General Assembly

Raised Bill No. 5379

February Session, 2018

LCO No. **1896**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT ESTABLISHING A STATE INDIVIDUAL HEALTH CARE RESPONSIBILITY FEE AND THE CONNECTICUT HEALTH CARE SAVINGS PROGRAM.

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

Section 1. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this section, unless the context otherwise requires:

(1) "Adjusted gross income" has the same meaning as in section 12-701 of the general statutes.

(2) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time.

(3) "Applicable dollar amount" means, with respect to any applicable individual for any calendar year, six hundred ninety-five dollars multiplied by the cost-of-living adjustment for such calendar year, except that if the total amount following any increase over six hundred ninety-five dollars is not a multiple of fifty dollars, the total amount shall be rounded to the next lowest multiple of fifty dollars. Notwithstanding any provision of this subdivision to the contrary, if an applicable individual is eighteen years of age or younger during

any portion of a month, the "applicable dollar amount" for such applicable individual for such month shall be equal to one-half of the amount calculated under this subdivision for the calendar year that includes such month.

(4) "Applicable individual" means, with respect to any month, an individual who (A) is a citizen or national of the United States or an alien lawfully present in the United States, (B) is not a member of an Indian tribe as defined in Section 45A(c)(6) of the Internal Revenue Code, (C) is not incarcerated, unless such individual is incarcerated pending the disposition of charges, and (D) has not received an exemption from the exchange pursuant to subdivision (15) of section 38a-1084 of the general statutes, as amended by this act, because such individual has not certified that such individual is (i) a member of a recognized religious sect or division thereof described in Section 1402(g)(1) of the Internal Revenue Code, and (ii) an adherent of the established tenets or teachings of such religious sect or division.

(5) "Cost-of-living adjustment" means the cost-of-living adjustment determined under Section 1(f)(3) of the Internal Revenue Code for a calendar year by substituting "calendar year 2015" for "calendar year 1992" in Section 1(f)(3)(B) of the Internal Revenue Code, as said sections were in effect on April 15, 2017.

(6) "Dependent" has the same meaning as in Section 152 of the Internal Revenue Code.

(7) "Eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to an employee, including a grandfathered health plan.

(8) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081 of the general statutes.

(9) "Family size" means, with respect to a taxpayer for a taxable

year, the number of individuals for whom the taxpayer is allowed a deduction under Section 151 of the Internal Revenue Code for the taxable year.

(10) "Grandfathered health plan" has the same meaning as in the Affordable Care Act.

(11) "Gross income" means gross income for federal income tax purposes.

(12) "Household income" means, with respect to a taxpayer for a taxable year, the taxpayer's modified adjusted gross income for the taxable year plus the modified adjusted gross incomes of all other individuals (A) for whom such taxpayer is allowed a deduction under Section 151 of the Internal Revenue Code for such taxable year, and (B) who were required to file a return of the tax imposed by Section 1 of the Internal Revenue Code for such taxable year.

(13) "Internal Revenue Code" means the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time.

(14) "Joint return" means a joint return filed under the federal income tax for a taxable year.

(15) (A) "Minimum essential coverage" means (i) coverage under the Medicare program under Part A or C of Title XVIII of the Social Security Act, (ii) coverage under the Medicaid program under Title XIX of the Social Security Act, (iii) coverage under the Children's Health Insurance Program under Title XXI of the Social Security Act, (iv) medical coverage under 10 USC Chapter 55, including coverage under the Tricare program, (v) coverage under a health care program under 38 USC Chapter 17 or 18, (vi) coverage for United States Peace Corps volunteers under 22 USC 2504(e), (vii) coverage under the Nonappropriated Fund Health Benefits Program of the United States Department of Defense established under Section 349 of the National

Defense Authorization Act for Fiscal Year 1995, P.L. 103-337, (viii) coverage under an eligible employer-sponsored plan, (ix) coverage under a health plan offered in the individual market as defined in Section 1304 of the Affordable Care Act, (x) coverage under a grandfathered health plan, or (xi) coverage under any other qualified health plan.

