OLR Bill Analysis

sSB 134

AN ACT CONCERNING PUBLIC OPTIONS FOR HEALTH CARE IN CONNECTICUT.

SUMMARY

This bill requires the comptroller to establish the ConnectHealth Plan, a "public option" health insurance program for Connecticut enrollees beginning January 1, 2021. Among other things, the plan must:

1. offer coverage that meets or exceeds coverage provided by qualified health plans (QHPs), including covering all 10 essential health benefits, without charging cost-sharing that exceeds QHP levels; and

2. within available appropriations, provide state financed cost-sharing subsidies for certain enrollees who do not qualify for federal Affordable Care Act (ACA) subsidies.

Certain plan provisions, including payment schedules and state subsidies, require legislative approval. The bill also establishes the (1) ConnectHealth Trust Account, which the comptroller can use to lower premiums and provide subsidies and (2) ConnectHealth Advisory Council, which must help design and administer the plan.

The bill allows the comptroller to offer nonstate public employers coverage under another group health insurance plan he creates, rather than through the state health insurance plan as required under current law. By law, a "nonstate public employer" is a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library.

Under the bill, the comptroller must also either (1) establish a group health insurance and pharmacy plan for private employers with less

than 50 employees or (2) allow these small employers to join the state health insurance plan. Under the bill a "small employer" has between one and 50 employees and excludes nonstate public employers (i.e., municipalities). (Opening up the state health insurance plan to private employers may impact the state's federal Employee Retirement Income Security Act (ERISA) exemptions, see BACKGROUND.)

The bill also makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2019

§§ 1 - 5 — CONNECTHEALTH

Under the bill, the comptroller must establish the ConnectHealth Program to offer Connecticut enrollees high-quality, low-cost health insurance coverage under the ConnectHealth Plan.

Plan Design and Administration

The comptroller, within available appropriations and in consultation with the Office of Health Strategy (OHS) and the ConnectHealth Advisory Council, which the bill creates, must:

1. design the plan, including establishing enrollment criteria;

2. implement a competitive process to select and contract with a third-party administrator (TPA) to administer the plan, and allow it to directly receive individual premiums and federal premium tax credits in accordance with federal law; and

3. determine whether to offer the plan through the state health exchange (i.e., AccessHealthCT) as a QHP.

The comptroller may also, at his discretion and within available appropriations, use third-party actuaries, professionals, and specialists he deems necessary to establish and administer the plan.

The bill also requires the comptroller, ConnectHealth advisory council, and OHS to:

1. establish a schedule of payments and reimbursement rates,

2. provide, within available appropriations, state financed cost-sharing subsidies for enrollees who do not qualify for ACA subsidies (including establishing eligibility criteria, recommended subsidy amounts, and a plan to administer and disburse them); and

3. seek a federal Section 1332 waiver from the federal departments of Health and Human Services and Treasury. (The bill does not specify the waiver's purpose. A 1332 waiver is named after an authorizing section of the ACA and allows a state to waive certain ACA requirements that might otherwise prohibit it from implementing certain programs.)

However, the bill requires them to submit proposals for these three provisions as part of a report to the Insurance and Real Estate Committee by March 1, 2020. Under the bill, if the committee does not act within 60 days, the proposals are deemed denied.

The comptroller, OHS, and advisory council must also include in the report:

1. a plan to implement the ConnectHealth plan and make it available by January 1, 2020;

2. strategies to ensure health care providers and facilities in the state participate in the plan; and

3. an analysis of ConnectHealth's likely impact on the state insurance market.

Benefit Design

The plan must provide coverage that meets or exceeds the level provided by QHPs, including covering all 10 essential health benefits (see BACKGROUND). In addition, the plan:

1. cannot charge premiums, deductibles, or cost-sharing that exceeds the amounts imposed by QHPs; and

2. must include an affordability scale for premiums, deductibles,

and enrollee cost-sharing that varies based on an enrollee's household income.

Plan Data

The comptroller, advisory council, and OHS must also use any data submitted to the all-payer claims database to evaluate, on an ongoing basis, the impact of ConnectHealth on (a) individuals, health care providers, and health care facilities in Connecticut and (b) the state individual and group health insurance markets.

ConnectHealth Trust Account

The bill establishes the ConnectHealth Trust Account as a separate, nonlapsing account within the General Fund. The money in the account must be used by the comptroller to lower the cost of the ConnectHealth Plan and provide state-financed cost-sharing subsidies for enrollees who do not qualify for ACA subsidies.

Under the bill, the account must contain any money required to be deposited into it by law. Investment earnings from the account must be credited back to it, and become part of the account's assets. Any balance remaining at the end of a fiscal year must be carried forward.

Regulations

The bill authorizes the comptroller to adopt implementing regulations for provisions related to the ConnectHealth Program, including the ConnectHealth Trust Account.

§ 3 — CONNECTHEALTH ADVISORY COUNCIL

The bill establishes the ConnectHealth Advisory Council consisting of 10 appointed voting members and six ex-officio, nonvoting members: the governor, lieutenant governor, comptroller, Office of Policy and Management secretary, and the insurance and social services commissioners. The appointed members are shown below in Table 1.

