Senate

General Assembly

File No. 338

January Session, 2015

Substitute Senate Bill No. 913

Senate, March 31, 2015

The Committee on Labor and Public Employees reported through SEN. GOMES of the 23rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE DATA REPORTING AND THE ENROLLMENT OF NONSTATE PUBLIC EMPLOYEES IN THE STATE EMPLOYEE HEALTH PLAN.

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

Section 1. (NEW) (*Effective July 1, 2015*) (a) Not later than October 1, 2016, and annually thereafter, each municipality that sponsors a group health policy or plan for its active employees, early retirees and retirees that provides coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes shall submit electronically to the State Comptroller, in a form prescribed by the Comptroller, the following information for the policy or plan year immediately preceding:

(1) A list of each type of group health policy or plan offered to the municipality's employees, early retirees and retirees and specific details for each such policy or plan, including, but not limited to:

(A) Covered benefits and any limits on such benefits;

(B) (i) The total premium costs or, if applicable, premium equivalent costs for each policy or plan, organized by coverage tier, including, but not limited to, single, two-person and family including dependents for active employees, early retirees and retirees, and (ii) the employee share, the early retiree share and the retiree share of each such total premium cost;

(C) Employee, early retiree and retiree cost-sharing requirements such as coinsurance, copayments, deductibles and other out-of-pocket expenses associated with in-network and out-of-network providers; and

(D) If a municipality sponsors a prescription drug plan, the value of any rebates or cost reductions provided to such municipality for such plan;

(2) A list of the total number of employees, early retirees and retirees in each policy or plan, organized by (A) municipal department, (B) collective bargaining unit, if applicable, (C) coverage tier, including, but not limited to, single, two-person and family, including dependents, and (D) active employee, early retiree or retiree status; and

(3) For the two policy or plan years immediately preceding, the percentage increase or decrease in the policy or plan costs, calculated as the total premium costs, inclusive of any premiums or contributions paid by active employees, early retirees and retirees, divided by the total number of active employees, early retirees and retirees covered by such policy or plan.

(b) No municipality submitting information pursuant to subsection (a) of this section shall include health information in such information.

Sec. 2. Section 38a-513f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) As used in this section:

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

(2) "Employer" means any town, city, borough, school district, taxing district or fire district employing more than fifty employees.

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

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

[(1)**]** (A) Not later than October first, annually, provide to an employer sponsoring such policy, free of charge, the following information for the most recent thirty-six-month period or for the entire period of coverage, whichever is shorter, ending not more than sixty days prior to the date of the provision of such information, in a format as set forth in **[**subdivision (3)**]** subparagraph (C) of this **[**subsection**]** subdivision:

[(A)**]** (i) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

[(B)**]** (ii) Claims paid by year, aggregated by practice type and by

service category, each reported separately for in-network and out-of-network providers, and the total number of claims paid;

[(C)**]** (iii) Premiums paid by such employer by month; and

[(D)**]** (iv) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

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

[(3)**]** (C) Provide such information **[**(A)**]** (i) in a written report, **[**(B)**]** (ii) through an electronic file transmitted by secure electronic mail or a file transfer protocol site, or **[**(C)**]** (iii) through a secure web site or web site portal that is accessible by such employer.

[(c)**]** (2) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the employer more than once in any twelve-month period.

[(d) (1)**]** (3) (A) Except as provided in **[**subdivision (2)**]** subparagraph (B) of this **[**subsection**]** subdivision, information provided to an employer pursuant to **[**subsection (b) of this section**]** subdivision (1) of this subsection shall be used by such employer only for the purposes of obtaining competitive quotes for group health insurance or to promote wellness initiatives for the employees of such employer.

[(2)**]** (B) Any employer may provide to the Comptroller upon request the information disclosed to such employer pursuant to **[**subsection (b) of this section**]** subdivision (1) of this subsection. The

Comptroller shall maintain as confidential any such information.