(B) "Minimum essential coverage" does not mean any health insurance coverage that consists of coverage of excepted benefits described in (i) Section 2791(c)(1) of the Public Health Service Act, 42 USC 300gg-91(c)(1), as amended by the Affordable Care Act, or (ii) Section 2791(c)(2), (3) or (4) of the Public Health Service Act, 42 USC 300gg-91(c)(2), (3) or (4), as amended by the Affordable Care Act, if such benefits are provided under a separate policy, certificate or contract of insurance.

(16) "Modified adjusted gross income" means adjusted gross income increased by (A) any amount excluded from gross income under Section 911 of the Internal Revenue Code, and (B) any amount of interest received or accrued by a taxpayer during a taxable year that is exempt from the federal income tax.

(17) "Qualified health plan" has the same meaning as in section 38a-1080 of the general statutes.

(18) "Required contribution" means the following, whichever is less: (A) For an applicable individual eligible to purchase minimum essential coverage through an eligible employer-sponsored plan, only the portion of the annual premium for such eligible employer-sponsored plan payable by the applicable individual to cover such applicable individual, regardless of whether such portion is paid through a salary reduction; or (B) for an applicable individual eligible to purchase minimum essential coverage only through the individual market, as defined in Section 1304 of the Affordable Care Act, the annual premium for the lowest cost bronze-level plan, or, if no bronze-

level plan is available, silver-level plan, available in the individual market through the exchange in the rating area in which the applicable individual resides, reduced by the amount of the credit allowable under Section 36B of the Internal Revenue Code for the applicable taxable year, determined as if the applicable individual was covered by a qualified health plan offered through such exchange for the entire applicable taxable year. For the purposes of subparagraph (A) of this subdivision, if an applicable individual is eligible for minimum essential coverage through an eligible employer-sponsored plan by reason of the applicable individual's relationship to an employee, the determination under subparagraph (A) of this subdivision shall be made by reference to that portion of the premium payable by the employee for family coverage.

(19) "Resident of this state" has the same meaning as in section 12-701 of the general statutes.

(20) "Taxable year" means the same accounting period as a taxpayer's taxable year for federal income tax purposes, or that portion of such year as either commences when the taxpayer becomes a resident of this state or ends when the taxpayer ceases to be a resident of this state.

(21) "Taxpayer" means any resident of this state who is a taxpayer within the meaning of Section 5000A of the Internal Revenue Code.

(b) (1) Each taxpayer shall, for each month beginning on or after January 1, 2019, ensure that such taxpayer, if such taxpayer is an applicable individual, and each dependent of such taxpayer, if such dependent is an applicable individual, maintains minimum essential coverage.

(2) For the purposes of subdivision (1) of this subsection, an applicable individual shall be deemed to have maintained minimum essential coverage for any month during which the applicable individual is not a resident of this state if:

(A) Such month occurs during any period described in Section 911(d)(1)(A) or (B) of the Internal Revenue Code that is applicable to such applicable individual;

(B) Such applicable individual is a bona fide resident of any possession of the United States, as determined under Section 937(a) of the Internal Revenue Code, for such month; or

(C) Such applicable individual is a bona fide resident of any other state of the United States for such month.

(c) (1) (A) If a taxpayer who is an applicable individual, or an applicable individual for whom a taxpayer is liable under subparagraph (B) or (C) of this subdivision, fails to maintain minimum essential coverage pursuant to subsection (b) of this section, the taxpayer shall, except as set forth in subdivision (2) of this subsection, pay a state individual health care responsibility fee in an amount determined under subsection (d) of this section.

(B) If an applicable individual fails to maintain minimum essential coverage for any month beginning on or after January 1, 2019, and a taxpayer claims such applicable individual as a dependent for the taxable year that includes such month, the taxpayer who claims such applicable individual as a dependent for such taxable year shall be liable for the dependent's failure to maintain minimum essential coverage for such month.

