other health plans to employees offered the partnership plan, the comptroller must forward the application to a health care actuary within five days of receiving it. The law prohibits the comptroller from forwarding the application to the actuary if it proposes to cover fewer than all employees because (1) the employer will not cover temporary, part-time, or durational employees or (2) individual employees decline coverage.

Within 60 days of receiving an application from the comptroller, the actuary must determine if it will shift a significant part of the employer group's medical risks to the partnership plan. If so, the actuary must inform the comptroller of this in writing and include specific reasons for the decision.

If the actuary finds a significant risk shift, the comptroller must deny the application and give written notice, including specific reasons for denial, to the employer and the Health Care Cost Containment Committee (HCCCC). If the actuary does not find a significant risk shift, the comptroller must accept the application and give the employer written notice of when coverage begins, pending the employer's acceptance of the plan's terms and conditions.

Retiree Coverage

By law, employer groups whose applications for coverage under a partnership plan are accepted may also seek coverage for their retirees. The application and decision processes for the retirees' coverage, including actuarial review if the employer does not propose to cover all of its retirees, are the same as for employees (see above).

Under the bill, as under current law, the comptroller is not required to forward an application to the actuary when the only retirees an employer excludes from the application are those who (1) decline coverage or (2) are Medicare enrollees.

Premiums, Cost Sharing, Fees, and Termination

The bill extends existing law on premiums, cost sharing, fees, and termination to small and municipal-related employers participating in a partnership plan.

By law, an employer group participating in a partnership plan must pay monthly premiums to the comptroller in an amount he determines. An employer may require a covered employee or retiree to pay part of the coverage cost.

The law allows the comptroller to charge participating employer groups an administrative fee calculated on a per member, per month basis. He may also charge a fluctuating reserves fee that he deems necessary to ensure an adequate claims reserve. He must do this in accordance with the actuarial standards developed in consultation with the HCCCC.

The law requires an employer who does not pay its premiums by the 10th day after the due date to pay interest, retroactive to the due date, at the prevailing rate the comptroller determines. The comptroller may terminate an employer group's participation in a partnership plan for failure to pay premiums if he gives it at least 10 days notice. The employer can avoid termination by paying the premiums and interest due in full before the termination effective date. By law, the comptroller may ask the attorney general to bring an action in the Hartford Superior Court to recover any premiums and interest

owed by, or seek equitable relief from, a terminated group.

Advisory Committee

PA 11-58 established a Nonstate Public Health Care Advisory Committee and a Nonprofit Health Care Advisory Committee to make recommendations to HCCCC on health care coverage for nonstate public employees and nonprofit employees, respectively.

The bill establishes an eight-member Private Sector Health Care Advisory Committee, appointed by the comptroller, to make recommendations to HCCCC on health care coverage for employees of small and municipal-related employers. The committee must consist of two representatives each of (1) small employers, (2) small employer employees, (3) municipal-related employers, and (4) municipal-related employees.

HCCCC and SEBAC Approval

The law prohibits the comptroller from offering coverage under a partnership plan until the (1) HCCCC provides the comptroller written approval of the law, as amended by the bill, and (2) State Employees Bargaining Agents Coalition (SEBAC) provides the House and Senate clerks written consent to incorporate the law's terms into its collective bargaining agreement (CGS § 3-123hhh).

The law also specifies that nothing in the partnership plan law modifies the state employee health plan without the written consent of SEBAC and the Office of Policy Management secretary.

§§ 2 & 13 – UTILIZATION, CLAIMS, AND PREMIUMS DATA

For Employers Eligible to Participate in a Partnership Plan (§ 2)

The bill requires each insurer or similar entity to give the comptroller, free of charge and in a secure and standardized format he prescribes, specified utilization, claims, and premiums data on behalf of an employer group eligible for coverage under a partnership plan.

The entities must provide the information (1) within 30 days after an employer asks them to do so and (2) for the most recent 36-month

period or for the entire coverage period, whichever is shorter. They are not required to give the comptroller the information more than once in any 12-month period.

The information must, in accordance with federal regulations, have all identifiers removed and cannot be individually identifiable. It must include:

1. complete and accurate medical, dental, and pharmaceutical utilization data, as applicable;
2. (a) the total number of claims paid and (b) claims paid by year, practice type, and service category, for in-network and out-of-network providers;
3. premiums the employer paid by month; and
4. the number of people insured under the policy, by month and coverage tier, including single, two-person, and family categories.

The information must be subject to disclosure under the federal Health Insurance Portability and Accountability Act. The bill specifies that the information is not subject to disclosure under the Freedom of Information Act (FOIA).