[(e)**]** (4) Any information provided to an employer in accordance with **[**subsection (b) of this section**]** subdivision (1) of this subsection or to the Comptroller in accordance with **[**subdivision (2)**]** subparagraph (B) of **[**subsection (d)**]** subdivision (3) of this **[**section**]** subsection shall not be subject to disclosure under section 1-210. An employee organization, as defined in section 7-467, that is the exclusive bargaining representative of the employees of such employer shall be entitled to receive claim information from such employer in order to fulfill its duties to bargain collectively pursuant to section 7-469.

[(f)**]** (c) If a subpoena or other similar demand related to information provided pursuant to subsection (b) of this section is issued in connection with a judicial proceeding to an employer that receives such information, such employer shall immediately notify the insurer, health care center, hospital service corporation, medical service corporation or other entity that provided such information to such employer of such subpoena or demand. Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall have standing to file an application or motion with the court of competent jurisdiction to quash or modify such subpoena. Upon the filing of such application or motion by such insurer, health care center, hospital service corporation, medical service corporation or other entity, the subpoena or similar demand shall be stayed without penalty to the parties, pending a hearing on such application or motion and until the court enters an order sustaining, quashing or modifying such subpoena or demand.

(d) (1) Not later than October 1, 2015, and annually thereafter, each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy sponsored by an employer and providing either administrative services only or providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-

469 shall submit to the Comptroller the information set forth in subparagraphs (A)(i) and (A)(ii) of subdivision (1) of subsection (b) of this section for the policy year immediately preceding for each such employer.

(2) Such information shall be submitted electronically to the Comptroller, in a form prescribed by the Comptroller, regardless of whether an employer requests such information pursuant to subparagraph (A) of subdivision (1) of subsection (b) of this section. Disclosure of any such information to the Comptroller pursuant to this subsection shall be made in compliance with subparagraph (B) of subdivision (1) of subsection (b) of this section.

Sec. 3. (*Effective July 1, 2015*) (a) With respect to the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259 of the general statutes, on and after July 1, 2015, and until June 30, 2016:

(1) The office of the State Comptroller shall have the authority to convene a working group, including, but not limited to, (A) to the extent applicable, health insurance companies, health care centers, hospital service corporations, medical service corporations or other entities delivering, issuing for delivery, renewing, amending or continuing such plans, (B) third-party administrators providing administrative services only for such plans pursuant to subdivision (2) of subsection (m) of section 5-259 of the general statutes, (C) health care providers, (D) health care facilities, (E) the Office of Policy and Management, and (F) state employees and retirees, to facilitate the development and establishment of health care provider payment reforms for the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259 of the general statutes, including, but not limited to, multipayer initiatives, patient-centered medical homes, primary care case management, value-based purchasing and bundled purchasing. Any participation by such entities and individuals shall be on a voluntary basis.

(2) (A) The Comptroller, or the Comptroller's designee, may (i)

conduct a survey of the entities and individuals specified in subparagraphs (A) to (D), inclusive, of subdivision (1) of this subsection, concerning payment delivery reforms, and (ii) convene meetings of the working group at a time and place that is convenient for the entities and individuals specified in subparagraphs (A) to (F), inclusive, of subdivision (1) of this subsection.

(B) The Comptroller, or the Comptroller's designee, shall ensure that no such survey or working group participants shall solicit, share or discuss pricing information.

(C) (i) Any survey conducted pursuant to subparagraph (A) of this subdivision shall not be a violation of chapter 624 of the general statutes or subject to disclosure under section 1-210 of the general statutes.

(ii) Any meeting convened pursuant to subparagraph (A) of this subdivision shall not be a violation of chapter 624 of the general statutes or constitute a meeting for the purposes of chapter 14 of the general statutes.

(3) (A) If the Comptroller determines that entering a cooperative agreement with any of the entities or individuals specified in subparagraphs (A) to (D), inclusive, of subdivision (1) of this subsection will likely produce efficiencies and improvements in health care outcomes, the Comptroller may enter into one or more such agreements to (i) identify and reward high quality, low-cost health care providers, (ii) create enrollee incentives to receive care from such providers, and (iii) create enrollee incentives to promote personal health behaviors that will prevent or effectively manage chronic diseases, including, but not limited to, tobacco cessation, weight control and physical activity.