(C) If a taxpayer, who is an applicable individual, fails to maintain minimum essential coverage for any month beginning on or after January 1, 2019, and files a joint return with another taxpayer for the taxable year that includes such month, both taxpayers who file the joint return shall be jointly liable for the taxpayer's failure to maintain minimum essential coverage for such month.

(2) No fee shall be imposed on a taxpayer under subdivision (1) of this subsection with respect to an applicable individual for a month:

(A) (i) During which sufficient funds have been deposited for such applicable individual in an individual savings account established pursuant to sections 2 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act, that includes such applicable individual as a designated beneficiary, as defined in section 2 of this act.

(ii) For the purposes of applying subparagraph (A)(i) of this subdivision, sufficient funds have been deposited in an individual savings account established pursuant to sections 2 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act, for an applicable individual if the deposit is not less than one-twelfth of nine and sixty-six hundredths per cent of the taxpayer's household income for the taxable year that includes such month.

(B) (i) If the last day of the month occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than three months.

(ii) For the purposes of applying subparagraph (B)(i) of this subdivision, (I) the length of the continuous period shall be determined without regard to the calendar years during which the months in such period occurred, (II) if a continuous period is longer than the period allowed under subparagraph (B)(i) of this subdivision, no exception shall be provided under subparagraph (B)(i) of this subdivision for any month during such period, and (III) if there is more than one continuous period described in subparagraph (B)(i) of this subdivision covering months in any single calendar year, the exception provided by subparagraph (B)(i) of this subdivision shall only apply to months in the first such period.

(d) (1) Except as provided in subdivision (3) of this subsection, the amount of the fee imposed under subsection (c) of this section on a taxpayer for a taxable year shall be equal to the lesser of:

(A) The sum of all monthly fee amounts, determined under subdivision (2) of this subsection, incurred by the taxpayer for all months during the taxable year;

(B) The annual premium for the lowest-cost qualified health plan offered through the exchange (i) that provides a silver level of coverage, (ii) for plan years that begin during the calendar year within which the taxable year ends, and (iii) that provides coverage for the taxpayer's family size;

(C) Nine and sixty-six hundredths per cent of the taxpayer's household income for the taxable year; or

(D) Ten thousand dollars.

(2) For the purposes of subparagraph (A) of subdivision (1) of this subsection, the monthly fee amount for a taxpayer for any month during which a failure described in subsection (b) of this section occurs shall be equal to one-twelfth of the amount calculated under subparagraph (A) or (B) of this subdivision, whichever is greater:

(A) An amount equal to the lesser of:

(i) The sum of all applicable dollar amounts for all applicable individuals with respect to whom such failure occurred during such month; or

(ii) Three hundred per cent of the applicable dollar amount, calculated for an applicable individual who is eighteen years of age or older during the entire calendar year, for the calendar year within which the taxable year ends.

(B) An amount equal to two and one-half per cent of the excess of

the taxpayer's household income for the taxable year over the amount of gross income specified in Section 6012(a)(1) of the Internal Revenue Code with respect to the taxpayer for the taxable year.

(3) If a taxpayer is subject to the fee imposed under subsection (c) of this section and the penalty imposed under Section 5000A of the Internal Revenue Code for a taxable year, the amount of the fee calculated under this subsection for the taxpayer for the taxable year shall be reduced by the amount of the penalty imposed on such taxpayer under Section 5000A of the Internal Revenue Code for such taxable year, except that any reduction under this subdivision shall not reduce such taxpayer's liability under this section to less than zero.

(e) (1) A taxpayer who incurs a fee under subsection (c) of this section for any month shall submit payment for such fee to the commissioner in cash or by check, draft or money order drawn to the order of the Commissioner of Revenue Services when the taxpayer files an income tax return pursuant to chapter 229 of the general statutes for the taxable year that includes such month.

(2) Notwithstanding any provision of the general statutes, the commissioner shall not file any levy or notice of lien against any property by reason of a taxpayer's failure to pay the fee imposed under subsection (c) of this section.

