
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)