(B) The Comptroller may establish guidelines for such cooperative agreements. Any such agreement shall be consistent with federal antitrust laws and regulations promulgated by the Federal Trade Commission and chapter 624 of the general statutes.

(b) Not later than January 1, 2017, the Comptroller shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, labor and public health on the recommendations of any working group convened by the Comptroller pursuant to subsection (a) of this section. Such report shall include, but not be limited to, (1) (A) any cost containment measures, and (B) descriptions of any quality measurement or quality improvement initiatives implemented as a result of the recommendations of such working group, and (2) any cost savings or health outcome improvements associated with such measures or initiatives.

Sec. 4. (NEW) (*Effective from passage*) As used in this section and sections 5 to 8, inclusive, of this act:

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

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

(3) "Nonstate public employer" means a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library. A municipality and a board of education may be considered separate employers.

(4) "State employee plan" means the group hospitalization, medical, pharmacy and surgical insurance plan offered to state employees and retirees pursuant to section 5-259 of the general statutes.

Sec. 5. (NEW) (*Effective October 1, 2015*) (a) Notwithstanding any provision of title 38a of the general statutes, the Comptroller shall offer to nonstate public employers and their nonstate public employees, and their retirees, if applicable, coverage under the state employee plan. Such nonstate public employees, or retirees, if applicable, shall be

pooled with the state employee plan, provided the Comptroller receives an application from a nonstate public employer and the application is approved in accordance with this section or section 6 of this act. Premium payments for such coverage shall be remitted by the nonstate public employer to the Comptroller and shall be the same as those paid by the state inclusive of any premiums paid by state employees, except as otherwise provided in this section or section 7 of this act. The Comptroller may charge each nonstate public employer participating in the state employee plan an administrative fee calculated on a per member, per month basis.

(b) (1) The Comptroller shall offer participation in such plan for not less than three-year intervals. A nonstate public employer may apply for renewal prior to the expiration of each interval.

(2) The Comptroller shall develop procedures by which nonstate public employers receiving coverage for nonstate public employees pursuant to the state employee plan may (A) apply for renewal, or (B) withdraw from such coverage, including, but not limited to, the terms and conditions under which such nonstate public employers may withdraw prior to the expiration of the interval and the procedure by which any premium payments such nonstate public employers may be entitled to or premium equivalent payments made in excess of incurred claims shall be refunded to such nonstate public employer. Any such procedures shall provide that nonstate public employees covered by collective bargaining shall withdraw from such coverage in accordance with chapters 68, 113 and 166 of the general statutes.

(c) Nothing in sections 4 to 8, inclusive, of this act shall (1) require the Comptroller to offer coverage to every nonstate public employer seeking coverage under the state employee plan, or (2) prevent the Comptroller from procuring coverage for nonstate public employees from vendors other than those providing coverage to state employees.

(d) The Comptroller shall create applications for coverage under and for renewal of the state employee plan. Such applications shall require a nonstate public employer to disclose whether such nonstate

public employer shall offer any other health care benefits plan to the nonstate public employees who are offered the state employee plan.

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

(f) (1) A nonstate public employer may submit an application to the Comptroller to provide coverage under the state employee plan for nonstate public employees employed by such nonstate public employer.

(2) If a nonstate public employer submits an application for coverage of all of its nonstate public employees, the Comptroller shall provide such coverage not later than the first day of the third calendar month following such application.

(3) (A) Except as provided in subsection (g) of this section, if a nonstate public employer submits an application for coverage for fewer than all of its nonstate public employees, or indicates in the application that the nonstate public employer shall offer other health plans to nonstate public employees who are offered the state health plan, the Comptroller shall forward such application to the Health Care Cost Containment Committee not later than five business days after receiving such application. Said committee may, not later than thirty days after receiving such application, certify to the Comptroller that the application will shift a significantly disproportional part of a nonstate public employer's medical risks to the state employee plan.

(B) If the Health Care Cost Containment Committee certifies to the Comptroller that the application will shift a significantly disproportional part of a nonstate public employer's medical risks to the state employee plan, the Comptroller shall not provide coverage to such nonstate public employer. If the Health Care Cost Containment

Committee does not certify to the Comptroller that the application will shift a significantly disproportional part of a nonstate public employer's medical risks to the state employee plan, the Comptroller shall provide coverage not later than the first day of the third calendar month following the deadline for receiving the certification.