(3) Notwithstanding any provision of the general statutes, a taxpayer shall not be criminally liable for failure to pay the fee imposed under subsection (c) of this section.

(4) The commissioner shall deposit all payments received under subdivision (1) of this subsection in the General Fund.

(f) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 2. (NEW) (*Effective January 1, 2019*) (a) As used in this section and sections 3 to 6, inclusive, of this act:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time;

(2) "Affordable qualified health plan" means a qualified health plan if the cost of such plan does not exceed nine and sixty-six hundredths per cent of the taxpayer's household income for the taxable year;

(3) "Applicable individual" has the same meaning as in section 1 of this act;

(4) "Dependent" means an applicable individual who is a dependent, as defined in section 1 of this act, of an eligible individual;

(5) "Depositor" means any person making a deposit, payment, contribution, gift or other deposit to the trust pursuant to a participation agreement;

(6) "Designated beneficiary" means (A) an eligible individual who has established, and is the owner of, an account established under the provisions of this section and sections 3 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act, and (B) any dependent of an eligible individual described in subparagraph (A) of this subdivision;

(7) "Eligible individual" means a taxpayer who (A) is required to maintain minimum essential coverage pursuant to subsection (b) of section 1 of this act, and (B) has received a certificate from the exchange pursuant to subparagraph (B)(ii) of subdivision (15) of section 38a-1084 of the general statutes, as amended by this act, indicating that such taxpayer is unable to secure coverage under an affordable qualified health plan;

(8) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 38a-1081 of the general statutes;

(9) "Health care expenses" means expenses for health care services incurred by a designated beneficiary;

(10) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(11) "Individual market" has the same meaning as in Section 1304 of the Affordable Care Act;

(12) "Minimum essential coverage" has the same meaning as in section 1 of this act;

(13) "Participation agreement" means the agreement between the trust and depositors for participation in a savings plan for a designated beneficiary;

(14) "Qualified health plan" means the lowest-cost qualified health plan, as defined in section 38a-1080 of the general statutes, offered through the exchange (A) in the individual market, (B) that provides a silver level of coverage, (C) for plan years that begin during the calendar year within which a particular taxable year ends, and (D) that provides coverage for a taxpayer's family size;

(15) "Taxable year" has the same meaning as in section 1 of this act;

(16) "Taxpayer" has the same meaning as in section 1 of this act; and

(17) "Trust" means the Connecticut Health Care Trust Fund established under the provisions of this section and sections 3 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision

(26) of section 38a-1084 of the general statutes, as amended by this act.

(b) There is established the Connecticut Health Care Savings Program to allow eligible individuals to plan for health care expenses that are not covered by an affordable qualified health plan. The exchange shall establish the Connecticut Health Care Trust Fund, which shall be comprised of individual savings accounts for those health care expenses incurred by eligible individuals and their dependents who are not covered by an affordable qualified health plan. Withdrawals from the fund may be used for health care expenses, upon receipt by the fund of a certification signed by an appropriately licensed health care provider, that a designated beneficiary is in need of health care services. Upon the death of the eligible individual who opened an individual savings account, any available funds in such account shall be an asset of the estate of such eligible individual.

Sec. 3. (NEW) (*Effective January 1, 2019*) Participation in the trust and the offering and solicitation of the trust are exempt from sections 36b-16 and 36b-22 of the general statutes.

Sec. 4. (NEW) (*Effective January 1, 2019*) The state pledges to depositors, designated beneficiaries and with any party who enters into contracts with the trust pursuant to the provisions of this section, sections 2 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act, that the state will not limit or alter the rights under said sections vested in the trust or contract with the trust until such obligations are fully met and discharged and such contracts are fully performed on the part of the trust, provided nothing contained in this section shall preclude such limitation or alteration if adequate provision is made by law for the protection of such depositors and designated beneficiaries pursuant to the obligations of the trust or parties who entered into such contracts with the trust. The trust, on

behalf of the state, may include this pledge and undertaking for the state in participation agreements and such other obligations or contracts.