Table 1: ConnectHealth Advisory Council Members

Appointing	*Number of*	*Initial Term*	*Appointees*

Authority	*Appointments*		
House speaker	Two	Five years	One must represent hospitals, and the other must represent community-based health care providers
Senate president pro tempore	Two	Five years	One must represent consumers, and the other must represent nurses
House majority leader	One	Four years	Patient representative
Senate majority leader	One	Four years	Health policy expert
House minority leader	Two	Three years	One must represent individual health insurers and the other must represent physicians practicing in the state
Senate minority leader	Two	Three years	One must represent small-group health insurers and the other must represent licensed insurance producers

Initial appointments must be made by October 1, 2019, or the Senate president pro tempore and the House speaker must jointly appoint a council member on behalf of the original appointing authority. Such an appointee serves a full term.

Under the bill, all terms expire on June 30, presumably in the year following an appointee's full term. At least 30 days before a term expires, the appointing authority must reappoint the current council member or appoint a new member. All members are eligible for reappointment. Board vacancies must be filled for the unexpired term by the original appointing authority.

After the initial term, all advisory council members serve five-year terms and until a successor is appointed. Any member may be removed by the appointing authority for misfeasance, malfeasance, or

willful neglect of duty.

The advisory council members must select a chairperson from their members, and may establish rules for its internal procedures. At least six council members are required for a quorum.

Under the bill, the council is not a state department, institution, or agency.

Council Duties. The council must advise the comptroller and OHS on the ConnectHealth Program, including on program implementation, affordability, marketing, outreach to prospective enrollees, and periodic evaluations.

Staffing. The Insurance and Real Estate Committee staff must provide the council's administrative support.

§§ 6, 7 & 10 — SMALL EMPLOYER GROUP HEALTH PLANS

Under the bill and regardless of any existing insurance law, the comptroller must (1) develop a group health insurance and pharmacy plan to offer to small employers or (2) allow small employers to purchase health insurance under the state employee plan. Under the bill, the comptroller is prohibited from offering coverage under the state employee plan without collective bargaining approval.

(Covering private employers through the state plan may risk the state's ERISA exemption, see BACKGROUND.)

The participating small employers must be pooled with the state employees and retirees under the state health insurance plan, provided the comptroller approves the small employer's plan application. Insurance premiums, which must be paid by small employers to the comptroller, must be the same paid by the state for state employees, inclusive of any premiums state employees pay, except that they may be adjusted for geographic cost-of-living and network differences. Specifically, they may be adjusted for:

1. the cost of health care in the geographic area in which a majority

of the small employer's employees work,

2. differences in network and benefits as compared to those offered to state employees, and

3. the demographics of the employer's employees.

The bill requires geographic adjustments to be phased in over a two-year period for any existing participants. (Since the bill newly allows small employers such coverage, it is unclear which participants are subject to this provision.) Beginning July 1, 2020, the comptroller may charge each small employer participating in the state employee plan an administrative fee calculated on a per member per month basis.

The comptroller must offer the plan for participation intervals of at least three years (i.e., A small employer must agree to be included in the plan for terms of at least three years). An employer may apply for renewal before the interval expires.

Under the bill, the comptroller must develop procedures for small employers to apply for, renew, and withdraw from coverage, as well as any rules of participation he deems necessary. He must also establish accounting procedures to track claims and premium payments from participating small employers.

§ 8 & 9 — NONSTATE PUBLIC EMPLOYERS

Under existing law, the comptroller must offer nonstate public employers and their employees and retirees coverage under the state employee plan. Under the bill, the comptroller has the option instead to offer nonstate public employers coverage under another group health insurance plan, as long as that plan is not a high deductible health plan used to establish a health or medical savings account.

The bill requires premiums for nonstate public employers to be the same as those paid by the state, but also allows the comptroller to adjust them for:

1. the cost of health care in the geographic area in which a majority of the small employer's employees work, and

2. differences in network and benefits as compared to those offered to state employees.

It also eliminates the state employee plan premium account, into which premiums paid by nonstate public employees are deposited, and certain associated requirements and instead requires the comptroller to establish accounting procedures to track claims and premium payments from nonstate public employers.

The bill also eliminates a requirement that the comptroller develops procedures by which excess premium payments may be returned if the participating nonstate public employer withdraws from coverage prior to the end of the statutorily required minimum of three years.

BACKGROUND

ERISA

ERISA, generally governs employee insurance and pension plans ("employee welfare plans"), but does not apply to, governmental plans (29 U.S.C. § 1003). A plan subject to ERISA requirements must, among other things:

1. manage plans for the exclusive benefit of participants and beneficiaries;

2. comply with limitations on certain plans' investments in employer securities and properties; and

3. report and disclose information on the operations and financial condition of plans to the government and participants.

Essential Health Benefits

Under state and federal law, "essential health benefits" are health care services and benefits that fall within the following categories:

1. ambulatory patient services;

2. emergency services;

3. hospitalization;

4. maternity and newborn health care;

5. mental health and substance use disorder services, including behavioral health treatment;

6. prescription drugs;

7. rehabilitative and habilitative services and devices;

8. laboratory services;

9. preventive and wellness services and chronic disease management; and

10. pediatric services, including oral and vision care.

Related Bills

sHB 7339, favorably reported by the Human Services Committee, creates a working group to study a public option for individuals with income below 400% federal poverty level.

SB 1004, favorably reported by the Labor and Public Employees Committee, requires the comptroller to procure and provide health insurance coverage to small employers under the state employee health insurance law.

sHB 7267, favorably reported by the Insurance and Real Estate Committee, is identical to this bill.

HB 7360, reported favorably by the Planning and Development Committee, similarly expands the types of health care plans that the comptroller must offer to nonstate public employers.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 8 (03/19/2019)