(4) Notwithstanding any provisions of the general statutes, initial and continuing participation in the state employee plan by a nonstate public employer shall be a mandatory subject of collective bargaining and shall be subject to binding interest arbitration in accordance with the same procedures and standards that apply to any other mandatory subject of bargaining pursuant to chapters 68, 113 and 166 of the general statutes.

(g) If a nonstate public employer included fewer than all of its nonstate public employees in its application for coverage because of (1) the decision by individual nonstate public employees to decline such coverage for themselves or their dependents, or (2) the nonstate public employer's decision to not offer coverage to temporary, part-time or durational employees, the Comptroller shall not forward such nonstate public employer's application to the Health Care Cost Containment Committee pursuant to subdivision (3) of subsection (f) of this section.

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

Sec. 6. (NEW) (*Effective October 1, 2015*) (a) Any nonstate public employer that is eligible to seek coverage under the state employee plan for its nonstate public employees may seek such coverage for such nonstate public employer's retirees in accordance with this section. Premium payments for such coverage shall be remitted by the nonstate public employer to the Comptroller and shall be the same as those paid by the state, inclusive of any premiums paid by retired state employees.

(b) (1) If a nonstate public employer seeks coverage for all of its retirees in accordance with this section and all of the nonstate public employees employed by such nonstate public employer in accordance with section 5 of this act, the Comptroller shall accept such application upon the terms and conditions applicable to the state employee plan and shall provide coverage not later than the first day of the third calendar month following such application.

(2) If a nonstate public employer seeks coverage for fewer than all of its retirees, regardless of whether such nonstate public employer is seeking coverage for all of the nonstate public employees employed by such nonstate public employer, the Comptroller shall forward such application to the Health Care Cost Containment Committee not later than five business days after receiving such application. Said committee may, not later than thirty days after receiving such application, certify to the Comptroller that, with respect to such retirees, the application will shift a significantly disproportional part of such nonstate public employer's medical risks to the state employee plan.

(3) If the Health Care Cost Containment Committee certifies to the Comptroller that the application will shift a significantly disproportional part of a nonstate public employer's medical risks to the state employee plan, the Comptroller shall not provide coverage to such nonstate public employer's retirees. If the Health Care Cost Containment Committee does not certify to the Comptroller that the application will shift a significantly disproportional part of a nonstate public employer's medical risks to the state employee plan, the Comptroller shall provide coverage not later than the first day of the third calendar month following the deadline for receiving the certification.

(c) Nothing in sections 4 to 8, inclusive, of this act shall diminish any right to retiree health insurance pursuant to a collective bargaining agreement or to any other provision of the general statutes.

Sec. 7. (NEW) (*Effective October 1, 2015*) (a) There is established an

account to be known as the "state employee plan premium account", which shall be a separate, nonlapsing account within the General Fund. All premiums paid by nonstate public employers and nonstate public employees pursuant to participation in the state employee plan shall be deposited into said account. The account shall be administered by the Comptroller, with the advice of the Health Care Costs Containment Committee, for payment of claims and administrative fees to entities providing coverage or services under the state employee plan.

(b) Each nonstate public employer shall pay monthly the amount determined by the Comptroller for coverage of its nonstate public employees or its nonstate public employees and retirees, as appropriate, under the state employee plan. A nonstate public employer may require each nonstate public employee to contribute a portion of the cost of his or her coverage under the plan, subject to any collective bargaining obligation applicable to such nonstate public employer.

(c) If any payment due by a nonstate public employer under this subsection is not paid after the date such payment is due, interest to be paid by such nonstate public employer shall be added, retroactive to the date such payment was due, at the prevailing rate of interest as determined by the Comptroller.

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

connection with such moneys.