The provisions apply to insurers, HMOs, hospital or medical service corporations, or other entities that deliver, issue, renew, amend, or continue any group health insurance policies in Connecticut that cover:

1. basic hospital expenses;
2. basic medical-surgical expenses;
3. major medical expenses;
4. hospital or medical services, including coverage under an HMO plan; and

5. single-service ancillary health coverage plans, including dental, vision, and prescription drug plans.

For Large Employers (§ 13)

Under current law, insurers and similar entities must give a municipal employer with more than 50 employees, at the employer's request, the same utilization, claims, and premiums data specified above. The bill expands this to all employers with more than 50 employees.

The law requires the information to be provided free of charge by October 1 annually and include data for the most recent 36-month period or entire coverage period, whichever is shorter. Current law requires that this information cover a period that ends not more than 60 days before the request. The bill instead requires the information to cover a period that ends no earlier than the previous August 1. It further specifies that data be provided in a secure and standardized format the comptroller prescribes. The entity is not required to provide the employer data more than once in any 12-month period.

By law, employers can use the information provided only to get competitive quotes for group health insurance or promote employee wellness initiatives, except that an employer may provide the information to the comptroller, who must keep it confidential.

By law, any information provided to an employer is not subject to disclosure under FOIA. But an employee organization that is the exclusive bargaining representative of the employer's employees is entitled to receive claim information from the employer so that it may fulfill its collective bargaining duties.

The law and bill apply to the same insurers and similar entities as listed in § 2 above.

§ 8 – PREMIUM QUOTES FOR CERTAIN ASSOCIATIONS

The bill requires an insurer that issues health insurance plans and insurance arrangements covering Connecticut employers to offer a

premium quote to an association that requests one for an association group plan. The premium rates proposed for any small employers that are part of such an association are not subject to the small employer rating law, which requires adjusted community rating.

The association must meet specified criteria to be eligible for a quote, but it is not required to accept the quote or association group plan.

To be eligible for a quote from the insurer, an association must offer:

1. a plan or plans that cover (a) small employers as a single entity and (b) at least 3,000 employees;
2. each small employer the same premium rate for each employee and dependent (i.e., pure community rating); and
3. the plan or plans on a guaranteed issue basis.

The association must also be a bona fide group under ERISA and not a fictitious group (i.e., a grouping for rating purposes where a rate differentiation is based solely upon group membership).

Under current law, small employer groups are exempt from the adjusted community rating law at the association group plan administrator's option if the association meets the above criteria.

Current law prohibits an association from issuing any plans that cause undue disruption to the insurance marketplace, as determined by the insurance commissioner. The bill instead prohibits insurers from issuing such a plan.

§ 11 – PREMIUM QUOTES FOR LARGE EMPLOYERS

The bill requires each insurer and HMO that delivers or issues a group health insurance policy or plan in Connecticut to offer a premium quote to a large employer for employee coverage upon the employer's request. The employer is not required to accept the quote or coverage.

The bill does not define large employer. Presumably, it means an employer that is not a small employer.

§ 12 – ACTUARIAL VALUE

The bill requires each insurer and similar entity to disclose in writing to each policyholder and subscriber the actuarial value of the health insurance policy or plan under which the policyholder or subscriber is covered.

The entity must provide this disclosure within 60 days after the U.S. Health and Human Services secretary either (1) issues final regulations on how to calculate the actuarial value of individual and small employer health insurance policies and plans or (2) publishes an applicable calculator or data needed to make the calculations.

This requirement applies to each insurer, fraternal benefit society, hospital or medical service corporation, and HMO that issues, delivers, renews, amends, or continues a health plan that covers (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

BACKGROUND

ERISA

Federal ERISA governs certain activities of most private employers who maintain employee welfare benefit plans and preempts many state laws in this area (USC Title 29). ERISA-covered welfare benefit plans must meet a wide range of fiduciary, reporting, disclosure, and benefit requirements. But ERISA does not apply to governmental plans.

ERISA defines a “governmental plan” 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 employee health plan permits private-sector employers

to join, it is unknown whether it will lose its status as a governmental plan, thereby subjecting it to the full requirements of ERISA.

The U.S. Department of Labor (DOL) has 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).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute Change of Reference
Yea 11 Nay 7 (03/15/2012)

Planning and Development Committee

Joint Favorable Change of Reference
Yea 13 Nay 8 (03/21/2012)

Appropriations Committee

Joint Favorable
Yea 31 Nay 16 (03/29/2012)