Sec. 5. (NEW) (*Effective January 1, 2019*) (a) The Connecticut Health Care Trust Fund shall constitute an instrumentality of the state and shall perform essential governmental functions, as provided in this section, sections 2 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act. The trust shall receive and hold all payments and deposits or contributions intended for the trust, as well as gifts, bequests, endowments or federal, state or local grants and any other funds from any public or private source and all earnings until disbursed in accordance with section 2 of this act.

(b) The amounts on deposit in the trust as individual savings accounts shall not constitute property of the state and such amounts shall not be construed to be a department, institution or agency of the state. Amounts on deposit in the trust shall not be commingled with state funds and the state shall have no claim to or against, or interest in, such funds. Any contract entered into by or any obligation of the trust shall not constitute a debt or obligation of the state and the state shall have no obligation to any designated beneficiary or any other person on account of the trust and all amounts obligated to be paid from the trust shall be limited to amounts available for such obligation on deposit in the trust. The amounts on deposit in the trust may only be disbursed in accordance with the provisions of this section, sections 2 to 6, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act. The trust shall continue in existence as long as it holds any deposits or has any obligations and until its existence is terminated by law. Upon termination, any unclaimed assets shall return to the state.

(c) The trust shall not receive deposits in any form other than cash. No depositor or designated beneficiary may direct the investment of any contributions or amounts held in the trust other than in the specific fund options provided for by the trust.

Sec. 6. (NEW) (*Effective January 1, 2019*) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement sections 2 to 5, inclusive, of this act, subdivision (23) of subsection (c) of section 38a-1083 of the general statutes, as amended by this act, and subdivision (26) of section 38a-1084 of the general statutes, as amended by this act.

Sec. 7. Subsection (c) of section 38a-1083 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(c) The exchange is authorized and empowered to:

(1) Have perpetual succession as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) Adopt an official seal and alter the same at pleasure;

(3) Maintain an office in the state at such place or places as it may designate;

(4) Employ such assistants, agents, managers and other employees as may be necessary or desirable;

(5) Acquire, lease, purchase, own, manage, hold and dispose of real and personal property, and lease, convey or deal in or enter into agreements with respect to such property on any terms necessary or incidental to the carrying out of these purposes, provided all such acquisitions of real property for the exchange's own use with amounts appropriated by this state to the exchange or with the proceeds of bonds supported by the full faith and credit of this state shall be

subject to the approval of the Secretary of the Office of Policy and Management and the provisions of section 4b-23;

(6) Receive and accept, from any source, aid or contributions, including money, property, labor and other things of value;

(7) Charge assessments or user fees to health carriers that are capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the operations of the exchange and impose interest and penalties on such health carriers for delinquent payments of such assessments or fees;

(8) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable;

(9) Invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state and in obligations that are legal investments for savings banks in the state;

(10) Issue bonds, bond anticipation notes and other obligations of the exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes and mortgages of others;

(11) Borrow money for the purpose of obtaining working capital;

(12) Account for and audit funds of the exchange and any recipients of funds from the exchange;

(13) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers. The contracts entered into by the exchange shall not be subject to the approval of any other state department, office or agency, provided copies of all contracts of the exchange shall be maintained by the exchange as public records, subject to the proprietary rights of any

party to the contract;

(14) To the extent permitted under its contract with other persons, consent to any termination, modification, forgiveness or other change of any term of any contractual right, payment, royalty, contract or agreement of any kind to which the exchange is a party;

(15) Award grants to trained and certified individuals and institutions that will assist individuals, families and small employers and their employees in enrolling in appropriate coverage through the exchange. Applications for grants from the exchange shall be made on a form prescribed by the board;

(16) Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices;

(17) Evaluate jointly with the **[**SustiNet**]** Health Care Cabinet, established pursuant to section 19a-725, the feasibility of implementing a basic health program option as set forth in Section 1331 of the Affordable Care Act;