Sec. 8. (*Effective from passage*) The Comptroller shall not offer coverage under the state employee plan pursuant to sections 4 to 7, inclusive, of this act until the State Employees' Bargaining Agent Coalition has provided its consent to the clerks of both houses of the General Assembly to incorporate the terms of sections 4 to 7, inclusive, of this act into its collective bargaining agreement.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2015*	New section
Sec. 2	*July 1, 2015*	38a-513f
Sec. 3	*July 1, 2015*	New section
Sec. 4	*from passage*	New section
Sec. 5	*October 1, 2015*	New section
Sec. 6	*October 1, 2015*	New section
Sec. 7	*October 1, 2015*	New section
Sec. 8	*from passage*	New section

LAB *Joint Favorable Subst.*

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 16 $	FY 17 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Accounts)	GF, TF - Potential Cost	See Below	See Below

GF & TF = General Fund and Special Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 16 $	FY 17 $
Various Municipalities	Potential Savings	See Below	See Below

Explanation

Sections 1 through 3 do not result in a fiscal impact to the state or municipalities. These sections require municipalities and health insurers to provide certain information to the Office of the State Comptroller (OSC) on the health plans provided for municipal employees and retirees by municipalities and health insurers each year electronically. Under current law, information on municipal health plans is already required to be submitted to municipalities by health plans. Municipalities have the option to provide that information to OSC. It is unclear if the bill's disclosure provisions apply to self-insured municipalities who in accordance with federal law are exempt from state regulations.

Section 3 does not result in a cost to the state or municipalities. This section allows, but does not require, OSC to convene a working group to look at various facets of healthcare impacting the state health plan, including payment reform. OSC is currently part of the State's Innovation Model Program (SIM) in collaboration with other public

and private health care providers/payers, which looks at health care issues, including payment reform. OSC is required to report to the general assembly recommendations of any committee.

Section 3 may result in a fiscal impact to the state by allowing OSC to enter into cooperative agreements with various entities, including but not limited to health insurers, health care facilities, and third party administrators. The fiscal impact to the state will depend on the nature and scope of any cooperative agreement and the extent to which it impacts the cost to provide health care by the state.

Sections 4 through 8 require OSC to allow nonstate public employers[1] to join the state employee health plan on a pooled experience basis. The bill requires OSC to admit those employers who request all their employees and or retirees to join the plan within three months of application. The OSC may reject any employers who seek to enroll a portion of their employees and/or retirees on the recommendations of the Health Care Cost Containment Committee that a disproportionate share of medical risk will be shifted to the state employee plan. The bill does not specify what a "disproportionate share" is equal to.

The state health plan is currently self-insured, whereby the state pays the cost of claims incurred versus a set premium. Premiums are established for the state employee and retiree health plan based on the medical risk associated with state employees, retirees and their dependents. Allowing nonstate public employers to join the state plan may result in a cost to the state if the premiums established for the state plan and extended to municipalities are less than actual claims incurred for the employer.[2] Section 5 of the bill requires OSC to develop procedures which include addressing how premiums made in excess of incurred claims will be refunded to the employer, therefore it is not anticipated there will be a gain to the state in the event

[1] Nonstate public employers are defined as municipalities or other political subdivisions of the state, including a board of education, quasi-public agency, or public library.

[2] The bill requires the premiums for municipalities to be equal to that for state employees (state and employee share) and does not include a reserve built into the premium.

premiums are greater than claims. The bill may result in a savings to municipalities if the premiums to join the state plan are less than their current rates.

The bill is not anticipated to result in any additional administrative costs to OSC as the agency currently operates the Partnership Plan on a non-pooled basis for municipalities. It is unclear to what extent the Partnership Plan will continue to operate in addition to the pooled plan created in the bill or if the pooled plan will replace the Partnership Plan. In the event there are administrative expenses related to the plan, the bill allows OSC to charge participating municipalities an administrative fee to cover those costs.

The bill requires the State Employees' Bargaining Agent Coalition's approval before municipalities can be pooled with the state plan.

The Out Years

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

OLR Bill Analysis

sSB 913

AN ACT CONCERNING HEALTH CARE DATA REPORTING AND THE ENROLLMENT OF NONSTATE PUBLIC EMPLOYEES IN THE STATE EMPLOYEE HEALTH PLAN.

SUMMARY:

This bill requires the comptroller to offer nonstate public employers and their employees and retirees coverage under the state employee health insurance plan. It defines "nonstate public employer" as a municipality or other state political subdivision, including a board of education, quasi-public agency, or public library. A municipality and a board of education may be considered separate employers.

It requires such nonstate employees to be pooled with the state employee plan as long as their employer's application meets the bill's requirements. Premium payments for such coverage must be set at the same rate as those for the state plan and may include state employee or retiree contributions. It permits the comptroller to charge an administrative fee.

The bill requires a nonstate public employer to pay monthly premiums to the comptroller in an amount he determines for providing coverage for the group's employees and retirees. It permits an employer to require a covered employee or retiree to pay part of the coverage cost, subject to any applicable collective bargaining agreement.

If an employer seeks to admit fewer than 100% of its employees, the comptroller must forward the application to the Health Care Cost Containment Committee (HCCC) to review it for a potential disproportionate shift of an employer's medical risks. If the committee finds a disproportionate shift, then the comptroller must deny the

application. The bill outlines the application process and other details related to joining the state plan.

Further, the bill prohibits the comptroller from admitting nonstate employees into the state employee pool unless the State Employees' Bargaining Agent Coalition consents to the bill's terms and submits this consent to both chambers of the General Assembly.

The bill requires entities that issue or administer group health insurance policies for certain municipal employers, by October 1, 2015, and municipalities that sponsor these policies for their employees or retirees, by October 1, 2016, to begin annually submitting specific policy and claims-related information to the state comptroller. The information must cover policies providing (1) basic hospital or medical-surgical expense coverage, (2) major medical expense coverage, (3) hospital or medical service plan contracts, (4) hospital and medical coverage for health care center subscribers, and (5) single service ancillary health coverage.

Lastly, the bill allows the comptroller to (1) convene a temporary working group to develop health care provider payment reforms for state employee group health plans and (2) enter into a cooperative agreement with certain group health insurers, administrators, and health care providers under certain conditions. The comptroller must report on the group's recommendations by January 1, 2017.

EFFECTIVE DATE: October 1, 2015 for the health insurance pooling provisions and July 1, 2015 for the insurance data provisions.

§§ 4-8 — POOLING NONSTATE PUBLIC EMPLOYEES IN THE STATE EMPLOYEE PLAN

The bill requires the comptroller to offer to any nonstate public employer coverage under the state employee health insurance plan for its nonstate public employees and retirees. Under the bill, nonstate public employees include employees and elected officials.

It requires that such nonstate participants be pooled with the state

employee plan as long as the employer application meets the bill's requirements. Current law permits the comptroller to provide insurance to these same employees and employers under another state plan, known as the partnership plan, but it does not pool them with state employees. Thus, the existing law created a separate insurance pool.

Premium payments for such coverage must be at the same rate as those for the state plan including state employee contributions, and the employer must make payments to the comptroller. It permits the comptroller to charge a monthly, per-member administrative fee. A nonstate public employer may require each nonstate public employee to contribute a portion of the cost of his or her coverage under the plan, subject to any collective bargaining obligation applicable to such nonstate public employer.

The bill specifies that it does not (1) require the comptroller to offer coverage to every nonstate public employer seeking coverage under the state employee plan and (2) prohibit the comptroller from procuring coverage for nonstate public employees from other vendors who are not providing state employee coverage.

§ 5 — Application Process

The bill requires the comptroller to create applications for coverage under, and renewal of, the state employee plan. The applications must require a nonstate public employer to disclose whether it will offer any other health care benefits plan to employees offered the state employee plan. Specifically, the bill bans employees covered by a nonstate public employer with a health plan or insurance arrangement operated through a trust established according to collective bargaining under the federal Labor Management Relations Act.

The bill permits a nonstate public employer to submit an application for coverage under the state employee plan to the comptroller. If an employer's application is for coverage of all of its nonstate public employees, the comptroller must provide coverage by the first day of

the third calendar month following such application (at least 60 days and as many as 90 days).