(18) Establish one or more subsidiaries, in accordance with section 38a-1093, to further the purposes of the exchange;

(19) Make loans to each subsidiary established pursuant to section 38a-1093 from the assets of the exchange and the proceeds of bonds, bond anticipation notes and other obligations issued by the exchange or assign or transfer to such subsidiary any of the rights, moneys or other assets of the exchange, provided such assignment or transfer is not in violation of state or federal law;

(20) Sue and be sued, plead and be impleaded;

(21) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the

exchange; **[**and**]**

(22) Do all acts and things necessary and convenient to carry out the purposes of the exchange, provided such acts or things shall not conflict with the provisions of the Affordable Care Act, regulations adopted thereunder or federal guidance issued pursuant to the Affordable Care Act; and **[.]**

(23) On behalf of the Connecticut Health Care Trust Fund, established pursuant to this subdivision, sections 2 to 6, inclusive, of this act, and subdivision (26) of section 38a-1084, as amended by this act:

(A) Establish consistent terms for each participation agreement, bulk deposit, coupon or installment payments, including, but not limited to, (i) the method of payment into the trust by payroll deduction, transfer from bank accounts or otherwise, (ii) the termination, withdrawal or transfer of payments under the trust, including transfers to a health care provider, (iii) penalties for distributions not used or made in accordance with this subdivision, (iv) changing the identity of the designated beneficiary or designated beneficiaries, as defined in section 2 of this act, and (v) any charges or fees in connection with the administration of the trust;

(B) Enter into one or more contractual agreements, including contracts for legal, actuarial, accounting, custodial, advisory, management, administrative, advertising, marketing and consulting services for the trust and pay for such services from the gains and earnings of the trust;

(C) Apply for and accept and expend gifts, grants or donations from public or private sources to enable the trust to carry out its objectives;

(D) Sue and be sued; and

(E) Take any other action necessary to carry out the purposes of this

subdivision, sections 2 to 6, inclusive, of this act, and subdivision (26) of section 38a-1084, as amended by this act, and incidental to the duties imposed on the exchange pursuant thereto.

Sec. 8. Section 38a-1084 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

The exchange shall:

(1) Administer the exchange for both qualified individuals and qualified employers;

(2) Commission surveys of individuals, small employers and health care providers on issues related to health care and health care coverage;

(3) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under Section 1311(c) of the Affordable Care Act, and section 38a-1086, of health benefit plans as qualified health plans;

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(5) Provide for enrollment periods, as provided under Section 1311(c)(6) of the Affordable Care Act;

(6) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans including, but not limited to, the enrollee satisfaction survey information under Section 1311(c)(4) of the Affordable Care Act and any other information or tools to assist enrollees and prospective enrollees evaluate qualified health plans offered through the exchange;

(7) Publish the average costs of licensing, regulatory fees and any

other payments required by the exchange and the administrative costs of the exchange, including information on moneys lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(8) On or before the open enrollment period for plan year 2017, assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the Affordable Care Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the Affordable Care Act;

(9) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(10) Inform individuals, in accordance with Section 1413 of the Affordable Care Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the application by the exchange, that such individual is eligible for any such program;

(11) Collaborate with the Department of Social Services, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under Section 36B of the Internal Revenue Code and is eligible for HUSKY A or any other state or local public program, to remain enrolled in a qualified health plan;

(12) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium

tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the Affordable Care Act;

(13) Establish a program for small employers through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(14) Offer enrollees and small employers the option of having the exchange collect and administer premiums, including through allocation of premiums among the various insurers and qualified health plans chosen by individual employers;

(15) (A) Grant a certification, subject to Section 1411 of the Affordable Care Act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

[(A)**]** (i) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

[(B)**]** (ii) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(B) (i) Grant a certification, subject to section 1 of this act, attesting that, for purposes of the state individual health care responsibility requirement or fee under section 1 of this act, an individual is exempt from the state individual health care responsibility requirement or fee imposed by said section because the individual meets the requirements for any exemption from such requirement or fee;