If a nonstate public employer applies for coverage for less than all of its nonstate public employees, or indicates that it will offer other health plans to the employees who are offered the state health plan, the comptroller must forward the application to the HCCC for review within five business days after receiving it. This requirement does not apply if the employer is not covering all employees because (1) some employees have declined coverage on their own or (2) the employer has chosen not to cover temporary, part-time, or durational employees.

§ 5 — Disproportionate Medical Risks

The bill requires the HCCC to examine the applications it receives to determine if the application will shift a significantly disproportional (presumably disproportionate) part of a nonstate public employer's medical risks to the state employee plan. It has 30 days after receiving the application to make this determination.

If HCCC certifies to the comptroller that the application will shift a significantly disproportionate part of an employer's medical risks to the state employee plan, the comptroller cannot provide that employer coverage. If HCCC does not certify that the application will shift a significantly disproportionate risk to the state employee plan, the comptroller must provide coverage by the first day of the third calendar month following the deadline for receiving the certification.

§ 5 — Collective Bargaining and Other Provisions

The bill requires a nonstate public employer's initial and continuing participation in the state employee plan to be a mandatory subject of collective bargaining and binding interest arbitration according to the same procedures and standards that apply to other mandatory subjects of bargaining under the state employee, municipal employee, or teacher bargaining laws.

The bill also requires that the state plan cannot be deemed (1) an unauthorized insurer, or (2) a multiple employer welfare arrangement.

It specifies that the bill overrides any state law that may conflict with this provision. Any licensed insurer in this state may conduct business with the state employee plan.

§ 6 — Retirees

The bill allows any nonstate public employer eligible to enroll its employees in the state employee plan under the bill to also apply for coverage of its retirees. Its premium must be the same as the state's, including any premiums paid by retired state employees. The bill otherwise provides the same criteria and mechanisms regarding retirees, including:

1. prohibiting approval of applications that shift a significantly disproportionate part of retiree medical risks to the state plan, and

2. the timeframes for an application's approval or rejection.

§ 5 — Plan Renewal and Withdrawal

The bill requires the comptroller to offer coverage in the plan for periods of at least three years.

He must also develop procedures for nonstate public employers already in the plan to (1) apply for renewal, or (2) withdraw from such coverage. A nonstate public employer can apply for renewal before the expiration of each interval.

The procedures must at least address:

1. the terms and conditions allowing a nonstate public employer to withdraw prior to the expiration date of the current coverage,

2. how premium payments or premium equivalent payments made in excess of incurred claims will be refunded to an employer, and

3. how the process of any unionized employees withdrawing from the plan must be in accordance with relevant state collective

bargaining law (state employee, municipal employee, or teachers).

§ 7 — Failure to Pay Plan Premiums and Plan Account

The bill requires a nonstate public employer to pay monthly premiums to the comptroller in an amount he determines for providing coverage for the group's employees and retirees. It permits an employer to require a covered employee or retiree to pay part of the coverage cost, subject to any applicable collective bargaining agreement.

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

The bill prohibits the treasurer or state officer from withholding state money from the group if doing so impedes receipt of any federal grant or aid.

State Employee Plan Premium Account

The bill establishes a separate, nonlapsing state employee plan premium account in the General Fund. The comptroller must (1) deposit the premiums collected from nonstate public employers, employees, and retirees into this account and (2) administer the account to pay claims and administrative fees to entities providing coverage or services under the plan.

§§ 1-4 — MUNICIPAL HEALTHCARE DATA REPORTING

The bill creates several new requirements regarding healthcare data for municipalities, insurers of municipal employees, and the comptroller.

§ 2 - Municipal Insurers' Report

By October 1, 2015, and annually thereafter, the bill requires certain entities to submit to the comptroller, for each covered municipal employer, the previous policy year's (1) complete medical, dental, and pharmaceutical utilization data, as applicable, and (2) annual claims paid, aggregated by practice type and service category, and reported separately for in- and out-of network providers and total number of claims paid. Covered municipal employers are municipalities and schools, taxing, or fire districts with at least 50 employees.

The reporting requirement applies to each insurer, health care center, hospital service corporation, medical service corporation, or other entity (1) delivering, issuing for delivery, renewing, amending, or continuing a covered employer's group health insurance policy and (2) providing either (a) only administrative services or (b) one of the specified types of coverage.

By law, policy issuers must provide this and other information to municipal employers upon request and the employer can provide it confidentially to the comptroller. The bill requires the reporting entities to submit this information electronically to the comptroller in a form prescribed by the comptroller, regardless of whether a covered municipal employer asked for the information. The disclosed information (1) can include only health information with identifiers removed, as required by federal regulations; (2) cannot be individually identifiable, as defined in federal regulations; and (3) must be allowed under the federal Health Insurance Portability and Accountability Act (HIPAA). The comptroller must keep the disclosed information confidential and it is not subject to state Freedom of Information Act disclosure.

§ 1 — Municipal Report

By October 1, 2016, and annually thereafter, the bill requires municipalities that sponsor group health policies or plans that provide the types of coverage specified above for their active employees or retirees to submit information to the comptroller. The required

information, which must be submitted electronically in a form prescribed by the comptroller, is:

1. a list of each of the municipality's offered group health policies or plans and their specific details including (a) covered benefits and benefit limits, (b) total premium costs or premium equivalent costs for each policy or plan, organized by coverage tier, including single, two-person, and family, including dependents, and (c) the employee, early retiree, or retiree share for each total premium cost;

2. cost-sharing requirements, such as coinsurance, copayments, deductibles, and other out-of-pocket expenses associated with in-network and out-of-network providers;

3. the value of any prescription drug plan rebates or cost reductions;

4. the total number of employees, early retirees, and retirees in each policy or plan, organized by (a) municipal department, (b) collective bargaining unit, if applicable, (c) coverage tier, and (d) active employee, early retiree, or retiree status; and

5. the percentage change in per-person policy or plan costs over the preceding two policy or plan years.

The bill prohibits municipalities from including health information in submitting this information.

§ 3 — Comptroller's Working Group

The bill allows the comptroller to convene a temporary working group, from July 1, 2015 to June 30, 2016, to develop and establish health care provider payment reforms for the group health insurance plans offered state employees. The reforms can include multi-payer initiatives, patient-centered medical homes, primary care case management, value-based purchasing, and bundled purchasing.

The comptroller cannot require any parties to participate in the

group, which can include:

1. health insurance companies, health care centers, hospital service corporations, medical service corporations, or other entities delivering, issuing for delivery, renewing, amending, or continuing group health insurance plans;

2. third-party administrators providing only administrative services for the state's self-insured plans;

3. health care providers;

4. health care facilities;

5. the Office of Policy and Management; and

6. state employees and retirees.

§ 3 — Working Group Survey and Meetings

The bill allows the comptroller, or his designee, to (1) survey the non-governmental entities eligible to participate in the working group about payment delivery reforms and (2) convene working group meetings at a time and place convenient to all participants. The comptroller, or his designee, must ensure that the survey and working group participants do not solicit, share, or discuss pricing information.

The bill specifies that the survey and working group meetings are not (1) violations of the state's Anti-Trust Act or (2) subject to the state Freedom of Information Act's disclosure or notice requirements.

§ 3 — Cooperative Agreements

The bill allows the comptroller to enter into cooperative agreements with any of the non-governmental entities eligible to participate in the working group if he determines that it will likely produce efficiencies and improvements in health care outcomes. The agreements can be to (1) identify and reward high-quality, low-cost health care providers or (2) create incentives for enrollees to (a) receive care from such providers or (b) promote personal health behaviors that prevent or

effectively manage chronic diseases, including tobacco cessation, weight control, and physical activity.

The comptroller can establish guidelines for these agreements, which must be consistent with federal and state antitrust laws and Federal Trade Commission regulations.

§ 3 — Report

By January 1, 2017, the comptroller must report to the Appropriations, Labor, and Public Health committees on the working group's recommendations. The report must include (1) any cost containment measures, (2) descriptions of any quality measurement or quality improvement initiatives implemented at the working group's recommendation, and (3) any cost savings or health outcome improvements associated with these measures or initiatives.

COMMITTEE ACTION

Labor and Public Employees Committee

Joint Favorable Substitute
Yea 6 Nay 5 (03/12/2015)