(ii) Grant a certification, subject to sections 2 to 6, inclusive, of this

act, subdivision (23) of subsection (c) of section 38a-1083, as amended by this act, and subdivision (26) of this section, as amended by this act, attesting that a taxpayer is unable to secure coverage under an affordable qualified health plan, as defined in section 2 of this act;

(16) (A) Provide to the Secretary of the Treasury of the United States the following:

[(A)**]** (i) A list of the individuals granted a certification under subparagraph (A) of subdivision (15) of this section, including the name and taxpayer identification number of each individual;

[(B)**]** (ii) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

[(i)**]** (I) The employer did not provide minimum essential health benefits coverage; or

[(ii)**]** (II) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

[(C)**]** (iii) The name and taxpayer identification number of:

[(i)**]** (I) Each individual who notifies the exchange under Section 1411(b)(4) of the Affordable Care Act that such individual has changed employers; and

[(ii)**]** (II) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(B) Provide to the Commissioner of Revenue Services the following:

(i) The information described in subparagraph (A) of this

subdivision; and

(ii) A list of the individuals and taxpayers granted a certification under subparagraph (B) of subdivision (15) of this section, including the name and taxpayer identification number of each individual and taxpayer;

(17) Provide to each employer the name of each employee, as described in subparagraph **[**(B)**]** (A)(ii) of subdivision (16) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(19) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the Affordable Care Act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the Affordable Care Act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that

plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(20) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(21) Credit the amount, in accordance with Section 10108 of the Affordable Care Act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(22) Consult with stakeholders relevant to carrying out the activities required under sections 38a-1080 to 38a-1090, inclusive, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations;

(23) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and

expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 38a-1080 to 38a-1089, inclusive, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications;

(24) (A) Seek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange, (B) encourage health carriers to offer tiered health care provider network plans that have different cost-sharing rates for different health care provider tiers and reward enrollees for choosing low-cost, high-quality health care providers by offering lower copayments, deductibles or other out-of-pocket expenses, and (C) offer any such tiered health care provider network plans through the exchange; **[**and**]**

(25) Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative

impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange; and **[.]**

(26) On behalf of the Connecticut Health Care Trust Fund, established pursuant to this subdivision, sections 2 to 6, inclusive, of this act, and subdivision (23) of subsection (c) of section 38a-1083, as amended by this act:

(A) Invest the amounts on deposit in the trust in a manner reasonable and appropriate to achieve the objectives of the trust, exercising the discretion and care of a prudent person in similar circumstances with similar objectives;

(B) Give due consideration to rate of return, risk, term or maturity, diversification of the total portfolio within the trust, liquidity, the projected disbursements and expenditures, and the expected payments, deposits, contributions and gifts to be received;

(C) Not require the trust to invest directly in the obligations of the state or any political subdivision of the state or in any investment or other fund administered by the state;

(D) Continuously invest and reinvest the assets of the trust in a manner consistent with the objectives of the trust until disbursed for health care expenses, as defined in section 2 of this act, expended on expenses incurred by the operations of the trust, or refunded to the depositor or eligible individual, as defined in section 2 of this act, on the conditions provided in the participation agreement, as defined in section 2 of this act;

(E) Obtain written advice of counsel or written advice from the Securities Exchange Commission, or both, that the trust and the offering of participation in the trust are not subject to federal securities laws; and

(F) Be responsible for the receipt, maintenance, administration, investing and disbursements of amounts from the trust.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section
Sec. 4	*January 1, 2019*	New section
Sec. 5	*January 1, 2019*	New section
Sec. 6	*January 1, 2019*	New section
Sec. 7	*January 1, 2019*	38a-1083(c)
Sec. 8	*January 1, 2019*	38a-1084

Statement of Purpose:

To establish (1) a state individual health care responsibility fee for taxpayers who fail to maintain minimum essential health insurance coverage, and (2) the Connecticut Health Care Savings Program.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]